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Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O God our rock, forgive us for deviating from Your will. Forgive us for careless work and half-finished projects. Forgive us for labors we have not yet begun because of procrastination. Forgive us for people we have hurt or disappointed. Forgive us for failing those who most need our help. Forgive us for the promises we have broken and the vows we have forgotten. Forgive the times we have disobeyed and grieved You.

Use Your lawmakers today as agents of reconciliation. Teach them to love You as You have loved them.

We pray in Your loving Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The PRESIDENT pro tempore. Under the previous order, there will be a period for the transaction of morning business for up to 60 minutes, with the first half of the time under the control of the majority leader or his designee and the second half of the time under the control of the Democratic leader or his designee.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning we have set aside the first hour for a period of morning business to allow Senators to speak. Following that time, we will begin consideration of the small business health plans bill. Yesterday we invoked cloture on the motion to proceed and last night we reached the agreement to begin the bill this morning.

Chairman ENZI will be here to speak with Members about their amendments. We hope we can consider amendments related to the bill throughout today's session, and therefore I expect votes today. I ask Senators who have relevant amendments to come to the floor to speak to the two managers to see if they can reach an agreement to debate those amendments.

In addition, we have the Tax Relief Act conference report that was filed in the House yesterday. We will consider that conference report this week once it arrives from the House.

SMALL BUSINESS HEALTH PLANS

Mr. FRIST. Mr. President, I want to take this opportunity to paint the larger picture of why the small business health plans are so important to our Nation, to everyday Americans, and to the 46 million people who do not have health insurance today, and how it affects the cost of health care and thus the quality and access to health care.

Much of the discussion that has gone on and that will go on as we proceed with this bill centers on the fact that America is facing a health insurance crisis. It centers on the fact that health care premiums are growing. They are growing faster than individuals' wages or income, and this growing cost—skyrocketing cost—of premiums translates into a significant portion of the 46 million people who don't have insurance today—solely because of the price of the premiums of health insurance. I do think—in fact, I know—that is unacceptable in a country that is as prosperous as ours.

The medical impact and the impact on quality of life and life itself is embodied in the statistic that the Institute of Medicine reported in the fact that 18,000 Americans die prematurely each year because they don't have health insurance. A lot of people say why, because you eventually can get into a hospital, but it boils down to the fact that if you have some health insurance—just some health insurance—you do better than if you don't have health insurance. People can still go to emergency rooms whether they have health insurance, but entry into our system is much easier if you have health insurance.

So this is a big problem that troubles me as a Senator and as a physician, and it troubles and should trouble every American. That is why we are on this issue today.

About 60 percent of uninsured employees today work for small businesses. Unfortunately, these skyrocketing health insurance costs, coupled with very complicated State regulations, are pricing small businesses out of the health insurance market. They simply can't afford to buy insurance and to offer that insurance to their employees.

We hear a lot of statistics on the floor, we have already heard a lot, and you will hear them continually over the next couple of days as we address this issue. In the past 5 years, the cost of health insurance to companies has nearly doubled from roughly $4,200 per family—almost double—to $8,100. In 2005 alone, health care costs rose three times faster than inflation, and even faster for many small businesses. Consequently, the small firms, the small

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

businesses are the ones that are hit the hardest.

Many of them are operating on a very narrow margin already. They have had to cut benefits and, in many cases, eliminate coverage altogether for their employees. Some of them have been forced to lay off workers because of the cost of health care. They simply can't sustain it; it eats into their profits and they can't stay in business. So it is no wonder that small businesses across America have said to us and have made it known that access to affordable health care is their No. 1 concern: access to affordable health care.

That is what this small business health insurance debate is all about. It is the guts, the thrust of the bill on the floor today. Small business owners want to take care of their employees and their families. They want to do everything they possibly can. Most small businesses are family affiliated, many of them family run, but it is becoming impossible to do in the face of increases that are so far greater than any margins they have, these double-digit increases in health insurance every year.

One survey reports that only 41 percent of firms with 9 employees or less can afford to offer health benefits, compared to 99 percent of large firms. That hurts the ability of small businesses to attract capable workers, to stay in business, to stay competitive in the larger marketplace. Unfortunately, the system is broken and small businesses are caught. They are stuck.

Eighteen hundred State mandates are choking the ability of the private sector to offer affordable choices, reasonable choices. We have to cut out the redtape. We have to streamline the process itself. We have to get rid of the waste and abuse in the system.

We all know that small businesses are the engine of economic growth in our economy. These small businesses are where innovation occurs and these innovators create 60 to 80 percent of all new jobs nationwide. They generate more than 50 percent of the gross domestic product. In my home State of Tennessee, 97 percent of all businesses are small businesses. This aspect of affordable health care is their No. 1 concern.

It makes sense that if we want to expand health care coverage, if we want to diminish the number of uninsured, we need to start to at least make a major advance in an area where we know we can make a difference, and that is where the jobs are. That is why the Enzi-Nelson-Burns small business health insurance bill that we bring to the floor and will formally open debate on here in about an hour is so important.

I want to applaud Chairman ENZI for his tremendous work to pull people together on both sides of the aisle to address these issues. This bill represents the first real, major, solid step to end the small business health plan stalemate that has characterized this body in over a decade. Its purpose is to deliver meaningful reform for millions of Americans employed in the small business sector.

Under this plan, small business firms would be able to combine their negotiating power and to group that negotiating power in a way that purchasing clout can be used to purchase more affordable plans. By allowing that to happen, they could reduce the cost of health insurance by as much as $1,000 per employee, while reducing the number of uninsured, people who are uninsured today, by more than 1 million. The CBO recently estimated the Enzi-Nelson-Burns plan would increase Federal revenue by $3.3 billion between 2007 and 2016, while saving States an estimated $600 million in Medicaid spending during the same period.

I know this is a very important bill. I am delighted that we will begin on this bill in an hour, or a little over an hour from now. It will be a substantive debate and will go right to the heart of a major problem facing this country, and that is the uninsured. It will address the issues of cost, access, and quality. I encourage Members on both sides of the aisle to participate in this debate, to stay on the issues—we are talking about small business health reform—to not bring in extraneous issues, and with that pass a very important and substantive bill for the American people.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The Democratic leader is recognized.

HEALTH CARE REFORM

Mr. REID. Mr. President, the problem with the Enzi bill is laid out in great detail in a report filed by the minority of the HELP Committee. This is not a question of my not liking the bill, it is not a question of Democrats versus Republicans, it is a question of the bill not being good. It is not a good bill, as indicated by 41 attorneys general. Forty-one attorneys general have signed letters saying the Enzi bill is not good for their States. These attorneys general are from Democratic States and Republican States. Insurance commissioners from around the country have acknowledged that the bill is not a good bill. The bill is opposed by 206 different advocacy groups and health care organizations, disability groups, and professional organizations.

For example, we know that the American Association of Retired People opposes this legislation. I was able to speak to Mr. Novelli a couple of times about this bill while it was moving through the system, and AARP believes the bill is very hurtful to senior citizens, as well as the Small Business Majority, the National Health Council, and the Lance Armstrong Foundation. As I said, more than 200 different organizations think this legislation is bad for the American people.

I have been led to believe that when this bill is brought to the floor, the 30 hours doesn't expire postcloture on the motion to proceed until sometime this afternoon. We have agreed to go to the bill at an earlier time. But it is not going to give the people in our country the opportunity to move forward on progressive, strong legislation. We will be stuck with the Enzi bill, and AARP doesn't think it is going to go anyplace. The amendments will be controlled by Senator ENZI. If he likes the amendment, he will allow us to offer it. If he doesn't, he won't. I submit that is not the way we should move forward on legislation brought forward during Health Care Week dealing with health care reform.

There are many issues related to health care we need to deal with. There are issues that are so fundamental to what is going on in the country today, and we believe the proposal put forward by Senator LINCOLN from Arkansas, the ranking member of the Finance Committee, Senator BAUCUS, and of course a person who has worked very hard on this legislation for months, Senator DURBIN, should be the legislation we debate. But it will not be. We should have the opportunity to offer amendments relating to postponing the May 15 cutoff line of the eligibility for Medicare drug benefits. That is not going to be allowed.

We should be able to offer legislation dealing with the ability of Medicare to be competitive and bid for drugs at a lower price. That won't be able to be offered.

We should be able to offer an amendment dealing with stem cell research, giving hope to millions of Americans. We won't be able to do that. That is unfortunate.

Walking into the Chamber today, I was asked by someone: Tell us what you stand for. I think, rather than what I stand for, what we stand for as a minority, it is who we stand for. I think that is the direction we should be focusing: Who do we stand for?

There are lots of people we stand for. We stand for parents with no health care. We stand for those people with maladies who are crying out for some research on stem cells so we can move forward finding cures for these diseases—Alzheimer's, Parkinson's, diabetes.

We stand for children who are attending failing schools because the Bush administration refuses to put money into the schools that needs it. It is reported today that very soon there will be 10,000 schools in America that will be failing. I don't think that speaks well. Why are they failing? It is because of this Leave No Child Behind Act that the President pushed so hard.

We stand for the soccer mom who, today, someplace, is going to fill up her vehicle with gasoline and find the price is prohibitive. Rather than filling up her tank, she will fill it half full,

enough to get through maybe the rest of this week, because the cost of gasoline is so high.

We stand for the high school graduates putting off being able to go to college because they simply can't afford the tuition. During the last 5½ years of this administration, college costs have gone up 40 percent. Student aid has been cut. Pell grants have been cut.

We stand for the guardsman who is concerned because he has been called back for the second tour of duty in Iraq. Reading the Washington Post today, I find that two Nevada soldiers were killed in Iraq yesterday, both from Las Vegas, a 46-year-old man and a 26-year-old man—killed yesterday.

We stand for the grandparents who are concerned about the debt this country is accumulating, recognizing their grandchildren will be forced to pay this debt. How big is the debt? During the 5½ years President Bush has been President, the national debt has almost doubled, now approaching $10 trillion. We just raised the debt ceiling to $9 trillion, and through some shuffling in the Republican-dominated House they have, in the last few days, raised that to $10 trillion.

We stand for senior citizens who are unable to have the proper medicine to take care of themselves.

The part that is so concerning is that we are doing nothing in this Congress to address the issues. There are editorials running around the country today talking about the majority, the Republicans, not raising issues of any kind because the debate is one they know they can't win. We need to be focusing on the high cost of energy and high cost of education. We need to focus on global warming, and we are not. It is being ignored because in the minds in the White House, it doesn't exist. We need to focus on this staggering debt. Remember, during the last 3 years of the Clinton administration, we paid down the debt. We were spending less money than we were taking in. That is certainly not the case now.

We are going to have a so-called debate on health care this week, but it is a so-called debate. It is really not a debate because we are being prohibited from offering amendments of significance. We are going to be forced to focus only on the Enzi legislation, which is a flawed bill. It is so flawed that it took the minority in the HELP Committee about 250 pages to outline the problems with this legislation. Usually minority reports are very short. This one is not. It is not because the consequences of the Enzi bill are so significant. This report looks at every State and indicates how every State is hurt as a result of the Enzi legislation.

I look forward to maybe a change of heart. Maybe there will be the ability for us to offer amendments. That doesn't appear to be the case. I hope that it is the case, that we will be allowed to offer amendments. That is the way we should deal with Health Care Week and not be stymied at offering amendments to this legislation, amendments that would really help—help those people who need help, not only with the hope of curing dread diseases but with the hope of 46 million people in America who have no health insurance, the senior citizens who hope they will be able to get prescription drugs at a lower rate, but because of the Medicare bill passed by this Republican-dominated town, Medicare cannot even negotiate for lower prices. They have to go to Rite Aid and buy their drugs like everyone else. HMOs can negotiate to lower prices because the legislation was directed toward managed care, not those Medicare recipients who badly need help.

MORNING BUSINESS

The PRESIDENT pro tempore. There is now 30 minutes under the control of the majority leader or his designee.

Who yields time?

The Senator from Idaho.

Mr. CRAIG. Mr. President, are we in morning business?

The PRESIDENT pro tempore. We are now in morning business for 30 minutes under the control of the majority leader or his designee.

Mr. CRAIG. I ask unanimous consent to speak for 10 minutes.

The PRESIDENT pro tempore. Without objection, it is so ordered.

ENERGY

Mr. CRAIG. Mr. President, I come on the heels of the minority leader speaking about or at least attempting to define what he and his party believe in. I watched him struggle this morning to try to shape what they are versus what we are, and that is really what we heard discussed a few moments ago. But he kept going back to the issue of high energy costs and the soccer moms and their inability to fill their gas tanks today. So I am going to focus on that part of what he struggled to define this morning and speak to the realities that are out there and what has transpired over the last several decades as it relates to the inability of this country to produce energy and why that inability exists.

A couple of weeks ago, I came to the Senate floor to inform this Senate and awaken America to the reality that just 50 miles off the coast of Florida, China is drilling for oil—Not the United States but China. And the reason China is drilling for oil is that we have prohibited our own companies from the opportunity to drill in the northern Cuban zone, so that Cuba is now leasing out to other countries in the world except the United States.

Then I watched a rush to judgment on the other side as there was a flurry to say not only do we have to stop Cuba, we dare not let America, American companies, experts in deepwater drilling, experts in environmental soundness, ever drill in that region.

Today I wish to expand on that idea. I wish to talk about why America is in trouble today with energy and why that soccer mom is paying more at the gas pump today than she ever has. The answer is really right here. It happened right here in the Senate over the last several decades, starting in 1950.

From the 1800s to 1950, we were energy independent. We were the great producer of oil. But as folks came home from World War II and as our economy began to expand, we began to use more oil. Then, starting in the 1960s and 1970s, we began to say about oil: We need it, but we can't drill here and we can't drill there and we will drill elsewhere.

Here is our problem today, so clearly defined in a supply and demand environment in which we have become 60 percent dependent upon foreign countries to produce our energy for us. America now knows that. Two weeks ago, we watched the other side blame and blame again somebody, including this administration, for a failure to produce. But they failed to tell you what they had not done, had denied over the last two or three decades.

I went to the White House during the Clinton years and asked President Clinton to work with us, to floor what we call marginal wells in west Texas and Oklahoma so they could continue to produce. Why? Because oil was below $18 a barrel and there was no economy there. They couldn't make money and they were shutting the wells in. We said: Let's floor it and keep them producing.

We couldn't do it because of the politics of that Democratic administration. What happened? Those wells went off line. They were filled with concrete, and they stopped producing what would be a million barrels of oil a day into this market right now. So to the American consumer who is paying those high gas prices, you are lacking a million barrels a day into our markets by a Democratic administration that denied its happening. Darn it, that is a fact. That is reality.

What transpired during that other time? Let's go on to the next chart that talks about our failure to get certain things happening. The Presiding Officer knows all about ANWR. He knows all about Alaska and Alaskan production. It was Bill Clinton who vetoed, a decade ago, the ANWR bill which would have put upwards of 10 billion barrels into the market at about a million barrels a day. Let's do the math now. We shut in a million barrels a day in Texas and Oklahoma because of the politics of that administration, and then they vetoed ANWR at 10 billion or a million a day. That is 2 million barrels a day to which they said no. So the answer to the minority leader as to why the soccer moms are paying the highest price ever today for gas is quite simple. It is because they said no. They said no to stripper wells, they said no to ANWR.

Now let's talk about the rest of the story because what I am interested in

is the reality of the ''no'' politics, the ''no'' production, the ''no'' refinement. That is the answer to our problem today. You saw it on the last chart, the chart of supply and demand and 60 percent dependency on foreign sources. We cannot even drill in our own hemisphere.

Then let's go to this map. I call it the no zone. Why is it called the no zone? Because you can't drill here and you can't drill here and you won't drill here and you can't drill here. Why? American politics today. It is the no-drill zone.

If we could drill in the no-drill zone, it is possible that we could find, through U.S. geological surveys already under way, 115 billion barrels of oil and a phenomenal amount of gas. But the answer is no. Who said no? They said no. Republicans didn't say no.

Let me talk about that for just a moment. President Bush comes to town. We meet over here in the leader's office. He says: My first priority is to allow the Vice President to assemble a group of the experts and put together a national energy policy. We have to get this country back into production. He said that as his first initiative. Five years later, after they kept saying no, last August we got a bill. We are beginning to produce. But this is still all ''no.'' Mr. President, 115 billion barrels are outside the reach of the American consumer today, even though our technology is the best in the world and even though, after the worst natural disaster ever, we proved ourselves out in the gulf. In this little clean area right over here where we have not said no—at least the States of Texas and Louisiana didn't say no—we found out that wells went off line, rigs got blown off their foundations, but no oil was spilled. Why? Because of the phenomenal technology today and because of environmental rules and regulations that we have asked for and demanded compliance and received it from the major oil companies that drill in deepwater and the Outer Continental Shelf.

The reason I bring these issues today is quite simple: We have to quit saying no. The other side can demogog and they can try to blame, but the reality is here. The facts are here.

Let's run down the rest of the chart. We have said no to ANWR, no to OCS, no to 181 leasing, no drilling in the northern Cuba zone—at least American companies—while China drills in our backyard. American consumers need to know that the answer to their problem is not no. It is, yes, we can produce and, yes, we ought to produce and, yes, we ought to be energy independent and, yes, it ought to happen in our hemisphere, and, yes, we ought to be less dependent on foreign oil.

If we put all of those things together, America can be independent today. But you are not independent by saying no. And the answer has been no, no, no, no. That is why we ought to talk about the ''no zone'' and the naysayers and the minority who have said no for so long.

Reality is at hand. The American consumer is being squeezed at the gas pump like never before, and the answer still remains no. Americans are demanding that this be resolved. We are rushing to new production in all kinds of alternatives, but you do not get away by denying the obvious.

The PRESIDING OFFICER (Mr. MARTINEZ). The Senator's time has expired.

Mr. CRAIG. I thank the leader for that time.

I will conclude by simply saying 115 billion barrels of oil are denied because somebody—and it was over here—said no, and now we enter the ''no zone.'' Americans do not believe it. Americans are going to demand a change, and we ought to be able to deliver.

I yield the floor.

Mr. NELSON of Florida. Will the Senator yield for a question?

The PRESIDING OFFICER. The Senator has no time to yield for a question.

Mr. NELSON of Florida. I thank the Presiding Officer. I will raise the questions in a speech later on. I thank the Chair.

Mr. WARNER. Mr. President, we want to accommodate colloques. If the request is to be asked and granted by the Chair, then I suggest the morning business hour for the Republican side be extended 10 minutes to accommodate that.

The PRESIDING OFFICER. Is there objection?

Mr. WARNER. How much time does the Senator require?

Mr. NELSON of Florida. I am not going to request time.

Mr. WARNER. Mr. President, at this time I seek the concurrence of the Presiding Officer to speak about 12 to 14 minutes regarding General Hayden.

The PRESIDING OFFICER. Without objection, it is so ordered.

APPOINTMENT OF MICHAEL HAYDEN

Mr. WARNER. I have known this fine officer for some time. I worked with him, and I'm very pleased that the President of the United States has asked the Senate for its advice and consent on this important nomination.

Mr. President, our Nation is at war on two main battlefields—Iraq and Afghanistan. The national security apparatus of our country centers around the White House, the National, Security Council there, the Secretary of State, the Secretary of Defense, the Secretary of Homeland Security and, most importantly, the new organization headed by John Negroponte, our national intelligence community.

It is imperative that this Nation receive as early as possible the replacement for Porter Goss to take over his position with the Central Intelligence Agency, and I hope that the hearings, which I believe will be scheduled, subject to Chairman Robert's views, early next week. Early next week there will be a very thorough investigation of this officer, and we, the Senate as a body, can conform General Hayden and move forward. This Senator, the Senator from Virginia, will give him the strongest support and as an ex officio member of the Intelligence Committee, I will participate in those hearings.

Before turning to General Hayden, though, I would like to say a few words about Porter Goss. Mr. President, I am privileged to know this fine public servant who, presumably, is going to step down here shortly and conclude, perhaps, maybe not, maybe another assignment some day, but he certainly has had a distinguished public record of service. He was at the CIA himself, and served thereafter in the Congress. That is when I first came to know him.

The Presiding Officer may recall that there was a time here, a dozen or so years ago, when, I remember, our good friend, Senator MOYNIHAN from New York, said, it is time to re-examine the CIA, and possibly abolish it. Well, I and others came to the forefront and did what we could to begin to put that debate into balance. And we successfully put in a bill, and Porter Goss in the other body put in a similar bill, to establish a commission to review the origins of the CIA, and see how it was an integral part of our intelligence system.

The late Les Aspen, the former Secretary of Defense, was the first chairman of that commission. He had an untimely death, and was succeed in that position by former Secretary of Defense Harold Brown, at that time also having finished his work in the Department of Defense. The Commission did an excellent job. I just point that out as a reference in history of how hard Porter Goss has fought throughout his career to preserve the integrity and the viability of the Central Intelligence Agency.

Now, we do not know, many of us, all the facts regarding this transition of positions. I personally hope to visit with Mr. Goss, and will do so prior to the hearings, so that I can understand his perspective more fully. But he did a lot of valuable work at that agency, notably he began to restore the focus of the agency to its principle function as it was established some 50 years ago, and that is the collection of human intelligence. So I say to Porter Goss, well done. And I say to General Hayden, you fill the shoes of a very able man, but you have a challenge of your own.

Now, there are several issues that have been brought up by the general's nomination, and I would like to address those issues. First, there is a question of surveillance. As the head of the NSA, the National Security Agency, General Hayden was in the business of collecting electronic signals from around the world, from emissions abroad. We will go into that very thoroughly during the course of the hearings. I think that debate I appropriate. But I wish to point out that a very important debate has proceeded on that

issue on the Senate floor. It will continue for some time. And that is a debate over the legal ramifications, in other words, what are the origins of the power of the President to have directed this type of collection?

I do believe that you can separate the collection, really, into two parts. One, the value of the collected intelligence from abroad as a contribution to our overall security. We have established now, here in the Senate, a larger committee that is looking into that, and I am confident that there will be a unanimous view that the collection of this intelligence, thus far, has been an important contribution to this Nation's effort in the war on terrorism.

The other question, equally important, is the question of legality. Now, let me make it clear. In my visit with General Hayden yesterday, I said to him, ''You're not a lawyer.'' He said, ''No, I'm not a lawyer . . . I, General Hayden, when instructed to initiate this program, carefully assessed all variety of legal opinions, and it was clear by those contributing the legal opinions, the Attorney General, the White House Counsel, and others, that I had the authority to do so. As a non-lawyer, I accepted their opinions, like all of us do every day in life, I accepted the opinions of our counsel, whether it be in private or public life.''

So I believe that the Intelligence committee, as it sorts that out, will eventually find that, while we may not resolve—and I doubt in the context of this nomination we will in fact resolve—the very important questions of the legalities of this program, we will decide that General Hayden acted in accordance with prudence, and was guided by appropriate counsel. So I believe that that issue will not be an impediment to his nomination.

Next is a question of the fact that this distinguished officer has risen through the ranks to become a four-star general. I have been privileged, I say with a sense of humility, to work with the uniformed people of this country for close to a half a century, in one way or another. I had a very modest military career of my own, but particularly when I was Secretary of the Navy, I had the opportunity work with and assess the biographies and the careers of many officers with worked their way from the lowest ranks up to four-star ranked general and flag rank in the Navy and Marine Corps.

Now, I certainly say to the people of this country, that an individual who can withstand all of the rigor, all of the competition, to come from the very bottom to the very top is one who has been screened and thoroughly reviewed by many peer groups. And how proud this officer is to have succeeded to have gained four-star rank. I do not personally have any trouble with his retaining that rank in this capacity, if confirmed by the Senate to lead the CIA. The question is raised, though, legitimately. It should be a civilian running our intelligence. But my distinguished colleagues, I say to you, it is a civilian that runs the intelligence community: John Negroponte. He is now the top individual in charge of this magnificent intelligence system that this country has.

Yesterday, I visited with Secretary Rumsfeld on this issue on several occasions by phone, and he spoke publicly to the issue, as well. He endorses General Hayden. He said, General Hayden will report directly to John Negroponte, the head of the overall intelligence community. And in no way does Secretary Rumsfeld feel that the fact that General Hayden continues to wear this uniform should there be any impediment in the chain of command, or in the responsibilities or the direction that this officer will give to his responsibilities. So, again, I believe that issue will be resolved in the committee hearings.

In the work of the Intelligence Committee to review the credentials, the integrity, the character of this individual, I am confident that he will meet the highest standards of the office which he aspires to take over at the direction of the President. So that will be behind us.

Finally, I would like to say a little bit about the Central Intelligence Agency itself. It is in Virginia, and I am privileged, as a current Virginia Senator, as have my predecessors, to give a little special attention, to that Agency. When the new structure of the intelligence community was devised here on the floor, I was active in the debate, and I think, if I can say with some modesty, helped to preserve more and more of the functions of that agency which I felt should remain in that agency, and the CIA has survived that legislation, I believe, quite well.

There is still more to be done in finally convincing various persons, distinguished individuals in that Agency, that this is the way it is under the law, and this is the way we have got to conduct our business in the future. General Hayden can do that. He did it at NSA. He made a transformation of the thought process over there, and likewise he can do it here.

But it is interesting: who would be his deputy? Well, we don't know entirely for sure, but I would like to read part of a column in today's Washington Post by David Ignatius. I happen to know him. His father, coincidentally, was Secretary of the Navy just before the late Senator CHAFEE and joined that Secretariat. And he is an author of some distinction.

He points out that the current thinking, and I believe it to be correct, is that the transition in the CIA would be painful for General Hayden, I read from his article, but he's got a good choice for the second person in Mr. Stephen Kappes. And it is interesting about Mr. Kappes' career. I would like to read just a part of the column.

At the core of the intelligence puzzle is the CIA, whose very name is outdated. It is no longer the Central Intelligence Agency, coordinating the work of the community. That's the DNI's job now. In a sensible reorganization, the CIA should refocus on the specific mission for which it was created more than 50 years ago—gathering HUMINT, which is intelligence jargon for the secrets between someone's ears. The days when the CIA could be all things to all intelligence consumers are over. Today's CIA should be a truly secret intelligence service in which the job of analysts is to target operations. The all-source analysis that creates finished intelligence should be managed by the DNI.

Making this transition at the CIA will be painful, and Hayden is a good choice for the necessary surgery. As a feisty military officer, he's paradoxically the right person to fend off poaching by the Pentagon. By his own admission, Hayden doesn't know much about the CIA's operational work, but he does know how to modernize a big, hidebound bureaucracy. He did that at the National Security Agency—helping the wiretappers adapt to a new world of e-mail, fiber-optic cables and wireless phones. He made enemies at the NSA, but he was a successful change agent.

Hayden will have the ideal partner in Stephen Kappes, who is slated to be deputy director. Kappes is something of a legend at the agency: a charismatic ex-Marine who knows how to lead from the front. He punched all the tickets—fixing a broken Iranian operations group that had lost a string of agents, serving as chief of station in Moscow and as head of counterintelligence, and visiting Moammar Gaddafi and persuading him to give up his nuclear weapons program. Kappes' pitch to the Libyan leader is said to have been blunt, and irresistible: ''You are the drowning man and I am the lifeguard.''

And on it goes. It points out very carefully that in the eyes of the professionals at the Agency, this gentleman, Mr. Kappes, is a man of impeccable credential, one who resigned from the Agency rather than fire his deputy, and that is to his everlasting credit.

So I believe the morale at the Agency will be raised, Mr. President. It is a magnificent group of professionals. Our Nation should take pride in the quality of persons who fortunately are selected to serve in the CIA for generations. And I am proud and humbled to have a voice in representing so many of the officers at the CIA, who are my constituents. But I do so in knowing that this Agency is essential to our intelligence operations. This new leadership team of General Hayden and Mr. Kappes will take over and provide the strong direction that is needed to even strengthen the Agency, and to the extent that there has been any diminution in morale, I am confident this team will raise in a very short period of time.

Mr. President, I ask unanimous consent to have printed in the RECORD the full column from David Ignatius, and an excerpt from the official biography of General Hayden.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Washington Post, May 10, 2006]

THE CIA'S MISSION POSSIBLE

(By David Ignatius)

Firing Porter Goss was the easy part. The challenge now is to complete the reorganization of U.S. intelligence so that the 16 spy agencies under Director of National Intelligence John Negroponte are fighting America's enemies rather than battling each other in bureaucratic turf wars.

But how to fit the pieces together? That's the quandary for Negroponte and Gen. Michael Hayden, the administration's nominee to succeed the miscast Goss. I suggest they take a careful look at the British model. The Brits have a basic division of labor: a small, elite Secret Intelligence Service (known as MI6) collects human intelligence; an interagency group known as the Joint Intelligence Committee analyzes that information for policymakers and tells the spies what to collect. When I look at Negroponte's organization chart, that's the model that I hope is emerging. If so, he's moving in the right direction.

At the core of the intelligence puzzle is the CIA, whose very name is outdated. It is no longer the Central Intelligence Agency, coordinating the work of the community. That's the DNI's job now. In a sensible reorganization, the CIA should refocus on the specific mission for which it was created more than 50 years ago—gathering HUMINT, which is intelligence jargon for the secrets between someone's ears. The days when the CIA could be all things to all intelligence consumers are over. Today's CIA should be a truly secret intelligence service in which the job of analysts is to target operations. The all-source analysis that creates finished intelligence should be managed by the DNI.

Making this transition at the CIA will be painful, and Hayden is a good choice for the necessary surgery. As a feisty military officer, he's paradoxically the right person to fend off poaching by the Pentagon. By his own admission, Hayden doesn't know much about the CIA's operational work, but he does know how to modernize a big, hidebound bureaucracy. He did that at the National Security Agency—helping the wiretappers adapt to a new world of e-mail, fiberoptic cables and wireless phones. He made enemies at the NSA, but he was a successful change agent.

Hayden will have the ideal partner in Stephen Kappes, who is slated to be deputy director. Kappes is something of a legend at the agency: a charismatic ex-Marine who knows how to lead from the front. He punched all the tickets—fixing a broken Iranian operations group that had lost a string of agents, serving as chief of station in Moscow and as head of counterintelligence, and visiting Moammar Gaddafi and persuading him to give up his nuclear weapons program. Kappes's pitch to the Libyan leader is said to have been blunt, and irresistible: You are the drowning man and I am the lifeguard.

Kappes is the CIA version of the ultimate stand-up guy. After achieving his dream of heading the Directorate of Operations, Kappes walked away from the job in late 2004 rather than fire his deputy, Mike Sulick, as demanded by one of the conservative hatchet men Goss had brought with him from Capitol Hill. A former agency officer remembers the reaction to Kappes's departure: ''It was a devastating body blow, like someone has punched you in the solar plexus. The wind came out of the sails that day and it has never come back.''

Kappes had a plan for reorganizing the Directorate of Operations when he left, and he's in a position to implement it now. It's said that he wants to create a far more nimble spy service—one that can attack terrorist groups and other targets around the world more aggressively. Today the CIA is still locked in a Cold War structure, with the same fixed array of directorates and geographical divisions. The agency is frantically hiring new case officers, but under the old structure there aren't ''OCPs'' (or overseas covered positions) ready for them, so many of the young recruits languish, ''stacked up at headquarters like cordwood'' in the phrase of one CIA insider.

CIA veterans say Kappes hopes to create an operations capability that's more like a flying squad—detached from headquarters and its layers of bureaucracy. If an al-Qaeda call surfaces on a remote island in the Philippines where the United States doesn't have an embassy or consulate, officers from Kappes's revamped spy service could grab a laptop and be on their way in hours.

Maybe it's time to say goodbye to those three spooky initials ''CIA'' and the bloated, barnacle-encrusted agency they represent. Let Negroponte move his shop to Langley and create a new elite analytical service there. Meanwhile, let the covert operatives slip away in the night to destinations unknown, where they can get to work stealing the secrets that will keep America safe.

BIOGRAPHY OF

U.S. AIR FORCE GENERAL MICHAEL V. HAYDEN

Gen. Michael V. Hayden is Principal Deputy Director of National Intelligence, Washington, D.C. Appointed by President George W. Bush, he is the first person to serve in this position. General Hayden is responsible for overseeing the day-to-day activities of the national intelligence program. He is the highest-ranking military intelligence officer in the armed forces.

General Hayden entered active duty in 1969 after earning a bachelor's degree in history in 1967 and a master's degree in modern American history in 1969, both from Duquesne University. He is a distinguished graduate of the university's ROTC program. General Hayden has served as Commander of the Air Intelligence Agency and as Director of the Joint Command and Control Warfare Center. He has been assigned to senior staff positions at the Pentagon, Headquarters U.S. European Command, National Security Council and the U.S. Embassy in the People's Republic of Bulgaria. The general has also served as Deputy Chief of Staff, United Nations Command and U.S. Forces Korea, Yongsan Army Garrison, South Korea. Prior to his current assignment, General Hayden was Director, National Security Agency, and Chief, Central Security Service, Fort George G. Meade, Md.

EDUCATION

1967 Bachelor of Arts degree in history, Duquesne University, Pittsburgh, Pa., 1969 Master's degree in modern American history, Duquesne University, 1975 Academic Instructor School, Maxwell Air Force Base, Ala., 1976 Squadron Officer School, Maxwell AFB, Ala., 1978 Air Command and Staff College, Maxwell AFB, Ala., 1980 Defense Intelligence School, Defense Intelligence Agency, Bolling AFB, D.C,, 1983 Armed Forces Staff College, Norfolk, Va., 1983 Air War College, Maxwell AFB, Ala.

Mr. WARNER. I yield the floor.

The PRESIDING OFFICER (Mr. DEMINT). The Senator from Tennessee.

Mr. ALEXANDER. How much time remains?

The PRESIDING OFFICER. Five minutes.

ENGLISH UNITES

Mr. ALEXANDER. Mr. President, on Monday night, with unanimous support, the Senate passed resolution No. 458 that I sponsored, along with 12 other Senators, affirming that the Pledge of Allegiance and the National Anthem be said or sung in the language that unites us as one Nation, that language being English.

This was more than bipartisan. It was unanimous, with one dissent expressed on the other side. It should be virtually unanimous.

This is the land of immigrants. Almost all Americans know we need and must value our common language, which is English. Yet during the last week, the idea of a non-binding resolution expressing the Senate's thought that whenever we say the Pledge of Allegiance, sing the Star-Spangled Banner, take the oath of citizenship, that it ought to be in our common language, produced quite a little storm across the country. Some said we were restricting liberty.

But this not about what we are free to do; this is about what we ought to do at the opening of the Senate, at the opening of a ball game or Boy or Girl Scout troop meeting. As Americans, we are free to sing the Star-Spangled Banner in Swahili, we are free to say the Pledge of Allegiance in pig Latin, but that is not what we ought to do. And the Senate, by unanimous consent, said that on Monday night.

Some said this was disrespect for other languages. Nothing could be further from the truth. I believe our official documents ought to be in our common language. I have always favored, including when I was Education Secretary of this country, what I call ''English plus.'' The luckiest among us are those who know more than one language, but one of those must be English. Children should learn it as quickly as possible if they want to succeed in the United States of America.

The real reason for the storm of reaction to the singing of the Star-Spangled Banner in a foreign language is that most Americans instinctively understand that while diversity is important, unity is more precious. That is why we pledge allegiance to the American flag rather than the flags of the countries from which our ancestors came. That is why most of our politics is about principles upon which we agree, principles found in our founding documents. That is why we give rights to individuals instead of to groups. That is why we honor our common language, English.

In Sunday's Washington Post, a Chilean-American playwright, a professor at Duke, said our country is well on its way to becoming a bilingual nation and that he thought we would endure just fine. I respectfully disagree. I think it would make it harder for us to endure. I think it would make us more a United Nations than the United States of America.

Now the Senate unanimously agrees. So does the mayor of Los Angeles, an

Hispanic American. Antonio Villaraigosa said:

I was offended by the idea of a national anthem in another language because for me the national anthem is something that deserves respect. Without question the vast majority of people in the United States were offended, as well. Our anthem should be spoken English.

So says New Mexico Governor Bill Richardson, a Hispanic American, who said on the ''CBS Early Show'' last week:

I agree. The national anthem should be in English. Most immigrants want to become American. They want to learn English. They want to be part of the American mainstream.

Twelve cosponsoring Senators agree. Many Democrats in the House of Representatives have joined as cosponsors. Senator CONRAD from North Dakota spoke on this in the Senate last week and said:

A common language is absolutely essential to our Nation. I look to our neighbors to the north [meaning Canada] and see incredible traumas they have been through because they are speaking in two different languages. My own strong belief is we ought to say the pledge in English and sing the national anthem in English.

Ramon Cisneros, the publisher of a Spanish language newspaper in Nashville, e-mailed me:

Thank you for the resolution. Our common language as Americans is and will always be English. Our national symbol should always be said and sung in English.

We have worked hard to make English our common language, creating common schools, requiring new citizens to learn English to the eighth grade level. The Senate last week passed grants to help prospective citizens learn English. We welcome legal immigrants to this country. But we expect they will become American, that they will learn our common language, English, that they will learn our history, that they will subscribe to our values as found in the Declaration of Independence and Constitution, and when they became citizens, they will renounce allegiance to their former government and swear allegiance to our laws and Constitution. That is what holds us together as the United States of America.

So I am glad, in conclusion, that as the Senate stood together for our economic identity as Americans, it did it unanimously and passed our resolution affirming that statements of national unity, including the Pledge of Allegiance and the national anthem, should be said or sung in our common language, English.

The PRESIDING OFFICER. The Senator from Hawaii.

NATIVE HAWAIIAN GOVERNMENT ACT OF 2005

Mr. AKAKA. Mr. President, I rise today to talk about an issue of significant importance to the people of Hawaii, S. 147, the Native Hawaiian Government Reorganization Act of 2005. While opponents of this legislation have sought to characterize this issue as a Native versus non-Native issue, I am here to tell you that there is nothing further from the truth. This bill is important to all of the people of Hawaii.

Why? It is significant because it provides a process, a structured process, for the people of Hawaii to finally address longstanding issues resulting from a dark period in Hawaii's history, the overthrow of the Kingdom of Hawaii. The people of Hawaii are multicultural and we celebrate our diversity. At the same time, we all share a common respect and desire to preserve the culture and tradition of Hawaii's indigenous peoples, Native Hawaiians.

Despite this perceived harmony, there are issues stemming from the overthrow that we have not been able to address due to apprehension over the emotions that arise when these matters are discussed. There has been no structured process. Instead, there has been fear as to what the discussion would entail, causing people to avoid the issues. Such behavior has led to high levels of anger and frustration as well as misunderstandings between Native Hawaiians and non-Native Hawaiians.

As a young child, I was discouraged from speaking Hawaiian because I was told that it would not allow me to succeed in the Western world. My parents lived through the overthrow and endured the aftermath as a time when all things Hawaiian, including language, which they both spoke fluently, hula, custom, and tradition, were viewed as negative. I, therefore, was discouraged from speaking the language and practicing Hawaiian customs and traditions. I was the youngest of eight children. I remember as a young child sneaking to listen to my parents so that I could maintain my ability to understand the Hawaiian language. My experience mirrors that of my generation of Hawaiians.

While my generation learned to accept what was ingrained into us by our parents, my children have had the advantage of growing up during the Hawaiian renaissance, a period of revival for Hawaiian language, custom, and tradition. Benefitting from this revival are my grandchildren who can speak Hawaiian and know so much more about our history.

It is this generation, however, that is growing impatient with the lack of progress in efforts to resolve longstanding issues. It is this generation that does not understand why we have not resolved these matters. It is for this generation that I have written this bill to ensure that we have a way to address these emotional issues.

There are those who have tried to say that my bill will divide the people of Hawaii. As I have just explained, my bill goes a long way to unite the people of Hawaii by providing a structured process to deal with issues that have plagued us since 1893. The misguided efforts of my colleagues who seek to delay the Senate's consideration of this bill, however, may have a divisive effect on my state.

This bill is also important to the people of Hawaii because it affirms the dealings of Congress with Native Hawaiians since Hawaii's annexation in 1898. Congress has always treated Native Hawaiians as Hawaii's indigenous peoples, and therefore, as indigenous peoples of the United States. Federal policies towards Native Hawaiians have largely mirrored those pertaining to American Indian and Alaska Natives.

Congress has enacted over 160 statutes to address the conditions of Native Hawaiians including the Native Hawaiian Health Care Improvement Act, the Native Hawaiian Education Act, and the Native Hawaiian Home Ownership Act. The programs that have been established are administered by federal agencies such as the Departments of Health and Human Services, Education, Housing and Urban Development, and Labor. As you can imagine, these programs go a long way to benefit Native Hawaiians, but they also serve as an important source of employment and income for many, many people in Hawaii, including many non-Native Hawaiians. There are many Hawaii residents whose livelihoods depend on the continuation of these programs and services.

This, colleagues, is why this bill is important to the people of Hawaii. I ask all of you to respect our efforts by voting to bring this bill to the floor for consideration and for a vote.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, under the previous order, if I might inquire, the time is allocated to this side; is that correct?

The PRESIDING OFFICER. That is correct. Twenty-two minutes remains on the minority side.

Mr. NELSON of Florida. I thank the Presiding Officer.

Mr. President, may I be recognized?

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. NELSON of Florida. Thank you, Mr. President.

HEALTH INSURANCE REFORM

Mr. NELSON of Florida. Mr. President, the underlying bill we are discussing is an attempt at a much needed reform of the health insurance system of this country.

If you wonder why there is the organization of health insurance in this country that we have, it is as a result of a historical accident. It was when all the veterans were coming home after World War II that employers, in order to get them to come and work for their company, would offer fringe benefits, one of those fringe benefits being health insurance. Therefore, a system developed in this country of organizing health insurance around an employer.

As time grew and things got more complicated, health insurance offered

by an employer that was a large employer, with hundreds and thousands of employees, could offer a cheaper rate because of the principle of insurance; that is, you take the health risk, you spread it over the most number of lives, and therefore you bring down the per-unit cost or the cost to the individual for the health insurance premium. Because in a much larger group, you have young and old, you have sick and well; instead of a group being smaller and smaller—especially if it is a mom-and-pop store that wants to insure their employees—there are not many lives over which to spread that health risk, and therefore the cost of that health insurance is going to be so much more than on a large group.

That is why we have used the Federal Employees Health Benefits Plan as an example we should try to achieve. There are approximately 9 million people in that health insurance plan. So you have 9 million people over which to spread the health risk, and therefore you can bring down the per-unit cost. You can let it be private enterprise with the individual insurance companies competing for that business. And you give the consumer the choice: do they want a ''Cadillac'' policy with a lot of bells and whistles or do they want a ''Chevrolet'' policy, which is much more pared down?

Now, that is the ideal we ought to achieve, and that is what the Enzi bill is trying to achieve. The problem is that the Enzi bill has a fatal flaw; that is, there is no regulation of the insurance companies. That is the fatal flaw.

Now, I can inform the Senate, this Senator from Florida, prior to coming to the Senate, had the privilege—and I might say the toughest job in my entire adult life of public service—to be the elected insurance commissioner of the State of Florida. And through one crisis and another, you kind of, in that crucible, start to learn something about insurance. One of the things I learned is, if insurance companies are not regulated, then, guess what, insurance companies will want to insure the lower risk—in other words, the healthier people, the younger people who are not going to get sick—and if they do insure the sicker and the older, the price is going to go up through the roof.

You need a regulator to regulate the business of insurance, to protect the interest of the public. That is why, in the 1930s, the McCarran-Ferguson Act, passed by the U.S. Congress, left to the 50 States the regulation of insurance, and that is why departments of insurance are set up in most States—most of which, by the way, have an appointed insurance commissioner; very few States have an elected insurance commissioner—and they are there for the purpose of protecting the consumers of a product which is not a luxury and has now become a necessity. In the case of health insurance, we Americans look at it as almost something that is, if not a right, clearly something that is a necessity for the good health we all want to have.

So what is wrong with the Enzi bill? I can tell you, there is not a finer Senator than Senator ENZI. There is not a finer gentleman than Senator ENZI. So as I have talked to Senator ENZI about the deficiency of his bill, the fatal flaw—the idea of pooling is great, but when insurance companies are not regulated, as is the case in his bill, what is going to happen? The price is going to get jacked up. The group is going to get smaller and smaller. It is going to get older and older. It is going to get sicker and sicker. And the insurance premiums are going to continue to go up.

So I have talked to Senator ENZI, and I have said: Let's correct this deficiency by amending it so we impose what has been the delivery of insurance in this country since the 1930s; that is, the protection of the consumers with a regulator. But guess what. Senator ENZI is under the direction of the majority leadership, and the majority leadership says, in the consideration of this bill, they will not allow it to be amended.

Now, isn't the Senate the place where deliberation is to occur? And if this Senator from Florida, on the basis of his experience for 6 years as an insurance commissioner, can point out an improvement to the bill that otherwise, if passed and went into law, would do one thing: jack the rates up—exactly the opposite that all the small businesses that are advocating for this bill want; it would have the exact opposite result, it would jack the rates up—is it not the business of the Senate to deliberate, to consider amendments, to amend, to perfect, to improve, and then, hopefully, pass a much needed piece of legislation to give small business some relief from this accident of history that started at the end of World War II with the veterans coming home, organizing insurance around an employer?

Small business has it rough because small business cannot afford the cost of the insurance.

Now, another amendment that, of course, we would like to entertain happens to do with health insurance as well. But it has to do with senior citizens' health insurance; that is, Monday, May 15, is a deadline for senior citizens signing up under the new prescription drug benefit. Increasingly, senior citizens are anxious because they have this deadline they are being forced into.

Many of them—millions of them—not the ones who have automatically gone into the new program under the new law—I am talking about senior citizens who have to make a choice, knowing they are going to be penalized if, by Monday, they choose a plan, and then, if it is the wrong plan, it cannot be changed until the end of this year. So they are stuck. Or if they do not sign up for this plan by Monday, May 15, they are going to be penalized 1 percent a month. How many months is that between May and the end of the year? Six or seven. In other words, then, when they sign up, they are going to have to pay a 6- or 7-percent penalty. That is not right. We should not do that to our seniors.

All we could do is amend this bill. OK. Do not take my position, which gives them to the end of the year. Well, let's give them 2 or 3 or 4 months before the deadline comes. But the clock is ticking, and it is ticking down to next Monday, May 15.

I yield to the Senator.

Mr. KENNEDY. Mr. President, wasn't the Senator's impression that the prescription drug program was going to be a voluntary program? And for millions of people—or for hundreds of thousands in my State—people felt it was going to be a voluntary program. They were absolutely confused. We have 45 different programs with a wide variance in copays and deductibles with individuals on a formulary one day and off a formulary another day.

I would be interested as well if the Senator would comment on the General Accounting Office's report that I thought was rather devastating in terms of the ability of the CMS to be able to communicate to seniors about their options.

As I understand what the Senator from Florida is saying, millions of Americans thought the prescription drug program was voluntary, so they did not think they really had to get involved in it. Then, they might have heard they better sign up. Now they are increasingly conscious about the penalty and, at the same time, we have a General Accounting Office report that said the ability for our seniors to understand the prescription drug program is a real mystery.

How has that played out for the people in Florida whom you represent? How have the conclusions of that General Accounting Office report played out that said people would call up and they would get misinformation on the phone? There was confusion even among those who were supposed to be doing the briefings for seniors. The degree and the extent of confusion for seniors is because of the multiplicity of programs.

I would be interested in what the Senator's experience in Florida has been.

Mr. NELSON of Florida. The distinguished Senator from Massachusetts is exactly right. In my State of Florida, being one of the States that has the highest percentage of senior citizens, indeed, they have been confused, they have been bewildered, and they have been frightened. They are confused because there are 43 plans in Florida they are trying to choose amongst. They are frightened because they know if they choose the wrong plan that maybe does not have the drug they need, they are stuck until the end of the year to make a change into another plan or they are frightened because if they are paralyzed to the point they cannot make a

decision by next Monday, then they know when they do make a decision, they are going to be penalized 6 or 7 percent on the premiums they are going to pay. Either way, they are going to get hit, through no fault of their own.

If only we would show some compassion here. As I said, as the Senator was coming to the floor, you do not have to take this Senator's position and delay it all the way to the end of the year. Why don't we get some compassion and delay it a few months so that, again, the groups that are out there that are trying to advise the seniors—one of the major concerns of the senior citizens is getting the health care they need; and prescription drugs today means so much to them, indeed, to us, as well, with regard to the quality of life we are privileged to have not compassionately extend this deadline a few months in order to give some relief?

Yet we come to the floor, we try to do that, and we are prohibited through a parliamentary procedure of filling the amendment tree so that we cannot offer these amendments, whether it be this one or the one I spoke about earlier which is to correct the deficiency of the Enzi bill and have some provision for regulation of insurance companies in health insurance.

Mr. KENNEDY. I understand the President is in his home State today. Given the track record of the administration and the mismanagement of the prescription drug program and the fact that there is genuine concern and confusion among seniors, what reason did the administration give you for not following your extremely reasonable, sound suggestion that could make a difference for seniors all over the country?

Mr. NELSON of Florida. I thank the distinguished Senator for his question. The answer is, I have asked representatives of the administration in two different committees this same question. The answer comes back, coldheartedly: We have a deadline. We have to enforce that deadline or people will not make a decision.

I understand the necessity of a deadline. The nature of human beings is that we often procrastinate. But there are compassionate exceptions that ought to be considered. This is one. Coming from a State, as I do, with a high percentage of our population made up of senior citizens, this certainly ought to be a compassionate exception.

Mr. DURBIN. Will the Senator yield for a question?

Mr. NELSON of Florida. I am happy to yield to the distinguished assistant minority leader.

Mr. DURBIN. I understand we are only about 5 days away from the deadline for people to sign up for Medicare prescription Part D. I know the Senator has joined me and others in suggesting this program could have been done differently, a lot fairer, a lot simpler, could have more competition so that seniors would have had even lower drug prices. Sadly, major parts of it were written by the pharmaceutical industry and by the insurance industry.

I know the Senator from Florida has spoken to many seniors, as I have, and knows that as they have tried to understand the program and sign up for it, some of them have been overwhelmed. In Illinois, there are over 45 different programs from which to choose. I talked to pharmacists, who are a good source of information, who tell me the seniors come in, throw up their hands, and say: What are we supposed to do?

I ask the Senator from Florida, when you reflect on the fact that there are some 35.8 million Medicare beneficiaries who have drug coverage, according to the administration, isn't it true that 70 percent of those people—more than 26 million—already had prescription drug coverage before this program was underway? And of the 16 million who previously did not have coverage, about 10 million or so have signed up. So we still have about 6 million of the 16 we were trying to sign up for drug coverage—sounds to me like a substantial percentage, 6 million—who have not signed up at this point, about 40 percent. They are facing a penalty.

Do I understand the Senator from Florida has joined with others, including myself, in legislation extending the deadline for signing up, also saying to the seniors: If you made a mistake in choosing a program, we will give you a makeover, a do over, so that you can change the program within 1 year without penalty? I ask the Senator to explain.

Mr. NELSON of Florida. The distinguished Senator from Illinois understands correctly. If the deadline were extended until the end of the year, the administration's own figures are that an additional 1 million-plus senior citizens would sign up of that group of 6 or 7 million. If that is a million seniors who would not suffer the economic hardship of an additional 6 or 7 percent penalty or the economic hardship of not being able to have the right drug they need because they signed up with a mistaken decision of a wrong formulary, then is that not worth it for the sake of the senior citizens to grant a compassionate extension?

Mr. DURBIN. I ask the Senator from Florida, does he believe, as I do, that if we would have allowed the Medicare Program to bargain with the drug companies to get, by bulk discount, the lowest prices for seniors, just the way the Veterans Administration does, that the end result would have been at least one kind of standard program, Medicare Program, with lower prices which other private companies could have competed with, if they chose? Wouldn't that have offered the lowest price to the seniors and one simple standard program to turn to if they had any doubts about the right choice?

Mr. NELSON of Florida. The Senator is correct. As a matter of fact, it is something the Federal Government has been doing for over two decades in the Veterans Administration. The Veterans Administration buys prescription drugs in bulk. As a result, the cost to veterans is $7 per month for their prescription drugs. Using the law of economics in the private free marketplace, buying drugs in bulk, you can negotiate the price down. But when this body passed the prescription drug bill 3 years ago, Medicare, the Federal Government, was prohibited from purchasing in bulk and negotiating the price down.

Mr. DURBIN. How much time remains, Mr. President?

The PRESIDING OFFICER. Less than 1 minute.

Mr. DURBIN. The administration has argued the reason they didn't let Medicare bargain down in bulk discounts is because they wanted the market to work its will. Am I correct in remembering that they also appropriated hundreds of billions of dollars to subsidize the insurance companies that were going to offer this? Is that kind of massive Federal subsidy consistent with free market economics?

Mr. NELSON of Florida. The Senator's point is not only correct, but it is so pointed that anyone who hears it should suddenly say: Ouch.

Mr. DURBIN. I thank the Senator.

Mr. NELSON of Florida. Mr. President, I yield the floor.

Mr. FRIST. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BURR. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ISAKSON). Without objection, it is so ordered.

MORNING BUSINESS

Mr. BURR. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business until 2 p.m., with Senators permitted to speak for up to 10 minutes each; further, that this time be equally divided and upon the conclusion at 2 p.m. the Senate majority leader be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KENNEDY. Madam President, as I understand, we are in a period of morning business.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator is correct.

HEALTH CARE WEEK

Mr. KENNEDY. Madam President, for those Americans who believe the Senate was going to have a debate this week on health care policy—and they have been watching the activities in the Senate this morning—they must be mystified about how and whether we are going to have a debate at all. We will know the answer to that at 2

o'clock, when the majority leader will address the Senate.

The best judgment now is, for all intents and purposes, that the debate on the issue of health care will be terminated through a parliamentary process that will be worked out, making it impossible to offer amendments to the underlying bill, which is the usual way of proceeding in the Senate. Instead of debate on health care, we will find that time will move on, there will be debate and discussion about some of the tax issues tomorrow and probably voting on cloture on the underlying Enzi legislation.

Let me point out how disappointed I am in this result. We are aware the leader said we were going to have a Health Care Week in early May, and we would have a chance to debate issues which relate to health care. Health care is a matter of enormous importance to families all over this country—we all know that. As Members of this Senate, we cannot go to our home States without being exposed to different aspects of the health care crisis. Certainly this is true more so today, perhaps, than in recent times. We are very disappointed that the Senate will not have the opportunity to address some of the underlying issues on health care.

We now have 46 million Americans who do not have health insurance. The total number of uninsured has been increasing by about a million a year over the period of the last 6 years. There is every indication that this increase in the number of uninsured is a phenomenon that is going to continue.

We know that in terms of the coverage, an increasing number of Americans are only a paycheck away from losing their health care insurance. They are very concerned about losing coverage, especially with all of the changes we see in terms of the economy and the challenges we are facing in terms of good jobs, good benefits, and health care protection.

For all of these reasons, Americans are concerned about losing health care insurance.

We have increased the total health care spending over 6 years from $1.3 trillion to $1.9 trillion. We are spending $600 billion more on health care and yet 6 million people have lost coverage. The numbers related to health are spending and the uninsured are going in the wrong direction. We have a growing number of uninsured, yet we are paying more in taxes and for the costs of health care. This does not make a great deal of sense. We ought to get about the business of trying to deal with the problem of decreasing numbers of insured Americans and increasing health care spending.

My State of Massachusetts has tried to get its arms around the problem of inadequate coverage of health are insurance, and I commend our leaders in Massachusetts for attempting to do that. We need to do that here in the Senate. Premiums have gone up 73 percent in the last 6 years. Wages have gone up approximately 13 percent. How do average working families possibly get ahead and afford the kind of health care they need when we see the costs of health care going right through the roof?

It is not just the costs of health care creating problems for working families. We know that working families are paying more in terms of gasoline, and they are paying more in terms of higher education. This last winter, in many instances my constituents were paying a great deal more on fuel assistance because of the rising costs of fuel. While costs are rising, wages are not.

All of these challenges are out there for Americans. Beyond this, we are in the age of the life sciences with new possibilities for breakthrough drugs in Alzheimer's and Parkinson's disease. If we had a break in terms of Alzheimer's disease and we were able act on that breakthrough, we would empty one-third of the nursing home beds in my home State of Massachusetts. There are profound implications in terms of the quality of life Americans people could live. Our influence could not only improve the quality of life for people in the United States but it could also influence the quality of life of people around the world. Though unimaginable, we have made reductions and cuts in NIH research at a time when we have splendid opportunities for breakthroughs in health care.

We thought we might have an opportunity to have a health care debate on stem cell research, an issue which led to legislation being passed in the House of Representatives. The legislation, which we believe a clear majority of this Senate favors, is now waiting on the calendar. I call it the legislation of hope—there are no guarantees about what stem cell research might be able to do in the future, but it will provide great hope for millions of families that have Parkinson's, Alzheimer's, spinal cord injuries, and so many other illnesses.

We should be able to do something that Senator NELSON from Florida has been talking about for weeks. Unless we take action, approximately 8 million American seniors will be paying more for prescription drugs if they do not file under the Medicare prescription Part D drug program in the next few days. We know most seniors are living on fixed incomes, and they will be paying hundreds of millions of dollars more if they do not file under Medicare Part D drug program. We have an opportunity to do something about this problem, but we are being blocked.

We are blocked on stem cell research. We are blocked on doing something for our senior citizens in terms of penalties related to the Medicare Part D drug program. We are blocked from perhaps changing our law and permitting our Medicare system to bargain with the pharmaceutical companies to get lower priced prescription drugs for our seniors as we do in the VA system. All of our seniors understand that Medicare should be able to negotiate lower prices for prescription drugs, but we are prohibited from doing that by law. There is virtual unanimity among the Democrats to change Medicare's ability to bargain for lower drug prices. Do we have an opportunity to do that? No, we cannot do that, either. We are prohibited from having that debate, having that discussion, having that vote which would mean so much to the quality of life of so many of our seniors, let alone the issues regarding the possibilities of reimportation of drugs, which has been an issue that many Members know can make a big difference in terms of availability of prescription drugs. However, we are not going to have that opportunity.

Finally, we are not even going to have the opportunity to see the small business proposal which has been prepared by Senator DURBIN and Senator LINCOLN which I strongly support. Their proposal can make a difference for small businesses. It helps small businesses retain health insurance for their workers and will provide incentives for those small businesses, the engine of the American economy, to bring people back into health care coverage. We ought to have the debate about Senator DURBIN and Senator LINCOLN's small business health plan proposal. Let the Senate make a judgment, a decision, about whether they favor, on the one hand, the proposal by Senators LINCOLN and DURBIN or, on the other hand, Senator ENZI. Let's have the votes and call it as we see it. But we are virtually prohibited from having that vote in the Senate.

Most Americans believed, when they elected their representatives, that they were going to come here, they were going to learn these issues, and they were going to tell their representatives what was on their minds. The Senators were going to learn the issues and then have a voice and a vote and try to move that process forward. Certainly that is what we all believe is our responsibility as elected officials. We thought we were going to have these debates and votes on health care this week, but we are not. I believe that this is a grave disappointment. It is an abdication of our leadership in the Senate on an issue which is of overwhelming importance—the quality of health care and the affordability of health care for the millions of American people.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Madam President, first I commend my colleague, Senator KENNEDY, for his leadership on this very important issue and all the many other issues on which he provides great leadership in the Senate.

I rise today to oppose this Senate bill, 1955. I believe it is well intentioned. I have the greatest respect for Senator ENZI and the role he is playing

as chairman of the Committee on Health and Education, on which I am privileged to serve.

However, I also believe this particular proposal, S. 1955, is flawed and has many potential unintended consequences which could have a devastating impact on millions of Americans who currently have health insurance coverage. It is for that reason that I am a strong supporter of the alternative to which Senator KENNEDY referred; that is, the alternative Senators DURBIN and LINCOLN have put together which I will speak about in more detail in a minute.

I also suggest an alternative proposal that would bridge the gap between these two approaches and would build on the bipartisanship we clearly need in order to make any progress on health care issues in the remaining weeks of this Congress, which are diminishing rapidly, as all are well aware.

First and foremost, we need to keep in mind the important tenet that is referred to often when we talk about health care; that is, first, do no harm. That is what physicians are taught when they go to medical school. Clearly, that is something we should be taught when we come to the Senate.

One of the most significant concerns I have with this legislation that is pending in the Senate is that the language contains sweeping preemptions of literally hundreds of State insurance laws, not just for association plans or for the self-employed or even just for small businesses, but the legislation as presented to us preempts those State laws for large businesses as well.

Consequently, for the millions of people who currently have insurance coverage and count on consumer protections and benefits—including coverage of cancer screenings, diabetes treatment and supplies, immunizations, well-baby care, prenatal care or whatever benefits and protections their States require be included in insurance policies—that security is wiped out by S. 1955.

In short, the bill literally puts at risk the health security of millions of Americans by preempting longstanding State insurance laws to impose an untried, untested proposal throughout the country.

While I certainly do not disagree with the idea that there may be insurance laws and mandates that States have enacted that are not needed, I do think most often the mandates and the provisions that are adopted at the State level are adopted in response to real needs those State legislatures have perceived and real crises that have been pointed out in those States. As such, by preempting those consumer protections, there are real national goals that we all share that would be undermined.

For example, we have a national goal to improve immunization rates among children. So why should we backtrack and potentially undermine what the States have done to ensure that insurance plans offered in the individual States provide for coverage of a full set of immunizations for their children?

While a number of Senators have come to the Senate floor condemning various State mandates, who really thinks we should not be covering cancer screenings, as an example, and treatment and prevention or diabetes education and supplies?

Some will argue that the benevolent insurance industry would never fail to cover these items. But, in fact, there are insurance products for sale in this country in some States—for example, in Ohio—that do not cover diabetes supplies and education, precisely because there is no requirement they do it.

State insurance laws, including mandates or laws regarding market conduct of insurance plans, were passed because of real problems that were perceived in the insurance market. Consequently, it makes little sense to preempt literally hundreds of State laws overnight and to put all hope that insurers would have to offer businesses a plan offered to State employees in one of the five most populated States. That is what is touted as the guarantee of consumer protections.

As the bill now reads, if a plan fails to offer certain protections, and it is being offered to employees in one of these five most populated States by that State, then that is a minimum that is acceptable throughout the country with regard to all insurance plans. I do not see why the people of New Mexico or the people of any other State should be at the mercy of what one of the Governors of these large States decides to offer to that State's employees.

The five Governors are certainly respected public servants—Governor Schwarzenegger, Governor Bush, Governor Perry, Governor Pataki, and Governor Blagojevich—that is a mouthful, Madam President—but I do not see why any of those Governors should be able to lessen the protections that we provide to consumers in New Mexico.

If Governor Bush passes a barebones package in Florida, do all of the people of my State of New Mexico have to fear losing health benefits? That would be the effect of the pending legislation.

In fact, for rural States, a package in the five most populated States is very likely to fail to recognize the special challenges we have in rural communities. Let me give you one example.

In New Mexico, we have a mandate for access to psychologists. If you sell a health insurance policy in New Mexico, you have to cover access to psychologists. This was passed in response to the fact that our State leads the Nation in the number of suicides per capita. Also, there are very few psychiatrists who are located in areas outside of Albuquerque and Santa Fe, which is our more urban part of the State.

So our State leaders, in part due to the leadership of my colleague, Senator DOMENICI, have been making great strides with respect to mental health coverage and benefits in New Mexico. But that could be undermined by this pending legislation. Literally overnight, our State mandates could be preempted and replaced with the allowance that insurance companies could provide whatever benefits they desire or that any plan offered by the five most populous States in the country to their employees would be adequate in New Mexico.

I would note that even though 42 States have requirements that insurance plans offer access to psychologists, Florida does not, and may not, in their State employees' plan. Therefore, any insurer could adopt that plan and hundreds of thousands of people would lose access to mental health professionals in a State such as mine, New Mexico. This is one example of real regional or local issues that I believe are not adequately addressed in this bill.

Another simple but important example of a problem with the legislation is that most States require insurance plans to cover newborns and adopted children and adult disabled children. This bill would undermine such requirements. Why should the Senate undermine this critical coverage of some of our Nation's most vulnerable children?

Fundamentally, we should not be encouraging underinsurance and benefit insecurity among most Americans as part of a bill that is intended to increase health coverage among small businesses, but, unfortunately, that is the unintended consequence of S. 1955.

It is why literally hundreds of national and State-based organizations have come out in opposition to S. 1955, including the Nation's State health insurance commissioners and 41 of our States' attorneys general. All of these groups and individuals are opposing S. 1955 precisely because the legislation contains numerous provisions that, as the attorneys general write, ''erode state oversight of health insurance plans and eliminate important consumer protections.''

While some organizations have literally tried to claim that the attorneys general did not know what they were doing by taking the position they have taken, I was an attorney general of my State, and I can assure you those attorneys general knew exactly what they were doing when 41 of them joined together in a letter of opposition to S. 1955. They surely know a lot more about the laws of their States and the consequences of eroding insurance laws than some of the groups that are attempting to criticize them in this debate.

But even if you do not believe the attorneys general, the bill's text reads clearly it will ''supercede any and all state laws'' applicable to small business health plans as well as State laws regulating all other types of health insurance plans, not small business health plans, in six key areas: No. 1,

mandated benefits; No. 2, rating requirements; No. 3, internal appeals; No. 4, rate and form filing; No. 5, market conduct reviews; and, No. 6, prompt payment of claims. So in all of those six areas, this legislation would override whatever the States have previously done.

So what are the consequences? As the attorneys general write:

> The point is that history has shown that eliminating state regulation of insurers has had extremely negative consequences for consumers, and there is no reason to exempt any insurer from the important consumer protections afforded by state regulation.

The sweeping nature of preemption of State laws and oversight is fairly breathtaking in this legislation. It is surprising to see how many of our colleagues, who are typically advocates for States rights, have embraced this legislation. It culminates with a provision in which insurance companies are afforded the right to sue States in Federal court.

The legislation, first of all, overturns and preempts this longstanding State authority over State insurance matters. Secondly, it imposes a new Federal system upon the States. Third, it declares States as nonadopted States if they do not conform their laws to the newly imposed Federal system. And, finally, it allows insurers to sue States in Federal court if they do not like the way the States are administering the federally imposed law.

Somewhere, it seems to me, the goal of the legislation has been lost. The stated goal was to give small businesses greater health insurance purchasing power and to reduce administrative costs in the purchase of health insurance. However, there are, in my opinion, far better approaches to achieving that goal than to gut State oversight of health insurance plans and to eliminate these important consumer protections.

For instance, eliminating the guarantee of coverage of insulin makes any insurance product meaningless to someone who has diabetes. As a result, I am a supporter—I know Senator KENNEDY indicated his strong support—and I also strongly support the legislation introduced by Senators DURBIN and LINCOLN precisely because it would address the affordability problems for businesses in the small group insurance market by giving them the ability to access a large purchasing pool which would be modeled on the successful Federal Employees Health Benefits Program, FEHBP. It would do so without eroding any of the consumer protections afforded people in State insurance laws and oversight.

Under this Durbin-Lincoln bill, small businesses would be allowed to band together in a large purchasing pool that would reduce premiums, reduce administrative costs, and give every small business and their employees a wide choice of plans. The amendment harnesses the power of market competition to bring down health care costs by using a proven negotiator that provides Federal employees across the Nation with access to affordable health care.

Let me make it very clear that we are not in any way affecting the health care coverage of Federal workers with this proposal, this Durbin-Lincoln proposal. Small businesses and their employees who choose to participate and buy their health care through this purchasing pool would be buying their health care through a separate pool—separate from Federal workers—but still a very large pool of small businesses around the country with 100 or fewer employees.

Last year, there were 249 private health insurance plans that participated and competed for the business of the FEHBP enrollees. This system would also benefit small employers. It would do so without undermining the benefits and coverage of large employers or the consumer protections that are afforded everyone under our State insurance laws.

What people fundamentally want from their insurance policy is something that is truly there when it is needed. Unfortunately, S. 1955 preempts that security and creates more unintended harm than good through an untested and unproven model of State preemption. In sharp contrast, this alternative that Senators DURBIN and LINCOLN—and I am proud to be a cosponsor—are proposing achieves the goals of helping small business in the underlying bill through a proven mechanism that each and every one of us and our staffs benefit from without upsetting the security that the health insurance marketplace provides to millions of Americans around the country.

There is also another alternative that I think is most promising for some type of health care reform in the reasonably near future in this Congress. This is bipartisan legislation that I was proud to join Senator VOINOVICH in introducing yesterday. This legislation, entitled the Health Partnership Act, is intended to move beyond the political gridlock we have in Washington on health care reform. I think that gridlock is, unfortunately, highlighted by the very debate we are having in the Senate this week.

Instead, the proposal Senator VOINOVICH and I have introduced sets us on a path toward finding solutions to affordable quality health care for all Americans by creating partnerships between the Federal Government and State and local governments and private payers and health care providers to implement some different and promising approaches to health care. In contrast to preempting State laws and solutions, the Health Partnership Act, which Senator VOINOVICH and I introduced yesterday, would provide for Federal funding and support to State reform efforts such as that recently enacted in the State of Massachusetts to reduce the number of uninsured, to reduce cost, and to improve the quality of health care. A Federalist approach to health reform, in sharp contrast to state preemption, would encourage a broad array of reform options that would be closely evaluated to see what is working and what is not.

Justice Brandeis is famous for his statement in 1932:

> It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

The Health Partnership Act encourages this type of State-based innovation through a partnership rather than through preemption. This would help the entire Nation to better address both the policy and the politics of health care reform. As the debate before us underscores, there is not a consensus at the Federal level on any one approach. Instead of preempting State laws and innovation, we should be encouraging States to adopt a variety of approaches that may help us all better understand what does work and what does not. Rather than fighting to a standstill over whether the Enzi bill or the Durbin bill is the best approach, I would argue that the best solution would be to have a few States experiment with a model based on Senator ENZI's bill, if they chose to do so; other States experiment with a model based on the Durbin-Lincoln approach, if they chose to do so; and other States adopt alternative reforms such as those that have recently been passed by Massachusetts, Maine, New Mexico, New York, Illinois, Oregon, and Montana. This would also include encouraging reforms in local areas such as the three-share initiatives in a number of communities.

If given the opportunity—and there is still uncertainty about whether I will have that opportunity—I plan to offer an amendment that would give the States the choice between being covered by the Enzi model or being covered by the Durbin-Lincoln model for their small businesses. Therefore, the amendment would add the Durbin-Lincoln language to the Enzi bill with additional language that gives States the choice of deciding which approach to take.

If the proponents of S. 1955 are so confident that their approach is the best, let's let the States choose for themselves.

The PRESIDING OFFICER. By unanimous consent, it was agreed that each Senator would be limited to 10 minutes under morning business. The Senator has exceeded that time.

Mr. BINGAMAN. I ask unanimous consent that I be given an additional minute.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. From monitoring the various reform approaches that are taking place around the country, it is far more likely that we might learn from those efforts to actually find a mutual solution to the problem than to

continue to have needless health care debates on the Senate floor. Just as States passed expansions of coverage for children prior to Federal enactment of the State Children's Health Insurance Act, we should once again let the States lead the way to reform. When the passions of this week die down and there appears to be nothing left standing, I hope people will take a serious look at the bipartisan legislation Senator VOINOVICH and I, Senators AKAKA and DEWINE have introduced. It is supported by groups such as the American Hospital Association, the American Medical Association, the National Association of Community Health Centers, and numerous other national and community-based organizations.

As speaker after speaker has noted, it is well past the appropriate time to act. I hope we can act and actually legislate in this area during this Congress.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Madam President, many Members over the last several days have come to talk about health care, specifically the effects on small business. I know my colleague didn't mean it the way it sounded, that this was a ''needless'' debate about health policy. It is a very needed debate about health policy.

In North Carolina, 98 percent of the firms with employees are considered small business. Small business is who we are here to represent in this piece of legislation. Small business is the American business today that can't afford to offer health care as a benefit to its employees. Why? Because small business has few employees. They don't have the ability to negotiate in the volume that large corporations do.

Some have argued this is not a crisis. In North Carolina, we have 1.3 million uninsured North Carolinians; 900,000 of that 1.3 million are individuals in a family or on their own where an individual works full time. There is somebody in the family who works full time in that house, be it the individual or a family member, who would have the option to be insured under this bill, at least individually or, if not, under a family plan, and our uninsured population from North Carolina could go from 1.3 million to 400,000 with the passage of one piece of legislation.

This is not a needless debate. This is a needed debate. This is a population that today has two choices—nothing and nothing. Because an employer has found that health insurance is cost prohibitive. What is the employer's choice? I can provide you health care, but I can't stay in business. What good have we done for the employees, whether they are in North Carolina or anywhere else, if the option is, I can give you a benefit, but I can't keep you employed? This is to attempt to try to bring the same ability that big business has to small business, to negotiate as an association, as a group. This is the most natural thing I could think of that we could do to begin to relieve the pressure.

Does it solve health care? Absolutely not. It will take much more pressure from the American people for us to tackle the real structural changes needed in health care. But let me relate some stories from North Carolina and around the country. This comes from Hickory, NC. This woman owns a custom plumbing and heating business. She says she would like to be able to offer her employees and their families affordable health care coverage.

As a parent and employer, I know the importance of having affordable insurance and the financial devastation that occurs when you have no coverage. Unfortunately, there has to be a tradeoff.

She says she only has one of two options to keep her doors open—either employees have no insurance or they don't have a livable wage.

Another one from an area in North Carolina, a small business owner has provided health insurance for his employees at no cost to them for the past 10 years. However, every 2 or 3 years he spends at least 2 months shopping for insurance because he knows that the rate increase is coming. We have all faced that. He would like to continue to provide insurance for his employees but he doesn't think he can hold out much longer.

Think about the employees. Think about the families.

This one is from Greenville, SC, a small business owner who says that providing health insurance is becoming unbearable for small businesses such as hers. She calls it a ''hardship.'' She is a widow. She is self-employed. Her health insurance is an expense she can hardly afford. Similar to many of her employees, she has a $5,000 deductible, and her monthly premium consistently increases 35 to 40 percent every 6 months. This is unbearable. It is not something that she can stand, and it is not something that we should strap the American people with. But small business after small business, State by State, is faced with the same thing today: They can't buy with the effective tools that large corporations can.

We have spent over 30 hours debating whether we would even proceed to debate the bill. This is incredible. Now we are getting to a point where we will debate the bill and we will consider amendments. We may consider alternatives such as my colleague from Arkansas will discuss. But make no mistake, this is a very needed debate. This is not a needless debate about health policy. This is one that we have needed to have. We have needed to have a policy in place for years now. It is incredible to me that we could think that small business can continue to hold on just like the fingertips on a windowsill.

Across the country, the No. 1 issue facing small business today is the rising cost and the lack of access to quality health care. Earlier this week, we debated liability reform, something that is driving doctors out of the profession, that is affecting new medical students as they choose a specialty, where they are shying away from specialties like neurology, OB/GYN, things that to a population that is growing older and a population that we want to repopulate, as families decide to have children, are absolutely vital.

But we were denied the ability to proceed, denied the ability to go to a debate because people said we don't have a liability problem in America. Yet I gave a firsthand story about a friend of mine who is a nephrologist. I don't even know what that is. But he told me this: We are likely not to get sued. He told me that in the past 2 years his premium has gone up 300 percent. Some come to this floor, and they say this is not a crisis. We don't have a problem. Medical liability does not contribute to the rising cost of health care.

Any place in health care that experiences a 300-percent increase in a matter of years has an inflationary factor on everybody's health care. That is one example of a profession that is not the most likely to be sued, as are the OB/GYNs, the neurosurgeons. But we were denied the ability to move forward. It took us 30 hours to be able to debate the assets that we find in S. 1955. Is it perfect? No. Is it a carefully crafted piece of legislation that incorporates the State insurance commissioners who are in the business of regulating insurance products? Absolutely. It incorporates everything that everybody who sat around the table who had an interest in this said had to be there. Change one little piece, and now you have affected all the moving parts that exist.

What are we trying to do? We are trying to make sure that small business has the opportunity, if they choose, to provide for their employees' health care coverage. Anybody who would be against that, I can only assume that the only way they want to provide health care coverage is if the Government provides it.

I will tell everybody a story. I was elected to the House of Representatives 12 years ago. I worked for a small business, less than 50 employees. When I came here, I had an option of all the choices I could choose for insurance. I chose the company and the exact same plan that I had before in a company of 50 employees. What was the only difference in my health care coverage? It cost me $50 more a month to be a Federal employee and to have that health insurance. But there are some up here who suggest that the Federal Government should negotiate everybody's health insurance. From firsthand experience, the Federal Government is the last one I want negotiating anything for me. I would be willing to bet that my constituents feel the same way.

Ask the business owners I referred to if they want the Federal Government negotiating their health care policies. Absolutely not. They want the option of being able to offer health insurance.

These employees today have two choices—nothing and nothing. This debate is very simple. It is about whether we are going to offer them something versus nothing. This is a debate that is well past due. It is a debate that has to be completed. I am not convinced today that this bill will find it to final passage. I think it will get blocked. I think it will be filibustered.

I think Members of this body will, in fact, block the consideration. In North Carolina, this will block 900,000 individuals who could have health insurance who, because somebody here decides we are not going to move forward, won't have that option. Their choices tomorrow will be nothing and nothing.

Health insurance costs are on a track to becoming the largest portion of an employer's total benefit package—more so than what employers are putting into retirement plans or 401(k)s.

Madam President, I am going to continue to come to this floor, and I am going to continue to talk about real people across this country, not just in North Carolina—the ones who have the horrors of no choices and cannot continue to afford the policies they have, the employers who really do want to offer their employees a benefit because it enables that employee to stay with them. I am going to continue to read these stories in hopes that my colleagues on the other side will understand that this is about real people, that for once maybe they will look at the human face of this issue and understand that there are casualties all across this country.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas is recognized.

Mrs. LINCOLN. Madam President, I, too, would like to echo the Senator from North Carolina, that this is a debate which is extremely critical. It is an issue which is—particularly from my standpoint—one that I get most consistently when I return home to Arkansas. I don't think the debate is whether it is a critical issue for us to discuss and come up with a solution; the critical question here is, Are we really doing our best? Are we really working hard to produce the best product we possibly can for the constituency that really needs us the most?

Small businesses are our No. 1 employer in Arkansas. They are the engine of our economy all across this great Nation. There is no doubt that they deserve the same quality of health care we have here as Members of Congress.

The Senator mentioned that, as he left small business and came to Washington, his premiums went up. The statistics show us that the premiums for Federal employees rise at a disproportionately lower percentage rate than the premiums rise in the small business market. We have seen drastic increases in the premiums in the small business market over the last several years. However, while we also, as Federal employees, have seen increases in our premiums, they have not been anything compared to the increases that have been seen in the small business marketplace. So there may have been some changes, but the point is that we have a good product that we enjoy as Members of Congress. The quality control on what we have is tremendous because we adhere to the State mandates and what States have seen in their States to be important to their constituency.

All States are different, but most of the States are consistent when it comes to things such as diabetes, maternity care, well baby care, immunization, cancer screening—things that have really made a difference not only in people's quality of life but also in terms of the cost of health care. States such as Connecticut actually cover anything—or mandate the coverage of Lyme disease because in Connecticut you actually see a prevalence of that. States have the choice. It is the State's right to be able to make sure that what their constituency wants in that product is going to be there. I believe that has worked very well. It is something we want to maintain. It is a quality control we enjoy, and there is no reason small businesses should not, also.

Madam President, I wish to comment and lend my voice to the fact that this is a critical debate, one about making sure we are providing for every other American out there, particularly in small businesses, the same opportunities and the quality of health care we enjoy.

I wish to address some of the issues that have been brought up in this debate that I have heard about the bill that I have worked hard on over the last 3 or 4 years—a bill Senator DURBIN and I helped each other put together after realizing what a great job the Federal Government had done in bringing the best of what Government can do in its oversight and the best of what private industry and competition in the marketplace can bring. It brings it to us as Federal employees and Members of Congress, and has for over 40 years, and it keeps down an administrative cost that is drastically lower than private plans out in the small business marketplace. At some point, it is somewhere around 25, or plus, percentage points lower in terms of administrative costs, which is practical in this day and age and something that is essential.

I applaud Senator ENZI in his effort and hard work at bringing about this issue and focusing on how important it is. I hope that the debate and our willingness to work to produce a good product is genuine and that we can actually do what is best for the American people and that we don't get caught up in a lot of the details of procedure here so that we miss the forest for the trees.

On the other side of the aisle, they have argued that our bill is just another costly Government program, which will cost taxpayers a ton of money. We are getting ready to spend a ton of money tomorrow in extending tax cuts that haven't even expired and don't expire for several years. We are going to spend a tremendous amount of money—$50 billion plus—on extending those tax cuts which don't even come up for expiration for another couple of years.

Here we have an opportunity to provide a tax cut to small business that could actually make an immediate impact on bringing down their cost of health insurance for themselves and their employees. This is kind of the first time I have ever noticed my colleagues on the other side, who all of a sudden don't want to provide a tax cut to small business because it costs. Yet we are going to have multiple tax cuts brought before us that come at a tremendous cost to the Government and to the deficit, and we don't even need them yet. Yet here is an opportunity to provide a direct tax cut, a credit, to small businesses to engage in the health care marketplace, encourage them to provide much needed health insurance for their employees, for themselves, and for the self-employed, and all of a sudden it is a cost that is just out of control. But if you look at that cost, it is amazing. It is maybe a third of the cost of the HSA that the President has been proposing. Yet we have the possibility and capacity under this plan to serve millions more Americans with health insurance—health insurance that is backed by the State mandate and the Office of Personnel Management, a proven negotiator, that negotiates for us, Members of Congress. So I just have a real problem with that argument.

The fact is that SEHBP won't create any new bureaucracy. Our plan will be run by the same agency that runs the health care program for all Federal employees and Members of Congress. The administrative costs are less than 1 percent. There is no new bureaucracy created. It already exists in the Office of Personnel Management. We might have to increase some of those people in that office, but we don't know what is going to happen at the Department of Labor, which is charged with implementing Senator ENZI's plan. There is no one in the Department of Labor who has ever done that. There is no part of that agency designed or created in order to do that. We would have to reinvent the wheel to provide a section of the Department of Labor that would be able to institute the Enzi bill.

In fact, most of the costs, as I have said, of our benefit plan for small businesses come in the form of a tax cut. So our costs are not administrative. We actually bring those down. Our costs are not an implementation. Our costs are providing the assistance to small business to actually get into the marketplace because we know that the more small businesses that get into the marketplace, the greater the pool.

I doubt there is anyone here who will argue with the fact that the real key to

providing good, quality, low-cost, consistent health insurance is in the volume of the pool because we all want to make sure that competition in the marketplace is what is driving the issue here. When you have a larger pool to negotiate with private industry, you are going to be able to negotiate a better deal. It is a better deal for everybody.

Forty-six million Americans are not getting health insurance now. Disproportionately, the largest percentage of those 46 million are working in small businesses. They are not getting health insurance. Health insurance companies should love the idea of being able to increase their market share with those numbers of people. In fact, we have worked hard over the last 2 or 3 years with the insurance industry to make sure that what we were creating was improvement on what was already in existence other than the Federal plan.

The PRESIDING OFFICER. The Senator has used 10 minutes.

Mrs. LINCOLN. Madam President, I ask unanimous consent for an additional 1 minute.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. LINCOLN. Madam President, I believe it is so important that we heed the words of most of our parents, I am sure, when we were growing up, and those are: If it is worth doing, it is worth doing right.

We enjoy, as Federal employees, an incredible opportunity to provide health insurance for ourselves and for our families which provides real, substantial quality. It is not something we buy into with the idea that we will never get sick; we buy into it knowing that maybe we are just one automobile accident or one chronic illness away from needing comprehensive health insurance.

The increases my colleague from North Carolina talked about in terms of the number of people who would be added, those are immediate and they are temporary. They are mostly young, healthy people. The fact is that if we don't include everybody and we don't make sure all of the different chronic illnesses that exist out there are going to be offered, those who are less healthy are going to be shut out, they will become more costly, and the first time one of those young individuals, healthy individuals, has an accident or reaches a chronic condition, they too are not going to be covered under this plan. So I hope we will heed the idea that it is important to do what is right.

We have an opportunity here, at no additional cost. We could eliminate it, if the other side doesn't want to provide a tax cut to small business, that is OK. But we should maintain the quality, and I hope my colleagues will join me in that.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. ISAKSON. Madam President, I was here about 15 minutes ago, and I learned one inevitable fact: this body is long on rhetoric and oftentimes short on results. In the case of health insurance and health coverage for the American people, we stand at a point in time when we have a chance to produce real results.

I have listened to the arguments over the last couple of days. In fact, I presided last night and got to listen to some of these negative arguments about S. 1955. I wish to try, in a positive way, to talk about the result that it affords and brings to the American people. I want to do it by, first of all, trying to establish credibility.

The reason I say that is, most of us come to the Chamber and speak oftentimes on subjects about which we have had few life experiences. Most of the Members—certainly a majority—have never really been in the private sector. Certainly, a lot have not been independent contractors. None of us right now are in the marketplace for health insurance in America.

For 33 years before coming to the Senate, I ran a small business. I had 200 employees but 800 independent contractors. My employees had medical benefits because we qualified under ERISA. My independent contractors, who were my salespeople, the assets of the company, because of Federal law and IRS treatment, were not allowed to be offered a benefit. They were subject to the free market, to buy spot insurance. They weren't the young and healthy. They were middle age, second- and third-career people, mostly women, and some men. They were very difficult people to cover in the spot market.

As a legislator during those 33 years, while I ran a small business, I did a ton of work on health care. In fact, I was the author of one of the State mandates in Georgia for direct access for dermatological coverage. I did so for a passionate reason: I am the survivor of a melanoma. My doctor caught it in time, and it was removed in time, and I am here today. I have great respect for that mandate for direct access.

As some of the people who have spoken—in fact, many on the other side have talked about the horrible thing this bill does by not including all of the mandates required of all of the States in this country. And the ads we see in some of the periodicals we read portend we are removing the possibility of people to have coverages that are mandated in their States. Let me address that and make the record straight.

Currently, in the United States, there are 109 mandated medical coverages in the 50 States and the District of Columbia. My State of Georgia has 39. This bill doesn't preclude any of those from being offered, but it doesn't mandate that they be offered, and it doesn't allow small businesses to associate across the Nation, form a large enough risk pool to be competitive in the marketplace and be able to compete and provide insurance to the American people who do not have insurance.

The first fantasy that has been purported as fact is that this bill takes away mandates. It doesn't take a mandate away from a single person who has it. What it does is give people who don't have any insurance at all the chance to get good, solid, basic health care, and when they get it, when they make their purchase decision, this requires they make that decision by being shown, at the same time they are presented with a basic policy, a policy that contains all the mandates contained in the five most populous States in the country. The consumer gets the choice that right now they do not have.

For the other side to allege we are taking away benefits, what we are doing is providing opportunity to folks who have no opportunity. I defy you to be 45 years old, a working carpenter with a wife and two kids, out in the marketplace trying to buy spot insurance. Can you buy it? Sure, if you want to pay $2,000, $2,500 a month, a price you can't afford to pay and put food on the table and shelter as well. So what do they do? They fly without coverage. When they get sick and they are really sick, they go to emergency rooms, and they end up raising the cost of health care to everybody, which raises the cost of health insurance to everybody.

What this bill does and what Chairman ENZI has done, which is the genius of it, it brings forth the ability of small businesses and people who cannot afford the coverage to go into the marketplace and buy health insurance.

On the mandate issue, there is no question that some of the insurance that will come out of this process will not include every mandate, maybe not all of the mandates, maybe not half the mandates. But what it will include is good, basic health care, and if a family that doesn't have good, basic health care coverage now all of a sudden has it, what happens? They start practicing better health. They start having more wellness. They start seeing physicians before they are sick rather than after they are sick and in pain. What happens is, we have more wellness, more preventive health care, and we have a lower cost of health care in this country to all the Americans who have coverage.

For the other side to say that what we are trying to do is take benefits away from people is disingenuous and wrong. We are trying to preserve the benefits of people in America, and to the 45 million who don't have any, we are trying to give them the opportunity.

For those who think the State knows best and therefore we ought to mandate they can't do this, they are denying choice of the most basic need in the United States of America, and that is the choice for a man and a woman and their children to be covered in the medical needs they have.

I can tell you that I spent most of my time running my business trying to make sure there was some access to affordable health care for those independent contractors to whom I could

not legally provide it. Over the 20 years I ran the company, it became more and more difficult. And over those same 20 years, the cost of health insurance went higher, higher, and higher. It went higher because the mandates became more and more difficult to provide to those individuals, in part because of the State mandates as well.

This opens a new door. It opens hope and opportunity for 45 million Americans. It gives us the chance to cover maybe 11 million, maybe 12, maybe 13. Senator BURR thinks 900,000 in North Carolina. The number I have heard for Georgia is the same. But whatever the number, S. 1955 offers hope and opportunity for affordable health insurance and better health care to millions of Americans. It takes away mandates from no one and ensures that the customer always has the choice of buying the product and the coverage they want and they can afford.

Chairman ENZI and the committee have done a great service to the American people. It is time for this Senate to do great service to their constituents. Give them a chance to have access to affordable, accessible health insurance for the 45 million Americans who do not have it.

I yield the floor.

The PRESIDING OFFICER (Mr. THUNE). Who yields time? The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, how much time do we have remaining on our side?

The PRESIDING OFFICER. There is 14 minutes, but each Senator has been allotted no more than 10 minutes.

Mr. LAUTENBERG. It is my understanding that there is no request for use of time on our side, so I ask unanimous consent that I be able to use all of the remaining time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LAUTENBERG. Mr. President, we are in the midst of Health Week. Apparently, during Health Week, we don't pass any of the bills the American people want but, rather, we schedule procedural votes.

Why aren't we taking up something such as stem cell research? That is what the American people want to see us do. There is such value in the use of stem cells for research and potential treatment of all types of diseases. Despite all the promises of stem cell research, we are not working on it this week. This week we are simply doing our political stuff: posturing for the next election.

There are other important health care issues besides stem cell research that we could be taking up; namely, Medicare. We should be discussing that on the floor of the Senate. We should be passing legislation to extend the Medicare enrollment date past May 15.

Right now, under the present Medicare drug plan, if you don't sign up by this coming Monday, you will be penalized permanently for signing up late.

Millions of Americans are having serious problems understanding this outrageously complex Medicare plan, but the administration, the President of the United States is saying: Hurry up and make the choice, we are not going to extend the enrollment date. It is insulated from what reality is. It is too bad.

In New Jersey, seniors have to choose among 45 plans offered by 19 providers, and we are saying rush, rush, rush. Most people can't get through the language, no less the dates and those requirements. But the administration is saying to my constituents that even though their health is at issue, they have to rush to a decision. It sounds like this is a deadline that nothing can move and, unfortunately, that is the truth coming from this administration.

If we want to talk about health initiatives, Republican health initiatives, let's talk about the one that is in place, this horrible new Medicare plan.

We have seen the Republican model of health care, and it is not pretty. In fact, many have called it a disaster. One need only pick up the local newspapers to see this disaster play out from Maui to Miami, from Portland, OR, to Portland, ME. The new Medicare drug plan is failing our seniors.

We see it demonstrated in this placard in the headlines: The Boston Globe:

Many seniors say Medicare drug plan will not help them.

Newsday:

Medicare guide is in need of Rx.

The New York Times:

Drug plan enrollment opens amid confusion.

It goes through all of these well-known newspapers, showing the opinions they are hearing from their constituents.

How did we get there? This Medicare Part D Program is an example of the majority vision for the future of health care in our Nation. One thing that is pretty clear about Medicare Part D is that whoever wrote it was clearly not focusing on the health of our seniors, and if the goal were to help our seniors, there would not be this thing called the donut hole, a gap in coverage.

Many Americans have not heard about it or don't know what this coverage gap is. When I explain it to people listening at home, they are not even going to believe it. But it is true because I have heard about it when I address people all across our State.

The way the program works is that for many people, in the middle of the year when you have spent $2,250 on drugs, which is not a lot of money considering the drug use for preserving health and for prolonging life, their prescription drug coverage will stop at $2,250. They will not have any coverage, but they will still have to pay the premium.

What does that mean? It means that sometime in the summer or fall of this year, millions of Americans will walk into a pharmacy for their medication and the pharmacist is going to ask them for hundreds of dollars in payment. When the person says, Wait a minute, I have Medicare, the pharmacist will say: Yes, but you are in the donut hole, when you don't get any benefit until you reach spending over $5,100; so you will have to pay the full price now.

It makes no sense. It is hard to understand, but unfortunately it is true and it is happening. My office has been contacted by constituents who experience this problem, and we are trying to help them, but this is only the beginning.

Another senseless component of the Republican Medicare law is the prohibition that prevents Medicare—can you believe this—prevents Medicare from negotiating prices directly with the pharmaceutical companies. The VA permits that and the discounts are significant. But you can't do that in Medicare because the focus is to protect the companies rather than it is to protect the citizens.

I come from New Jersey, home of the world's leading drug companies. And I admire these companies. Their discoveries have saved the lives of untold millions of people. To be quite honest, they are often targets of unfair criticism. But I don't see any reason to prohibit Medicare from negotiating prices with these companies. Medicare, the largest health care system in the entire world, is prevented from negotiating with these companies. The Republican Medicare law prohibits Medicare from negotiating for a good price, and there is no valid reason for it.

When I talk with my constituents about this new Medicare law, all of them ask the same question: Why is this program so complicated? That is a good question. The program is complicated because the people who wrote it were not focused on helping seniors. Rather, they were focused on promoting ideology. The Republican ideology is now destroying Medicare because it is based on the need to privatize everything, outsource Medicare.

If the goal were to help seniors get their prescription drugs, the result would not be so complicated. We can't blame seniors and their families for being confused when we present them with the kind of complex picture they see.

The Democrats invented Medicare, and when it comes to serving the American people, running an effective Government, we do know how to do it. I think it is pretty obvious now in the wake of this Medicare mess and the bungled response to Hurricane Katrina that there is little ability to run our Government. It doesn't seem to work. Incompetence runs rampant.

Why can't they run a Government? Because they always want to farm out the hard work to the companies—Halliburton, the HMOs, and the list goes on and on. They even want to outsource our air traffic control system. Remember that fight? And that still looms in front of us. I will give you a real-world

example of why the Republican insistence on privatizing Medicare is hurting America's seniors. In one of my local papers back in New Jersey, the Bergen Record, there was an article about a pharmacist who has been trying very hard under tough circumstances to help his customers with this new Medicare program. One of the customers needed a 25-milligram version of a drug because her doctor found that the 50-milligram pill was causing too many side effects. When the pharmacist filled the 25-milligram prescription, the Medicare drug plan, run by United Healthcare, said they will not cover the 25-milligram, the smaller milligram, version. It is hard to understand.

United Healthcare told the pharmacist to cut the 50-milligram pills in half. The pharmacist correctly told the insurance company that it was a sustained-release drug and cutting it in half would make the pill ineffective. After waiting for some time on hold with United Healthcare, the pharmacist was told the customer would have to go back to her doctor and ask the doctor to file an appeal with United Healthcare, looking for special permission to get the smaller dose of the pill.

That is what real seniors are going through every hour, every day under this drug program.

I want to talk about United Healthcare in particular. United Healthcare paid its CEO, William McGuire, $124 million last year. That is right. The CEO of United Healthcare made almost $124 million in 2005. Now, if they were making widgets, that would be all right. But they are supplying health care to seniors and having this man walk away with millions of dollars—when the people who need health care are paying for it—it is not right. Those people are paying for that kind of a salary, that kind of an asset base.

The seniors in my State are upset, while the real beneficiaries of the Republican Medicare bill are still paid these outrageous salaries. It doesn't make sense. It is a disgrace.

The question has been asked: Should we scrap this program and do a real Medicare drug benefit? Maybe. But I would say this to the American people: As long as the same group is running this Congress, you are going to see more of the same happening. All we have to do is look at the condition that we find ourselves in over in Iraq, not knowing whether we are going or whether we are staying, and lives are still being lost. The cost for that war is going to be somewhere around half a trillion dollars before this year is over, and we are funding it with supplementals that carry all kinds of pork-laden projects. The management is terrible.

Management of the environment is terrible, when we look at what is happening and we see that snowfields in Mount Kilimanjaro in Africa that were there since the beginning of time will no longer be there in a few years, when we see that Glacier National Park will soon not have a glacier there, having had glaciers there since the beginning of time. The glaciers are melting in front of our eyes. If you look at pictures of animals up in Alaska, such as the polar bear, they are scrawny. They don't have the body size they should have when they are not getting sufficient nourishment. There is nothing being done about that. There is nothing being done about global warming as the Earth that we live on gets warmer and as the threats of flooding all over the seacoast States and communities becomes more and more apparent. So there is a question of competency that we have to look at. It is certainly not reflected in this Medicare plan.

Although it is late, I wish the President would show some good heartedness and say: You know what, seniors of America, we are going to help you. We know you can't get through this Medicare drug plan in time, so what we are going to do is delay it a few months. What is the big deal? I don't get it. Instead of permitting people to adequately review these plans so they can understand what they are getting into, there is a push to sign up. It is one that I don't understand.

Mr. President, I yield back the remainder of my time.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

Mr. ALLARD. Mr. President, I understand we are in morning business?

The PRESIDING OFFICER. We are. That is correct.

SMALL BUSINESS HEALTH PLANS

Mr. ALLARD. Mr. President, I am going to speak under morning business on Senate bill 1955, the small business health plans legislation that is going to be before us shortly for formal debate. I come to the floor to talk about a piece of legislation that is important to my Colorado constituents. I would like to talk about the Health Insurance Marketplace Modernization Act, sometimes known as HIMMA.

This legislation, which is also known as the small business health plans bill, would allow for small businesses to come together to form a group which could then use their combined purchasing power to influence insurance companies for affordable health plans.

It has been suggested that those who serve in the Senate have no understanding of what small business folks are going through and that most of us have never been faced with the reality of having no health insurance and therefore don't understand the plight of the small businessman. I come to dispel that rumor. I am a former small businessman who couldn't afford the cost of health insurance for myself or for my employees.

My wife and I discussed options for ourselves and for our employees. Similar to many other small business owners across the country, we decided it would be better to raise our employees' rate of pay and allow them to purchase their own individual plans. My wife and I decided to begin setting aside our own savings account to pay for health care costs in case, for some reason or another, I had an incident or she had an incident where we needed to go to the hospital and thus needed health care coverage.

Being a veterinarian and lifting heavy dogs onto the exam table all the time, and not expecting the dog owner to pick up the other half of a giant breed such as a Great Dane, I ended up having back problems and had to have back surgery. I didn't have health insurance, but I paid for it myself out of my own pocket. Fortunately, my wife and I had the foresight to set aside a savings plan so that if something such as this did happen, we could pay for it. But it did set us back.

We were able to survive that particular incident. It was kind of an interesting thing, what happened to me when I went to go to the hospital. The administrators didn't want me to go into the hospital. The hospital would not let us in because we did not have health insurance. I said: Well, I will pay for it. When we got in there, I had the surgery, and I did very well, and I am very active today. The doctors did a great job on surgery. When we checked out of the hospital, the administrator said that they would reduce our costs by 20 percent because they did not have to deal with the paperwork and with the cost of having to process my claim. So much of the paperwork is driven by trying to protect the hospital, the doctors, and the administrators from frivolous lawsuits. That has been my personal experience.

I must admit I was disappointed when, earlier in the week, Members of the Senate chose to side with trial lawyers instead of women and children. And I was disappointed that Members of the Senate decided to support turning the medical profession into a cash cow for the legal profession instead of allowing for legitimate compensation.

Again, in a matter of minutes, we will be debating the small business health plans bill and another attempt to bring down the high cost of health care, specifically for working class families who are employed by small businesses that, similar to my own situation, cannot afford to provide health insurance for their employees.

I think it is important for us to focus this debate on at least giving small businesses the opportunity to make a choice on providing health care for themselves and for their employees. Currently, because of the prohibitive cost of health care coverage for their employees, many small business employers don't even have the option of offering coverage.

Some of my constituents have brought to my attention over the past few weeks their worries that because of the lack of insurance benefit mandates, they could lose important benefits such

as diabetes services and supplies, and coverage of preventive services such as colorectal screenings and mammograms. These worries are unfounded. Today there are over 1,800 different State mandates for health care coverage, including different coverage mandates in different States for the same preventive care, services, and supplies. This huge variation in mandates has made it nearly impossible to provide standardized coverage on a national basis.

Additionally, the Government Accountability Office, which is an agency which helps to watch our dollars, has also found that the cost of mandates to a typical plan results in an increase between 5 and 22 percent. The Congressional Budget Office, another dollar-watching agency, estimates that for every 1 percent increase in insurance costs, a minimum of 200,000 Americans are left uninsured.

Facts suggest that things such as diabetes services and supplies and preventive services such as mammograms and colorectal screenings are usually covered by health plans, regardless of the State mandates. For example, the five most populous States require that diabetes care be covered. According to the American Diabetic Association and the GAO, only 4 out of 50 States do not require diabetic coverage.

The General Accounting Office also studied States that are not subject to mandated coverages of diabetic services and supplies. Despite not being subject to mandated requirements for coverage, several of the largest plans and many of the largest Fortune 500 companies provide comprehensive coverage for diabetes care.

This factual evidence also applies to preventive services such as cancer screening. The Government Accountability Office found that the majority of States that do not have mandates continue to provide coverage in a majority of their employer plans for cancer screening.

The bottom line is that the small business health plan bill makes logical sense. It will give small business owners what they want and what they need, and they will offer insurance coverage for their employees. It makes logical sense that plans covering preventive care will be offered because preventive care costs less in the long run. It makes logical sense that small business owners who currently cannot provide their employees with health care would purchase coverage because it is more affordable.

It is important to note at this point that a small business owner who buys health care coverage is also naturally subject to the same health care coverage that he provides his employees. Small business owners are pushing for health insurance coverage for themselves and their employees, which they otherwise could not afford. It is not logical that they would pay money for a plan that does not provide them with medical coverage. Also, the point of small business health plans is so that small businesses can join together to use joint collaboration to get their health care needs met.

I support the legislation because I support giving small businesses a choice. I support giving small businesses the opportunity for health care coverage that they currently do not receive. I support giving diabetics the opportunity for health care coverage, instead of leaving them completely without services and supplies. I support giving small business employees the opportunity for cancer screening and preventive care, instead of leaving them with nothing and no opportunity to provide health care for themselves and their families.

I urge my colleagues to support the small business health plans legislation, and I urge my colleagues to vote in favor of Senate bill 1955, the Health Insurance Marketplace Modernization Act. I urge my fellow Senators to give small businesses the opportunity to access health care for themselves and their employees.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ALEXANDER. Mr. President, I come to the Senate floor to speak about getting some long overdue help for small business men and women in Tennessee who have really been struggling to afford health insurance for themselves, their employees, and their families. We have an opportunity in this body to do something about it. This is not some abstract discussion we are having here; this is about something every single one of us hears—at least I know I hear it. Whether I go to Mountain City or Sevierville or Lexington or Memphis—wherever I go in Tennessee, a small business man or woman says to me: We cannot afford health care costs; we need some help.

We have some help. We have a proposal by Senator ENZI that will provide some help to small business men and women. Now is the time for us to act. Now is the time for the people of this country who are listening to this, who know we need this, to say to Senators: Let's go. Let's do this. Let's take the Enzi bill and reduce health care costs for small businesses across this country, and at the same time let's cut into the millions of Americans who are uninsured because the people for whom they work cannot afford to offer them health care insurance.

Here is the situation in Tennessee. We have well over 2 million people at work in Tennessee, and 97 percent of all businesses are what we would call small businesses. So that is whom we are talking about in our State—more than 2 million people who work, many of whom are working for companies that cannot afford to provide them health care insurance or are gradually reaching the point where they can't give them that benefit anymore. Increased health insurance costs are driving employers and families away from comprehensive coverage. Increased costs are taking away the opportunity for a working family in Tennessee to be able to work for a company that can offer a basic insurance policy that the family and the employer can afford. What we are doing this week is moving away from that situation. What we are doing in the Senate this week and next week is providing an opportunity to change that situation.

Dennis Akin runs the Wash Wizard car wash in Hendersonville, TN. We are not talking about big-time CEOs who make $350 million a year and fly corporate jets somewhere. We are talking about Dennis Akin who runs the Wash Wizard car wash in Hendersonville, TN, just outside of Nashville. This is what he says:

> I am currently providing health care for all my employees and their families. The cost at the present time is over $44,000 per year for 5 employees, up 28 percent from last year. The premiums have escalated at about that rate for the last several years, and twice I have had to drop to plans with lesser coverage to be able to pay the premiums.

Dennis Akin went on to say:

> We really need to be able to find some kind of relief or we'll have to reduce our benefit level to where the financial burden on my staff could be devastating. In a business as small as mine health care costs are my largest expense and there seems to be no end in sight.

According to the Kaiser Family Foundation, about a third of Tennessee firms with 50 or fewer employees offer health insurance to their employees. In contrast, 95 percent of Tennessee firms with 50 or more employees offer health insurance to their employees.

Our economy is not static. It changes all the time. Every year, we lose an estimated 5 to 8 percent of our jobs. That is a lot of jobs. That is between 100,000 and 150,000 jobs just in Tennessee. The good news is we have the strongest economy in the world and we are gaining more jobs than we lose. But where do those jobs come from? They don't primarily come from Federal Express or Eastman Chemical or the Aluminum Company of America or DuPont. We are glad to have all those great employers in Tennessee, but most of the new jobs come from the Wash Wizard car wash in Hendersonville, TN, and companies like that. These are new companies, small companies. They may be adding two or three employees a year. Currently, only a third of those firms, those firms with 50 or fewer, can afford to offer health insurance of any kind to their employees.

What does that mean? That means that most Tennesseans are simply left without any access to health care that they can afford because in our country, the way things are today, most people

get their health insurance from their employer. Maybe that is not the way it should be. Maybe 10 years from now, we will be in a different sort of system. But since World War II, that has been the way it has been. By an accident of our history, most Americans get their health insurance at the place where they work.

What we are saying is, in States such as Tennessee, and all across this country, only a third of the people who work for small businesses—which is where 97 percent of the people work—can get a health care plan there. No wonder we have a lot uninsured people, and no wonder we have a lot of families worrying about the rising cost of health care.

The reason we are having this debate is the chairman has a bill that will fix that situation. It will lower health care costs for small businesses and help families be able to afford a basic health insurance plan. Every American ought to want that to succeed, and we need to pass this bill. We need to do this, and it is important for the American people to know that we intend to bring this to a vote in the next few days.

The discrepancy between what is available in the big companies and what is available in the small, independent companies is absolutely unfair. There is no reason for it.

Earlier this month, the National Federation of Independent Business, Tennessee's largest small business advocacy group, delivered 10,905 petitions in support of this bill signed by small business owners in Tennessee who want lower health care costs. We must make health insurance affordable for Tennessee's small business owners and for working families.

How will the Enzi bill help? When I say the Enzi bill, that is the chairman of the committee who has worked on this bill and who has been able to work through a lot of obstacles that prevented this from happening in the Senate before.

The Small Business Act—a fancy name is the Health Insurance Marketplace Modernization and Affordability Act—I, like Chairman ENZI, like to call it the Small Business Health Insurance Act. That is a pretty good name because that says what it does. Here is what it will do.

It will allow businesses and trade associations to band their members together and offer group health insurance coverage on a national or regional basis.

It will empower small business owners and give them the opportunity to choose a health plan that is best for their families and best for their employees. This bill will promote lower costs and greater access to health care. Lower cost means the employer can afford it. The plan itself, with the employee contribution—if the employee can afford it—being available means there will be more access to it. It will do that by, No. 1, permitting the creation of fully insured small business health plans; No. 2, creating more options in benefit design—in other words, you will have more choices; if you want this or this, if you can't afford that, you can try this—and, No. 3, it harmonizes insurance regulations across State lines while keeping States as the primary regulators.

I am a former Governor. I am for States rights. You often see me on the Senate floor asserting the principle of federalism. I believe strong States and strong communities are important for our country and that we ought not be constantly passing national solutions to problems without recognizing that.

But I believe the Enzi bill properly respects the principle of federalism. It protects State oversight. It protects State authority. I also believe it is important to have a level playing field for everyone in the market—and the bill does that as well.

A study prepared by the Milwaukee firm of Mercer Oliver Wyman for the National Small Business Association found that the Enzi bill would, one, reduce health insurance costs for small businesses by 12 percent, about $1,000 per employer, and reduce the number of uninsured and working families by 8 percent, approximately 1 million people nationwide would have basic health insurance who today don't have it.

This bill would cut the cost of health insurance for small businesses, which is 97 percent of where the people in my State work. That is No. 1. No. 2, it reduces the number of uninsured and working families by 1 million people across this country.

This is a piece of legislation worth passing. It actually does something for somebody. This is a rare opportunity to help small businesses. It is a real milestone moment, and Chairman ENZI is to be commended for getting the bill this far.

The House of Representatives has passed this legislation, on which the Presiding Officer served, and I am sure he has voted for it three, four, or five times over in the House of Representatives. But then it gets over here to the Senate, and we have been in gridlock for 10 years on this issue. The House of Representatives has passed this legislation eight times, and for 10 years we haven't been able to find a way to say we are going to reduce the health care costs for small businesses by 12 percent and decrease the number of Americans who are uninsured, that we are going to give 1 million of them insurance. That was until Chairman ENZI set his sights on trying to unravel the stalemate. He did it. He got the small business community together with the insurance commissioners and the insurance companies all around one table to discuss how to make it work.

We need to take advantage of this rare opportunity to help the small business men and women in Tennessee and across this country to find affordable health insurance by passing this important legislation.

We have said on the Republican side that this is Health Week; that we have heard the American people; we know that there are uninsured Americans; and, we know that small businesspeople are struggling. They are struggling with the cost of runaway litigation. We are trying to stop that, but the other side of the aisle blocked that twice this week when we put up legislation that would have given mothers and babies a chance to be better served by OB/GYN doctors.

Who can be against that? The other side of the aisle was against it. They basically kept Tennessee mothers who are pregnant from having a chance to be served by OB/GYN doctors. Now they have to drive a long way to have their babies. Unfortunately, they are going to have to keep driving because the other side of the aisle said, no; you are not going to even be able to vote on that.

Now we have moved to the next issue that will help small business. If we couldn't this week help mothers who are about to have babies by giving them better access to health care, at the very least we can take the Enzi bill and pass it and say to the thousands and thousands of realtors, to the thousands and thousands of barbershops, gas stations, and say to Dennis Akin who runs the Wash Wizard car wash in Hendersonville, TN, we can say to the small businesses in Tennessee—which is 97 percent of all the businesses—we will cut your insurance costs by 12 percent, or at least give you that option, and to the people of this country we will increase by 1 million the number who are able to get insurance.

This legislation is a good piece of legislation to help lower the cost of health insurance. I hope very much that in the next several days we can pass it. The House has passed it eight times. We can at least pass it once, and then the American people will see that we hear them and we are doing the job they want us to do.

Thank you. I yield the floor.

EXTENSION OF MORNING BUSINESS

Mr. ALEXANDER. Mr. President, on behalf of the leader, I ask unanimous consent that at 2 p.m. the Senate extend morning business until 2:30 p.m. with the time equally divided between the majority and minority, and upon conclusion at 2:30 p.m. the majority leader be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ALEXANDER. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KENNEDY. Mr. President, I will yield myself such time as I might use.

Mr. President, as I mentioned earlier, we thought we would have a good opportunity to have a good, healthy debate on a range of different health policy issues. This was designated as Health Week. A number of our colleagues had some very important amendments—some that are extraordinarily timely—one by the Senator from Florida, Mr. NELSON, to address what is going to be effectively a new tax or fee on millions—the best estimate is 8 million of our senior citizens—who are not enrolled in the Medicare Part D Program. That will cost seniors hundreds of millions of dollars if that is not the addressed. We have a good opportunity to address that in the Senate.

We have the issues on stem cell research. That is enormously important legislation at the desk. The bill offers such extraordinary hope to millions who are affected by Parkinson's disease, Alzheimer's disease, diabetes, other genetic diseases. The possibilities are unlimited. I call it the hope bill because it offers so much hope. We thought we might have an opportunity to move forward on that. There are a clear majority of Senate Members who are for a good stem cell research program.

We have passed a good program in my own State of Massachusetts, Republicans and Democrats alike coming together, as we would on this legislation, but we are not going to be able to address that issue.

The whole issue about whether we give the Medicare system the ability to negotiate lower prices for prescription drugs that could benefit our seniors is something the VA does and it does very effectively. It saves millions and billions of dollars for our elderly people because of the ability to get a better price, which Medicare is prohibited from doing now. We believe we should at least have an opportunity to debate that issue and come to judgment on it. It can make a major difference. These are just several of the amendments out there.

I was looking forward to offering an amendment to the Enzi legislation that permits States to opt out of the Enzi proposal, if they so desired. It sounded to me that we had a vote on that issue in our Committee on Human Resources, and it was defeated. It seems to me we should give the State the option.

We have had at least a pretty good discussion of the underlying Enzi bill, which effectively means skyrocketing premiums for many if they are older or have had some illness in their families. I will get into that in greater detail. But we permit States to opt out. That was defeated. We ought to have an opportunity to vote on that in the Senate.

All this can be done. I know the proponents of the amendments would be willing to agree to very reasonable time limitations on this. However, we effectively are being told that is not going to be possible. We are going to have a take-it-or-leave-it approach. That is not the wise way to proceed. I certainly hope we are not going to have to be required to take it.

I will review some of the statements and comments made by some of those who have been in support of this legislation that need focus, attention, and some correction. Those who support the Enzi proposal are doing it enthusiastically, but I think it is worthwhile to put the facts out on the table. The facts are we have some 47 million Americans who do not have health insurance. The fact remains, as we have seen in the Congressional Budget Office, the Enzi proposal actually benefits some 600,000. That is 1 percent of the 45 million who are uninsured.

In my State of Massachusetts, the Democratic leadership, with Sal DiMasi and President Travaglini coming together with Governor Romney, have the goal of covering 95 percent, minimum. Most believe we will get to 98 percent of all the people in our State. It is a valuable undertaking.

We have a proposal with 45 million uninsured and we expect, according to the Congressional Budget Office, some 600,000 will be included. That is from the assessment on page 5 from CBO.

In terms of the firms themselves, the CBO has pointed out one-quarter of all the small business firms will actually pay more for their health benefits. Those that support it have neglected that. A quarter of all the firms under the Enzi bill will have to pay more.

That is not true with the Durbin-Lincoln proposal, and the Durbin-Lincoln proposal will cover millions—not 600,000—millions of small businesses.

These are some of the facts from CBO. The premium decrease, according to CBO, would be 2 percent to 3 percent, a one-time savings of only $80 to $120 for the average individual and $215 to $325 for a family plan. The cost is lesser benefits. If you are going to eliminate your cancer screening, your well-baby care, your help and support in terms of diabetes, if you are going to eliminate the mental health benefits, sure, you can get some reduction in premium. That is what they do. But in State after State, including mine, we have those protections. That is the savings, one-time savings, according to the Congressional Budget Office.

For those who want to have a good understanding of exactly what this bill does and what it does not do, I hope they will have a chance to review the CBO estimate and analysis because it is at odds with a great deal of what those who have been supporting the proposal have stated. Finally, the total savings on employer-sponsored coverage are two-tenths of a percent.

On the other hand, let me mention an excellent analysis that has been done by Alex Feldvebel, the deputy commissioner in New Hampshire and an expert on this type of health insurance issue. These are his comments, talking about the market relief. That is what we call the ratings. What is the swing in a particular State? States can vary the ratings in terms of the market.

In, Alaska 2.5 percent to 1; Arkansas 3.3 to 1; California, 1.2 to 1. If you are an older person, older worker, if your family has maybe had some illness, you can only vary the premiums 1.2 percent in the State of California. In my State, it is 3 percent, 3 to 1. There are a number of States, such as New York, where you cannot change it. You cannot vary it. Everyone is in the same boat, so to speak.

Now, in the Enzi proposal, listen to this regarding the ratings, the permitted rate variation under this small group market rules is extreme. The total permitted variation between the highest rate group and the lowest rate group for the same health benefit is 25.4 to 1, or 2,540 percent. If the lowest rate is paying $100 per month, the highest rate would pay 2,500 per month. If you are young and healthy and just out of school, they give you the physical, and you are an A–1 specimen, you get it for $100. But if your family has had some illness or sickness and maybe your company has dropped its health insurance, if you have to purchase this, you can pay $2,500. Think what that will do. That is obviously going to be prohibitive, and more and more people will be left out.

Here is how the variable comes out. Age, 500 percent. Gender, 25 percent, it should be saying, women, 25 percent. They are automatically, under these calculations in this bill, gender, will be paying a higher premium. This is the Enzi legislation. And the variance continues. If you are in a wellness program, you get a 5-percent benefit. If you come in with a whole group of very young people who are very healthy, you can get a 40-percent reduction, but if you are an older person with sickness, you are up to 500 percent. That is the variation.

That is not acceptable. We all know what is going do happen. That is going to be the incentives.

This legislation, on page 100, talks about the definition relating to the model ''small group'' and those who supported the legislation use the Model Small Group Rating Rules for the Small Employer Health Insurance Availability Model Act of 1993. It is interesting that the insurance commissioners have upgraded this review and study several times. Do you think we are dealing with the most recent publication? No. We are back to 1993. It is the insurance organization, the NAIC model, that basically has been rejected and repudiated by the State insurance commissioners.

All you have to do is read from your own insurance commissioners, and they ask: Why in the world would the Senate use an old model, when we have much more recent information, much more updated information? The reason is, if you use this, the profits for the insurance industry are going to be much higher.

We ought to understand that. The insurance commissioners themselves have effectively rejected this particular proposal.

If we go to page 110, we will see ''Superseding of State Law.''

This part shall supersede any and all State laws . . .

This does not just say small business. This is about all State laws. Here it is, the clinical trials, cancer screening, diabetes, effectively preempt all the State laws, to and after the date relating to rating and in the small group insurance market.

It says to Massachusetts and to most of the States, if you have a benefit package, those are going to be preempted. That is what it says right there on page 110.

Page 110 actually is where it permits the fluctuation of the rating system. It talks about ratings. And that gives you the flexibility that I have mentioned. And then the preemption of State benefits is actually on page 119.

I would have thought, if we were serious about trying to do something for small business, we would have had the opportunity—Mr. President, how much time do I have left?

The PRESIDING OFFICER. The time under the control of the minority has now expired.

Mr. KENNEDY. My time has expired?

The PRESIDING OFFICER. Yes, the Senator's time has expired.

Mr. KENNEDY. I yield the floor.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. THUNE. Mr. President, the debate we are having today on small business health plans is a debate that I hope will ultimately lead to a vote in the Senate on this legislation.

This bill, or something very similar to it, has passed the House of Representatives on eight—eight—different occasions. Small business health plans have passed the other body, the House of Representatives, on eight different occasions.

I believe if we were allowed to vote today on this legislation in the Senate, we would have a big majority vote—a decisive majority vote—because I believe a majority of Senators support the legislation that has been produced by the Health, Education, Labor, and Pensions Committee under the leadership of Chairman ENZI. I believe there is strong majority support for that in the Senate.

Unfortunately, what will happen today—and in the days ahead—is we will not get a chance to have that vote because our colleagues on the other side have decided again to filibuster this legislation, to block it from ultimately being voted on. That is unfortunate. It is unfortunate for, most importantly, the people across this country who do not have health insurance coverage.

Mr. KENNEDY. Will the Senator yield on that point?

Mr. THUNE. I will not yield at this point. You had your time, Senator.

Mr. KENNEDY. I was wondering if you would yield for a question.

Mr. THUNE. I am not prepared to yield at this time. I will allow you to speak on your own time.

But the important point is that this particular legislation has not had an opportunity to be voted on in the Senate, legislation that would help small businesses in this country that currently cannot cover their employees, that currently have families of those employees without coverage.

In fact, if you ask small businesses today—and about 22.5 million of the 45 million uninsured in this country are employees of small businesses or are their families, and about another 15 million are self-employed in small businesses—the reason they cannot cover their employees is the cost.

What this legislation attempts to do is address the issue of cost, to make health insurance more affordable to more Americans, to small businesses, to their employees, to their families, to self-employed people in this country who currently do not have coverage because of the cost.

It is a very simple concept. It is a concept that has been passed eight times by the House of Representatives but never voted on in the Senate because of obstruction on the other side. They will not allow it to come to a vote. That is unfortunate because this is an issue the American people expect us to address.

So I hope when all is said and done, my colleagues on the other side—the Senator from Massachusetts has strong feelings on this particular issue, which he has articulated—have an opportunity to air those opinions, to debate this issue, but that, in the end, they let it be voted on.

Let's let this come to a vote. Let the will of the majority in the Senate decide one way or the other about whether we want to do something about the high cost of health care in this country to cover more people.

The Congressional Budget Office has said—the Senator from Massachusetts quoted the CBO—the Congressional Budget Office has said, if this legislation is enacted, almost a million more people in this country will be covered and, in fact, it will lead to lower insurance costs.

So it is a good deal for the people who are uninsured. It is a good deal for the small businesses that are trying to cover their employees. And I might add, it is a good deal for the taxpayers because the Congressional Budget Office has also said if this particular piece of legislation is enacted, the cost of Medicaid to the Federal Government will go down by almost $1 billion and the cost of Medicaid to State governments will go down by about $600 million.

Further, the Congressional Budget Office has also found that this will actually lead to higher revenues for the Federal Government. Why? Because when the small business cost of health care goes down, they are able to provide more benefits and more in the form of salaries to their employees. Those salaries and some of those benefits are taxable. Health insurance benefits are tax excluded in many cases. So those benefits and those additional salaries would be taxed at the marginal income tax rates, and it would generate, according to the Congressional Budget Office, an additional $3.3 billion over a 10-year period for the Federal coffers.

So we have a bill that covers more people, according to CBO, that lowers insurance rates, according to CBO, and that actually generates more revenue for the Federal Government. Yet we cannot vote on it. Why? Because our colleagues on the other side will not allow this legislation to be voted on.

I think the American people deserve and expect more from their elected leadership. As I said, the House of Representatives has voted eight times in support of this, with strong majorities. I believe there is a majority in the Senate in favor of this bill, if we could bring it to a vote today. Maybe we won't vote on it today. Maybe we would vote on it tomorrow or maybe we would vote on it next week, but let's vote on it.

Let's vote. That is what we are here for. Let's debate the issue, but let's vote. Let's not use the rules of the Senate to obstruct something that has clear majority support in the House, something that has been debated here but never voted on in the Senate because it has been blocked from final consideration.

Let me also say one other thing about this debate because there is a proposal that has been talked about some on the floor of the Senate, offered up by some of our colleagues on the other side, that is intended to respond to the Enzi legislation, the small business health plan legislation, that we are currently debating.

Interestingly enough, that particular piece of legislation offered by our colleagues on the other side is a Government-type approach to this issue. The CBO, the Congressional Budget Office, has found that the proposal they put forward actually costs the taxpayers $73 billion over a 10-year period.

So you have two bills. You have a bill that has been offered by Senator ENZI, the chairman of the HELP Committee, offered by the leadership on this side of the aisle, which lowers cost, which covers more people, which has been found to actually save the taxpayers money; and a bill that has been offered by our colleagues on the other side, at a cost to the taxpayers of $73 billion in additional tax dollars over a 10-year period.

Now, it seems to me, at least, that if you are a taxpayer, that bill is not a very good deal. It is also a proposal that leads to more redtape, more bureaucracy, more Government, at a time when we ought to be looking for ways to improve the market-based system we currently have in this country, by

allowing our small businesses to take advantage of the leverage they could gain by joining larger groups.

The very simple principle behind this legislation, behind the Enzi bill, is to allow small businesses around this country and their employees to be part of a larger group, thereby driving down the cost of their insurance premiums.

Mr. DURBIN. Will the Senator yield for a question?

Mr. THUNE. I will not yield at the moment. We have a few minutes left on our time, and then the Senator from Illinois could use his time to speak.

Mr. DURBIN. Will the Senator yield for a question?

Mr. THUNE. Not at the moment. Thank you, though.

What I would simply say is, the bill offered by the Senator from Illinois and by his colleagues on the other side is, again, legislation that comes at a high cost to the taxpayers: $73 billion over a 10-year period.

So it is important, when we have this debate, that the people in this country who are following the debate have a clear understanding of what the differences are between the approaches that are being offered—the Enzi bill, the bill that is under consideration today, the small business health plans bill, and the bill offered by our colleagues on the other side—the differences in terms of their approach, one being a Government approach, one being a market-based approach, one actually being scored by the Congressional Budget Office as achieving savings for the Federal taxpayer, and one that clearly adds to the costs of the taxpayer by about $73 billion over a 10-year period.

This has been dubbed Health Week because we are debating health care legislation. Small business health plans is one component of that. We also tried, Monday, to get a vote on legislation that would allow for reforms in our medical malpractice system that would, hopefully, again, drive down the cost of covering people in this country. The high cost of medical malpractice insurance is driving OB/GYNs and other specialists and providers out of the profession, driving up the cost of health care in this country.

In fact, the Department of Health and Human Services, a couple years ago, did a study that suggested the cost of defensive medicine and the cost of the medical malpractice system we have in the country today is actually costing the taxpayers, under Medicaid, an additional $22.5 billion a year.

It is important we address these issues. I believe the American people want us to act. More importantly, they want us at least to vote. That is all I am simply saying. For those on the other side who have consistently resisted the enactment of these two pieces of legislation, that is fine. I understand that is part of this process, that we have a very open and free-flowing debate. That is part of the Senate. That is part of our democratic process we have here.

But when all is said and done, let's bring this to a vote so the people of this country, who expect action out of the Senate, at least know where their elected folks stand when it comes to the issue of small business and whether we are going to provide health care for the employees of small businesses across this country and whether we are going to do anything to address what I think is a very important economic issue to a majority of Americans; that is, this ever-rising, increasing cost of health care.

These two pieces of legislation—small business health care plans, S. 1955, offered by Senator ENZI, the chairman of the HELP Committee—and it is a bipartisan bill; it also has Democratic support, although not enough to stop a filibuster—and the medical malpractice reform legislation, which, again, there were two pieces of medical malpractice reform legislation voted on Monday—we were not able to get enough votes to stop a filibuster to invoke cloture—but, there again, I believe both pieces of legislation have majority support in the Senate and, clearly, have majority support in the House of Representatives.

They have already passed there repeatedly. Small businesses health plans have passed eight times in the House of Representatives. Medical malpractice reform has passed five times in the House of Representatives. That legislation has come to the floor of the Senate and has been blocked from receiving an up-and-down vote.

I think it is in the best interest of people across this country who are expecting Congress to act on the issue of health care and the high cost of health care. They want us to come up with solutions that respect and are in the best interest of the American taxpayer. I believe these two pieces of legislation accomplish that objective.

So I hope before this Health Week is over—and even if we have to push this into next week—we at least get a vote on the floor of the Senate that will enable us to take final action on a couple of pieces of legislation that have been lingering around here for way too long and deserve action by the Senate.

With that, Mr. President, I yield back the remainder of my time.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, morning business is closed.

HEALTH INSURANCE MARKETPLACE MODERNIZATION AND AFFORDABILITY ACT OF 2006

The PRESIDING OFFICER. The Senate will proceed to the consideration of S. 1955, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1955) to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace.

The Senate proceeded to consider the bill which had been reported from the Committee on Health, Education, Labor, and Pensions, with an amendment in the nature of a substitute.

(Strike the part shown in black brackets and insert the part shown in italic.)

S. 1955

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

[(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2005''.

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

[TITLE I—SMALL BUSINESS HEALTH PLANS

[SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

[(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

[''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

[''SEC. 801. SMALL BUSINESS HEALTH PLANS.

[''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

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

[''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue

Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

[''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

[''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

[Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

["SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

[''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

[''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—a small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

[''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small employer health plan involved is failing to comply with the requirements of this part.

[''(d) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for small business health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such small business health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 806(a).

["SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

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

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

[''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

[''(A) BOARD MEMBERSHIP.—

[''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

[''(ii) LIMITATION.—

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

[''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

[''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

[''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005.

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

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

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

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

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

["SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

[''(1) each participating employer must be—

[''(A) a member of the sponsor;

[''(B) the sponsor; or

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

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

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

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

[''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of a small business health plan in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

[''(1) the affiliated member was an affiliated member on the date of certification under this part; or

[''(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such small business health plan.

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

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

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

[''(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

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

["SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

[''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

[''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

[''(i) provides that the board of directors serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

[''(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

[''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance

coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

[''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

[''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged.

[''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan, and at the request of such small business health plan, from—

[''(i) setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of clause (ii); or

[''(ii) varying contribution rates for participating employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2005.

[''(3) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

[''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan, from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2005, provided that, upon issuance by the Secretary of Health and Human Services of the List of Required Benefits as provided for in section 2922(a) of the Public Health Service Act, the required scope and application for each benefit or service listed in the List of Required Benefits shall be—

[''(1) if the domicile State mandates such benefit or service, the scope and application required by the domicile State; or

[''(2) if the domicile State does not mandate such benefit or service, the scope and application required by the non-domicile State that does require such benefit or service in which the greatest number of the small business health plan's participating employers are located.

[''(c) STATE LICENSURE AND INFORMATIONAL FILING.—

[''(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

[''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located, an insurer issuing coverage to such small business health plan shall not be required to obtain full licensure in such State, except that the insurer shall provide each State insurance commissioner (or applicable State authority) with an informational filing describing policies sold and other relevant information as may be requested by the applicable State authority.

[''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

[''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

[''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

[''(1) IDENTIFYING INFORMATION.—The names and addresses of—

[''(A) the sponsor; and

[''(B) the members of the board of trustees of the plan.

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

[''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

[''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

[''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

[''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

[''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

[''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

[''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

[''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

[''(3) submits such plan in writing to the applicable authority.

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

[''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

[''(a) DEFINITIONS.—For purposes of this part—

[''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

[''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

[''(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

[''(C) in the case of a small business health plan in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2005, a person eligible to be a member of the sponsor or one of its member associations.

[''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

[''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

[''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

[''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

[''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

[''(7) INDIVIDUAL MARKET.—

[''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

[''(B) TREATMENT OF VERY SMALL GROUPS.—

[''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

[''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

[''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

[''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

[''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

[''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

[''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

[''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.''.

[(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

[(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

[(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

[(C) by redesignating subsection (d) as subsection (e); and

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

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

[''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of section 805(a)(2)(B) and (b) (concerning small business health plan rating and benefits) are met.''.

[(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

[(A) in clause (i)(II), by striking ''and'' at the end;

[(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

[(C) by adding at the end the following new clause:

[''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

[(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''.

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

[(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

[(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

[''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

[''801. Small business health plans.
[''802. Certification of small business health plans.
[''803. Requirements relating to sponsors and boards of trustees.
[''804. Participation and coverage requirements.
[''805. Other requirements relating to plan documents, contribution rates, and benefit options.
[''806. Requirements for application and related requirements.
[''807. Notice requirements for voluntary termination.
[''808. Definitions and rules of construction.''.

[SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

[Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

[''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

[''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

[''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

[''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

[''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

[SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

[(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 1 year after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 1 year after the date of the enactment of this Act.

[(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

[(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

[(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which—

[(i) is elected by the participating employers, with each employer having one vote; and

[(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

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

[(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

[The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

[(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

[TITLE II—NEAR-TERM MARKET RELIEF

[SEC. 201. NEAR-TERM MARKET RELIEF.

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

["TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE REFORM

["SEC. 2901. GENERAL INSURANCE DEFINITIONS.

[''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

["Subtitle A—Near-Term Market Relief

["PART I—RATING REQUIREMENTS

["SEC. 2911. DEFINITIONS.

[''In this part:

[''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted either the NAIC model rules or the National Interim Model Rating Rules in their entirety and as the exclusive laws of the State that

relate to rating in the small group insurance market.

[''(2) COMMISSION.—The term 'Commission' means the Harmonized Standards Commission established under section 2921.

[''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

[''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage consistent with the National Interim Model Rating Rules in a nonadopting State;

[''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the National Interim Model Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

[''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the National Interim Model Rating Rules and an affirmation that such Rules are included in the terms of such contract.

[''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in small group health insurance market.

[''(5) NAIC MODEL RULES.—The term 'NAIC model rules' means the rating rules provided for in the 1992 Adopted Small Employer Health Insurance Availability Model Act of the National Association of Insurance Commissioners.

[''(6) NATIONAL INTERIM MODEL RATING RULES.—The term 'National Interim Model Rating Rules' means the rules promulgated under section 2912(a).

[''(7) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

[''(8) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

[''(9) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

["SEC. 2912. RATING RULES.

[''(a) NATIONAL INTERIM MODEL RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall, through expedited rulemaking procedures, promulgate National Interim Model Rating Rules that shall be applicable to the small group insurance market in certain States until such time as the provisions of subtitle B become effective. Such Model Rules shall apply in States as provided for in this section beginning with the first plan year after the such Rules are promulgated.

[''(b) UTILIZATION OF NAIC MODEL RULES.—In promulgating the National Interim Model Rating Rules under subsection (a), the Secretary, except as otherwise provided in this subtitle, shall utilize the NAIC model rules regarding premium rating and premium variation.

[''(c) TRANSITION IN CERTAIN STATES.—

[''(1) IN GENERAL.—In promulgating the National Interim Model Rating Rules under subsection (a), the Secretary shall have discretion to modify the NAIC model rules in accordance with this subsection to the extent necessary to provide for a graduated transition, of not to exceed 3 years following the promulgation of such National Interim Rules, with respect to the application of such Rules to States.

[''(2) INITIAL PREMIUM VARIATION.—

[''(A) IN GENERAL.—Under the modified National Interim Model Rating Rules as provided for in paragraph (1), the premium variation provision of subparagraph (C) shall be applicable only with respect to small group policies issued in States which, on the date of enactment of this title, have in place premium rating band requirements that vary by less than 50 percent from the premium variation standards contained in subparagraph (C) with respect to the standards provided for under the NAIC model rules.

[''(B) OTHER STATES.—Health insurance coverage offered in a State that, on the date of enactment of this title, has in place premium rating band requirements that vary by more than 50 percent from the premium variation standards contained in subparagraph (C) shall be subject to such graduated transition schedules as may be provided by the Secretary pursuant to paragraph (1).

[''(C) AMOUNT OF VARIATION.—The amount of a premium rating variation from the base premium rate due to health conditions of covered individuals under this subparagraph shall not exceed a factor of—

[''(i) +/- 25 percent upon the issuance of the policy involved; and

[''(ii) +/- 15 percent upon the renewal of the policy.

[''(3) OTHER TRANSITIONAL AUTHORITY.—In developing the National Interim Model Rating Rules, the Secretary may also provide for the application of transitional standards in certain States with respect to the following:

[''(A) Independent rating classes for old and new business.

[''(B) Such additional transition standards as the Secretary may determine necessary for an effective transition.

["SEC. 2913. APPLICATION AND PREEMPTION.

[''(a) SUPERCEDING OF STATE LAW.—

[''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, in a nonadopting State.

[''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

[''(A) prohibit an eligible insurer from offering coverage consistent with the National Interim Model Rating Rules in a nonadopting State; or

[''(B) discriminate against or among eligible insurers offering health insurance coverage consistent with the National Interim Model Rating Rules in a nonadopting state.

[''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

[''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

[''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

[''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the small group health insurance coverage issued in the nonadopting State. In no case shall this paragraph, or any other provision of this title, be construed to create a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such a plan.

[''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE NATIONAL RULE.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other State agency) with the authority to enforce State law requirements relating to the National Interim Model Rating Rules that are not set forth in the terms of the small group health insurance coverage issued in a nonadopting State, in a manner that is consistent with the National Interim Model Rating Rules and that imposes no greater duties or obligations on health insurance issuers than the National Interim Model Rating Rules.

[''(5) NONAPPLICATION TO SUBSECTION (A)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

[''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

[''(c) EFFECTIVE DATE.—This section shall apply beginning in the first plan year following the issuance of the final rules by the Secretary under the National Interim Model Rating Rules.

["SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

[''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

[''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a state law that violates this part.

[''(c) VIOLATIONS OF SECTION 2913.—In the case of a nonadopting State that is in violation of section 2913(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.

["SEC. 2915. SUNSET.

[''The National Interim Model Rating Rules shall remain in effect in a non-adopting State until such time as the harmonized national rating rules are promulgated and effective pursuant to part II. Upon such effective date, such harmonized rules shall supersede the National Rules.

["PART II—LOWER COST PLANS

["SEC. 2921. DEFINITIONS.

[''In this part:

[''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the State Benefit Compendium in its entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

[''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer

that is licensed in a nonadopting State and that—

[''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage consistent with the State Benefit Compendium in a nonadopting State;

[''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage in that State consistent with the State Benefit Compendium, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

[''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the State Benefit Compendium and that adherence to the Compendium is included as a term of such contract.

[''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets.

[''(4) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

[''(5) STATE BENEFIT COMPENDIUM.—The term 'State Benefit Compendium' means the Compendium issued under section 2922.

[''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

[''SEC. 2922. OFFERING LOWER COST PLANS.

[''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of the benefit, service, and provider mandates that are required to be provided by health insurance issuers in at least 45 States as a result of the application of State benefit, service, and provider mandate laws.

[''(b) STATE BENEFIT COMPENDIUM.—

[''(1) VARIANCE.—Not later than 12 months after the date of enactment of this title, the Secretary shall issue by interim final rule a compendium (to be known as the 'State Benefit Compendium') of harmonized descriptions of the benefit, service, and provider mandates identified under subsection (a). In developing the Compendium, with respect to differences in State mandate laws identified under subsection (a) relating to similar benefits, services, or providers, the Secretary shall review and define the scope and application of such State laws so that a common approach shall be applicable under such Compendium in a uniform manner. In making such determination, the Secretary shall adopt an approach reflective of the approach used by a plurality of the States requiring such benefit, service, or provider mandate.

[''(2) EFFECT.—The State Benefit Compendium shall provide that any State benefit, service, and provider mandate law (enacted prior to or after the date of enactment of this title) other than those described in the Compendium shall not be binding on health insurance issuers in an adopting State.

[''(3) IMPLEMENTATION.—The effective date of the State Benefit Compendium shall be the later of—

[''(A) the date that is 12 months from the date of enactment of this title; or

[''(B) such subsequent date on which the interim final rule for the State Benefit Compendium shall be issued.

[''(c) NON-ASSOCIATION COVERAGE.—With respect to health insurers selling insurance to small employers (as defined in section 808(a)(10) of the Employee Retirement Income Security Act of 1974), in the event the Secretary fails to issue the State Benefit Compendium within 12 months of the date of enactment of this title, the required scope and application for each benefit or service listed in the List of Required Benefits shall, other than with respect to insurance issued to a Small Business Health Plan, be—

[''(1) if the State in which the insurer issues a policy mandates such benefit or service, the scope and application required by such State; or

[''(2) if the State in which the insurer issues a policy does not mandate such benefit or service, the scope and application required by such other State that does require such benefit or service in which the greatest number of the insurer's small employer policyholders are located.

[''(d) UPDATING OF STATE BENEFIT COMPENDIUM.—Not later than 2 years after the date on which the Compendium is issued under subsection (b)(1), and every 2 years thereafter, the Secretary, applying the same methodology provided for in subsections (a) and (b)(1), in consultation with the National Association of Insurance Commissioners, shall update the Compendium. The Secretary shall issue the updated Compendium by regulation, and such updated Compendium shall be effective upon the first plan year following the issuance of such regulation.

[''SEC. 2923. APPLICATION AND PREEMPTION.

[''(a) SUPERCEDING OF STATE LAW.—

[''(1) IN GENERAL.—This part shall supersede any and all State laws (whether enacted prior to or after the date of enactment of this title) insofar as such laws relate to benefit, service, or provider mandates in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, in a nonadopting State.

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

[''(A) prohibit an eligible insurer from offering coverage consistent with the State Benefit Compendium, as provided for in section 2922(a), in a nonadopting State; or

[''(B) discriminate against or among eligible insurers offering or seeking to offer health insurance coverage consistent with the State Benefit Compendium in a nonadopting State.

[''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

[''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

[''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

[''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the group health insurance coverage issued in a nonadopting State. In no case shall this paragraph, or any other provision of this title, be construed to create a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such plan.

[''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE COMPENDIUM.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other state agency) authority to enforce State law requirements relating to the State Benefit Compendium that are not set forth in the terms of the group health insurance coverage issued in a nonadopting State, in a manner that is consistent with the State Benefit Compendium and imposes no greater duties or obligations on health insurance issuers than the State Benefit Compendium.

[''(5) NONAPPLICATION TO SUBSECTION (A)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

[''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

[''(c) EFFECTIVE DATE.—This section shall apply upon the first plan year following final issuance by the Secretary of the State Benefit Compendium.

[''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

[''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

[''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a State law that violates this part.

[''(c) VIOLATIONS OF SECTION 2923.—In the case of a nonadopting State that is in violation of section 2923(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.''.

[TITLE III—HARMONIZATION OF HEALTH INSURANCE LAWS

[SEC. 301. HEALTH INSURANCE REGULATORY HARMONIZATION.

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

[''Subtitle B—Regulatory Harmonization

[''SEC. 2931. DEFINITIONS.

[''In this subtitle:

[''(1) ACCESS.—The term 'access' means any requirements of State law that regulate the following elements of access:

[''(A) Renewability of coverage.

[''(B) Guaranteed issuance as provided for in title XXVII.

[''(C) Guaranteed issue for individuals not eligible under subparagraph (B).

[''(D) High risk pools.

[''(E) Pre-existing conditions limitations.

[''(2) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

[''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

[''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

[''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer group health insurance coverage in that State consistent with the State Benefit Compendium, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

[''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

[''(4) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards adopted by the Secretary under section 2932(d).

[''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market.

[''(6) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 2 years of the date in which final regulations are issued by the Secretary adopting the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

[''(7) PATIENT PROTECTIONS.—The term 'patient protections' means any requirement of State law that regulate the following elements of patient protections:

[''(A) Internal appeals.

[''(B) External appeals.

[''(C) Direct access to providers.

[''(D) Prompt payment of claims.

[''(E) Utilization review.

[''(F) Marketing standards.

[''(8) PLURALITY REQUIREMENT.—The term 'plurality requirement' means the most common substantially similar requirements for elements within each area described in section 2932(b)(1).

[''(9) RATING.—The term 'rating' means, at the time of issuance or renewal, requirements of State law the regulate the following elements of rating:

[''(A) Limits on the types of variations in rates based on health status.

[''(B) Limits on the types of variations in rates based on age and gender.

[''(C) Limits on the types of variations in rates based on geography, industry and group size.

[''(D) Periods of time during which rates are guaranteed.

[''(E) The review and approval of rates.

[''(F) The establishment of classes or blocks of business.

[''(G) The use of actuarial justifications for rate variations.

[''(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

[''(11) SUBSTANTIALLY SIMILAR.—The term 'substantially similar' means a requirement of State law applicable to an element of an area identified in section 2932 that is similar in most material respects. Where the most common State action with respect to an element is to adopt no requirement for an element of an area identified in such section 2932, the plurality requirement shall be deemed to impose no requirements for such element.

["SEC. 2932. HARMONIZED STANDARDS.

[''(a) COMMISSION.—

[''(1) ESTABLISHMENT.—The Secretary, in consultation with the NAIC, shall establish the Commission on Health Insurance Standards Harmonization (referred to in this subtitle as the 'Commission') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the laws adopted in a plurality of the States.

[''(2) COMPOSITION.—The Commission shall be composed of the following individuals to be appointed by the Secretary:

[''(A) Two State insurance commissioners, of which one shall be a Democrat and one shall be a Republican, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

[''(B) Two representatives of State government, one of which shall be a governor of a State and one of which shall be a State legislator, and one of which shall be a Democrat and one of which shall be a Republican.

[''(C) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

[''(D) Two representatives of health insurers, of which one shall represent insurers that offer coverage in all markets (including individual, small, and large markets), and one shall represent insurers that offer coverage in the small market.

[''(E) Two representatives of consumer organizations.

[''(F) Two representatives of insurance agents and brokers.

[''(G) Two representatives of healthcare providers.

[''(H) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

[''(I) One administrator of a qualified high risk pool.

[''(3) TERMS.—The members of the Commission shall serve for the duration of the Commission. The Secretary shall fill vacancies in the Commission as needed and in a manner consistent with the composition described in paragraph (2).

[''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

[''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Commission shall identify and recommend nationally harmonized standards for the small group health insurance market, the individual health insurance market, and the large group health insurance market that relate to the following areas:

[''(A) Rating.

[''(B) Access to coverage.

[''(C) Patient protections.

[''(2) RECOMMENDATIONS.—The Commission shall recommend separate harmonized standards with respect to each of the three insurance markets described in paragraph (1) and separate standards for each element of the areas described in subparagraph (A) through (C) of such paragraph within each such market. Notwithstanding the previous sentence, the Commission shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the State Benefit Compendium pursuant to section 2922(a).

[''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

[''(1) IN GENERAL.—The Commission shall develop recommendations to harmonize inconsistent State insurance laws with the laws adopted in a plurality of the States. In carrying out the previous sentence, the Commission shall review all State laws that regulate insurance in each of the insurance markets and areas described in subsection (b)(1) and identify the plurality requirement within each element of such areas. Such plurality requirement shall be the harmonized standard for such area in each such market.

[''(2) CONSULTATION.—The Commission shall consult with the National Association of Insurance Commissioners in identifying the plurality requirements for each element within the area and in recommending the harmonized standards.

[''(3) REVIEW OF FEDERAL LAWS.—The Commission shall review whether any Federal law imposes a requirement relating to the markets and areas described in subsection (b)(1). In such case, such Federal requirement shall be deemed the plurality requirement and the Commission shall recommend the Federal requirement as the harmonized standard for such elements.

[''(d) RECOMMENDATIONS AND ADOPTION BY SECRETARY.—

[''(1) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this title, the Commission shall recommend to the Secretary the adoption of the harmonized standards identified pursuant to subsection (c).

[''(2) REGULATIONS.—Not later than 120 days after receipt of the Commission's recommendations under paragraph (1), the Secretary shall issue final regulations adopting the recommended harmonized standards. If the Secretary finds the recommended standards for an element of an area to be arbitrary and inconsistent with the plurality requirements of this section, the Secretary may issue a unique harmonized standard only for such element through the application of a process similar to the process set forth in subsection (c) and through the issuance of proposed and final regulations.

[''(3) EFFECTIVE DATE.—The regulations issued by the Secretary under paragraph (2) shall be effective on the date that is 2 years after the date on which such regulations were issued.

[''(e) TERMINATION.—The Commission shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

[''(f) UPDATED HARMONIZED STANDARDS.—

[''(1) IN GENERAL.—Not later than 2 years after the termination of the Commission under subsection (e), and every 2 years thereafter, the Secretary shall update the harmonized standards. Such updated standards shall be adopted in accordance with paragraph (2).

[''(2) UPDATING OF STANDARDS.—

[''(A) IN GENERAL.—The Secretary shall review all State laws that regulate insurance in each of the markets and elements of areas set forth in subsection (b)(1) and identify whether a plurality of States have adopted substantially similar requirements that differ from the harmonized standards adopted by the Secretary pursuant to subsection (d). In such case, the Secretary shall consider State laws that have been enacted with effective dates that are contingent upon adoption as a harmonized standard by the Secretary. Substantially similar requirements for each element within such area shall be considered to be an updated harmonized standard for such an area.

[''(B) REPORT.—The Secretary shall request the National Association of Insurance Commissioners to issue a report to the Secretary every 2 years to assist the Secretary

in identifying the updated harmonized standards under this paragraph. Nothing in this subparagraph shall be construed to prohibit the Secretary from issuing updated harmonized standards in the absence of such a report.

[''(C) REGULATIONS.—The Secretary shall issue regulations adopting updated harmonized standards under this paragraph within 90 days of identifying such standards. Such regulations shall be effective beginning on the date that is 2 years after the date on which such regulations are issued.

[''(g) PUBLICATION.—

[''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards adopted under this section on the Internet website of the Department of Health and Human Services.

[''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards adopted under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

[''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 2 years after the issuance by the Secretary of final regulations adopting harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

[''SEC. 2933. APPLICATION AND PREEMPTION.

[''(a) SUPERCEDING OF STATE LAW.—

[''(1) IN GENERAL.—The harmonized standards adopted under this subtitle shall supersede any and all State laws (whether enacted prior to or after the date of enactment of this title) insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, in a nonadopting State.

[''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

[''(A) prohibit an eligible insurer from offering coverage consistent with the harmonized standards in the nonadopting State; or

[''(B) discriminate against or among eligible insurers offering or seeking to offer health insurance coverage consistent with the harmonized standards in the nonadopting State.

[''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

[''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

[''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

[''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not apply to any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the terms of the health insurance coverage issued in a nonadopting State. In no case shall this paragraph, or any other provision of this subtitle, be construed to permit a cause of action on behalf of an individual or any other person under State law in connection with a group health plan that is subject to the Employee Retirement Income Security Act of 1974 or health insurance coverage issued in connection with such plan.

[''(4) NONAPPLICATION TO ENFORCE REQUIREMENTS RELATING TO THE COMPENDIUM.—Subsection (a)(1) shall not apply to any State law in a nonadopting State to the extent necessary to provide the insurance department of the State (or other state agency) authority to enforce State law requirements relating to the harmonized standards that are not set forth in the terms of the health insurance coverage issued in a nonadopting State, in a manner that is consistent with the harmonized standards and imposes no greater duties or obligations on health insurance issuers than the harmonized standards.

[''(5) NONAPPLICATION TO SUBSECTION (a)(2).—Paragraphs (3) and (4) shall not apply with respect to subsection (a)(2).

[''(6) NO AFFECT ON PREEMPTION.—In no case shall this subsection be construed to affect the scope of the preemption provided for under the Employee Retirement Income Security Act of 1974.

[''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 2 years after the date on which final regulations are issued by the Secretary under this subtitle adopting the harmonized standards.

[''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

[''(b) ACTIONS.—A health insurance issuer may bring an action in the district courts of the United States for injunctive or other equitable relief against a nonadopting State in connection with the application of a State law that violates this subtitle.

[''(c) VIOLATIONS OF SECTION 2933.—In the case of a nonadopting State that is in violation of section 2933(a)(2), a health insurance issuer may bring an action in the district courts of the United States for damages against the nonadopting State and, if the health insurance issuer prevails in such action, the district court shall award the health insurance issuer its reasonable attorneys fees and costs.

[''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS.

[''There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.''.]

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

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

TITLE I—SMALL BUSINESS HEALTH PLANS

SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

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

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan

shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

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

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

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

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

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

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

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

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

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

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

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

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

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

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

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

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

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

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

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

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

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

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

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of clause (ii), except that small business health plans shall not be subject to paragraphs (1)(A) and (3) of section 2911(b) of the Public Health Service Act; or

''(ii) varying contribution rates for participating employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A

of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

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

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

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

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

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

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

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

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

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

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 201. MARKET RELIEF.

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

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''(a) GENERAL DEFINITIONS.—In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted either the Model Small Group Rating Rules or, if applicable to such State, the Transitional Model Small Group Rating Rules, each in their entirety and as the exclusive laws of the State that relate to rating in the small group insurance market.

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in subsection (b).

''(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

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

''(b) DEFINITION RELATING TO MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means adapted rating rules drawn from the Adopted Small Employer Health Insurance Availability Model Act of 1993 of the National Association of Insurance Commissioners consisting of the following:

''(1) PREMIUM RATES.—Premium rates for health benefit plans to which this title applies shall be subject to the following provisions relating to premiums:

''(A) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

''(B) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under subparagraph (A).

''(C) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(ii) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(D) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(E) USE OF INDUSTRY AS A CASE CHARACTERISTIC.—A small employer carrier may utilize industry as a case characteristic in establishing premium rates, so long as the highest rate factor associated with any industry classification does not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

''(F) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(G) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(H) RESTRICTED NETWORK PROVISIONS.—For purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain a similar provision if the restriction of benefits to network providers results in substantial differences in claims costs.

''(I) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—The small employer carrier shall not use case characteristics other than age, gender, industry, geographic area, family composition, group size, and participation in wellness programs without prior approval of the applicable State authority.

''(J) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(2) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to paragraph (3), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(A) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(B) The small employer carrier has acquired a class of business from another small employer carrier.

''(C) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(3) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under paragraph (2), excluding those classes of business related to association groups under this title.

''(4) ADDITIONAL GROUPINGS.—The applicable State authority may approve the establishment of additional distinct groupings by small employer carriers upon the submission of an application to the applicable State authority and a finding by the applicable State authority that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

''(5) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(6) SUSPENSION OF THE RULES.—The applicable State authority may suspend, for a specified period, the application of paragraph (1) to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the applicable State authority either that the suspension is reasonable when considering the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

''SEC. 2912. RATING RULES.

''(a) IMPLEMENTATION OF MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the enactment of this title, the Secretary shall promulgate regulations implementing the Model Small Group Rating Rules pursuant to section 2911(b).

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the Model Small Group Rating Rules, the Secretary, in consultation with the NAIC, shall promulgate Transitional Model Small Group Rating Rules in accordance with this subsection, which shall be applicable with respect to certain non-adopting States for a period of not to exceed 5 years from the date of the promulgation of the Model Small Group Rating Rules pursuant to subsection (a). After the expiration of such 5-year period, the transitional model small group rating rules shall expire, and the Model Small Group Rating Rules shall then apply with respect to all non-adopting States pursuant to the provisions of this part.

''(2) PREMIUM VARIATION DURING TRANSITION.—

''(A) TRANSITION STATES.—During the transition period described in paragraph (1), small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by less than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the premium variation provision of section 2911(b)(1) of the Model Small Group Rating Rules and shall instead be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1).

''(B) NON-TRANSITION STATES.—During the transition period described in paragraph (1), and thereafter, small group health insurance coverage offered in a non-adopting State that had in place premium rating band requirements or premium limits that varied by more than 12.5 percent from the index rate within a class of business on the date of enactment of this title, shall not be subject to the Transitional Model Small Group Rating Rules as promulgated by the Secretary pursuant to paragraph (1), and instead shall be subject to the Model Small Group Rating Rules effective beginning with the first plan year or calendar year following the promulgation of such Rules, at the election of the eligible insurer.

''(3) TRANSITIONING OF OLD BUSINESS.—In developing the transitional model small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market, promulgate special transition standards and timelines with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the Transitional Model Small Group Rating Rules under paragraph (1), the Secretary shall provide for the application of the Transitional Model Small Group Rating Rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

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

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Benefit Choice Standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the Benefit Choice Standards, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(7) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits,

services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

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

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

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

''Subtitle B—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2932(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

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

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

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

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

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

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 2922(a).

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

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

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

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

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

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

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

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

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to inhibit the development of health savings accounts pursuant to section 223 of the Internal Revenue Code of 1986.''.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. With the authorization of the majority of the HELP Committee members, I ask that the committee substitute be modified with the changes that are at the desk.

The PRESIDING OFFICER. The substitute is so modified.

The committee amendment in the nature of a substitute, as modified, is as follows:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

TITLE I—SMALL BUSINESS HEALTH PLANS

SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

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

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust

agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

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

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

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

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

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

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

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

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

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

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

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

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

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

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

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

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

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

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

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

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

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title

XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

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

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

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

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

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

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

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

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

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

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 201. MARKET RELIEF.

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

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer

intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

''(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

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

''(11) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

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

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

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

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

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

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

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

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

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided

for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

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

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Benefit Choice Standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the Benefit Choice Standards, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall

have the meaning given the term 'small group market' in section 2791(e)(5).

''(7) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

"SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

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

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

"SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

"SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

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

"Subtitle B—Standards Harmonization

"SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2932(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

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

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

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

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

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

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the covered benefit, service, or category of provider mandate standards provided for in section 2922.

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

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

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

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

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

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

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NON-APPLICATION WHERE CONSISTENT WITH MARKET CONDUCT EXAMINATION HARMONIZED STANDARD.—Subsection (a)(1) shall not supersede any State law of a nonadopting State that relates to the harmonized standards issued under section 2932(b)(1)(B) to the extent that the State agency responsible for regulating insurance (or other applicable State agency) exercises its authority under State law consistent with the harmonized standards issued under section 2932(b)(1)(B).

''(5) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(6) PREEMPTION LIMITED TO HARMONIZED STANDARDS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State requirements for form and rate filing, market conduct reviews, prompt payment of claims, or internal reviews that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

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

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

AMENDMENT NO. 3886

Mr. FRIST. I send a first-degree amendment to the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment No. 3886 to S. 1955, as modified.

Mr. FRIST. I ask unanimous consent that reading of the amendment be with dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the modified amendment add the following:

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

Mr. FRIST. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3887 TO AMENDMENT NO. 3886

Mr. FRIST. I send a second-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3887 to amendment No. 3886.

Mr. FRIST. I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Mr. President, I haven't had an opportunity to see the amendment. I want to cooperate, but I would like to have reading of the amendment.

The PRESIDING OFFICER. The clerk will read the amendment.

The assistant legislative clerk read as follows:

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

Mr. KENNEDY. I have no objection to waiving the reading.

Mr. FRIST. Was that the second-degree amendment?

The PRESIDING OFFICER. The second-degree amendment has been read.

AMENDMENT NO. 3888 TO MOTION TO RECOMMIT

Mr. FRIST. I now move to recommit the bill to the HELP Committee, and I send that motion to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] moves to recommit the bill to the Committee on Health, Education, Labor, and Pensions with instructions to report back forthwith with the following:

(Purpose: In the nature of a substitute)

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

TITLE I—SMALL BUSINESS HEALTH PLANS

SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

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

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

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

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

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

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

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

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

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

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

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

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

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

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

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

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

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

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

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

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

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

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

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

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

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

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

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

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

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

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any

State law in the case of a small business health plan which is certified under part 8.''.

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

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

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

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

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 201. MARKET RELIEF.

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

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

''(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

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

''(11) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

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

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

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

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

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

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

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

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

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary

shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

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

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Benefit Choice Standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the Benefit Choice Standards, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(7) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are

covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

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

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

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

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

''Subtitle B—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2932(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers

that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

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

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

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

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

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

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the covered benefit, service, or category of provider mandate standards provided for in section 2922.

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

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

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

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

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan

designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

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

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NON-APPLICATION WHERE CONSISTENT WITH MARKET CONDUCT EXAMINATION HARMONIZED STANDARD.—Subsection (a)(1) shall not supersede any State law of a nonadopting State that relates to the harmonized standards issued under section 2932(b)(1)(B) to the extent that the State agency responsible for regulating insurance (or other applicable State agency) exercises its authority under State law consistent with the harmonized standards issued under section 2932(b)(1)(B).

''(5) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(6) PREEMPTION LIMITED TO HARMONIZED STANDARDS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State requirements for form and rate filing, market conduct reviews, prompt payment of claims, or internal reviews that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months and one day after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

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

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

Mr. FRIST. I ask for the yeas and nays on the motion.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3889

Mr. FRIST. I send a first-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3889 to the instructions to the motion to recommit.

Mr. FRIST. I ask unanimous consent that reading of the amendment be dispensed with.

Mr. KENNEDY. Mr. President, until I have a chance to see the amendment, I will have to object.

The PRESIDING OFFICER. The clerk will read the amendment.

The assistant legislative clerk read as follows:

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

Mr. KENNEDY. I withdraw my objection.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3890 TO AMENDMENT NO. 3889

Mr. FRIST. I now send a second-degree amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST] proposes an amendment numbered 3890 to amendment No. 3889.

Mr. FRIST. I ask unanimous consent that reading of amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the amendment add the following;

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

Mr. FRIST. Mr. President, let me summarize or attempt to summarize where we are in terms of what we just did and where we have been. After a 96-to-2 vote on invoking cloture on the motion to proceed, we have now finally proceeded to the small business health plans bill. We are now at a point that we can begin debating the substance of this bill.

Chairman ENZI is here and is ready for relevant amendments to come forward and be debated. He will have more to say on that shortly.

What is clear is that there have been attempts or suggestions that we use this bill as a Christmas tree for all sorts of amendments, as well intended as they might be, but amendments that don't relate to the underlying bill.

Earlier this week, we began to address and tried to address issues surrounding medical liability. We were unable to do so. We have now proceeded to the small business bill, and it is my intention to stay on that bill, with amendments related to the bill. This bill should have strong, bipartisan support. As it plays out, we will see how strong that bipartisan support may be.

Mr. DURBIN. Will the majority leader yield for a question?

Mr. FRIST. Yes.

Mr. DURBIN. I ask the majority leader to clarify something in his remarks. He referred to amendments as ''Christmas tree amendments.'' There is one amendment on this side of the aisle that he supports on stem cell research. If this is Health Care Week, it would seem that this is a related issue. Does the majority leader characterize that amendment as a ''Christmas tree amendment''?

Mr. FRIST. Mr. President, the issue of stem cells is a very important issue. As my colleague knows, I am very committed to addressing that particular issue.

What is very clear to me, as we started discussing health care on Friday of last week—and it is now Wednesday—is that we need to systematically take an issue, one by one, that is important to the American people, that I have clearly laid out, starting with medical liability, and then proceed to another medical liability bill and proceed to small business, without jumping to other important issues. There is a whole range of issues that affect cost, quality, research, and affect people's lives and affect access to health care. But the only way we are going to be able to address those in an intelligent, effective, step-wise way is to take them one at a time, like medical liability. We were unsuccessful there. We are now moving to small business and focusing on that. There will be amendments, and we welcome them. The chairman is here and ready to talk substance on those amendments. Let's dispose of those and stay on small business. Then we will go and look at a whole range of other issues on health care at an appropriate time.

My intention is to go step-wise through this, with relevant amendments. The chairman is willing to address that and address the issue of small business health plans. We have 46 million people out there who are uninsured today. This doesn't solve the problem, but it fits very nicely with allowing the people out there who don't have access to health care today, who work in small businesses, to have for the first time the opportunity to get the reasonable, affordable health care they simply don't have today. There are a million people—if we pass this bill and it is signed by the President—who are uninsured who will have the opportunity to have insurance.

Let me yield to our chairman because I do encourage our Members on both sides of the aisle to come forward so that we can have substantive debate on the small business health insurance issues out there, without trying—because I know the other side wants to address many other issues, as has been expressed over the last several days, which are their priorities that they want to put before small business health reform plans. But we are simply not going to do that.

Mr. KENNEDY. Well, Mr. President, I say with the greatest respect that it is kind of interesting that the majority leader presents a proposal to the Chamber on behalf of the human resources committee—and as we know, under the Senate rules, that is entirely appropriate—and then in the same breath he asks us to recommit the legislation back to the committee, after he has just spoken for the committee, which suggests that there is a parliamentary maneuver, which is now quite apparent to all of us, that we are not going to have the opportunity to even get a debate on small business assistance, because we have on this side of the aisle the Durbin legislation dealing with relief for small business which effectively we are precluded from having an opportunity to offer.

If I understand the last sentence of the leader, he said we are going to have to dispose of this and go this route before we consider any other amendments. As I understand it from our Democratic leader, we could have reduced those to four or five different amendments that deal with the emergency penalties that some 8 million seniors are going to pay on the prescription drug program, the issue of the ability of Medicare to be able to negotiate lower prices, and the stem cell issue, which my friend has commented on, and Senator HARKIN and Senator FEINSTEIN, and I know the Senator from Tennessee understands the full potential of this. But effectively, as I understand it, this is Wednesday at 3 o'clock; we were here Wednesday morning. I have been effectively here since 10 o'clock in the morning, and we have Wednesday and Thursday and a full week where we can deal with these issues.

It just is troubling to many of us, when we went through this whole argument a week or 10 days ago on the immigration issue, where we were listening to those on that side of the aisle say: Let's have some amendments. Now we hear from them that, no, we cannot. We want lots of amendments on that, but we refuse to have amendments on this.

I daresay that the Senate rules permit debate on different amendments. We have a set of rules out there. You can have an amendment in the first or second degree, and you can have ultimate judgments and decisions. I just want to mention at this time that the action that has been taken now by the leader is effectively going to foreclose an opportunity at this time, when we are having our health care debate, to debate either stem cell research or relief for our senior citizens, who will be paying the penalty because of the requirements of the prescription drug program. We will be denied an opportunity to consider reimportation or negotiation for lower prices. Those are effectively issues that I think most Americans can understand. Certainly these are issues which Members of this body are familiar with and not new issues. We have not been able to get an opportunity.

I certainly regret that is the case because I think, with all respect, as the CBO talks about, there are 48 million Americans without health insurance. According to CBO, this is going to help solve it for 600,000, where we have the option with the Durbin proposal to solve it for millions in small business. But we are denied that opportunity. It is difficult for me to follow that kind of rationale, but we are where we are. I regret that judgment and decision, but that is where we are.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I wish to comment a little bit on that. I think there is plenty of blame to go around for any delays that are happening around here. When we are talking about incorporating in this bill, which deals with small business health plans, an opportunity to give small businessmen a chance at negotiating in the market to bring down costs, with an alternative being proposed—when we are being asked to incorporate into this and put all the weight of the stem cell debate or drug reimportation or Medicare Part D on top of this as a full-blown debate, everybody in this body knows that any one of those would easily take up not just a full week but probably 3 weeks because there would be other kinds of motions and parliamentary objections and processes that would drag any one of those out for that time.

The difficulty with being able to debate anything around here is the

length of time as a result of the right to offer any amendments that anybody wants on any topic. So we do make some efforts to try to keep them relevant. If we do cloture, then they are germane. Germane is a much tougher test, but relevant is not any health care idea in the whole world that could be amended and amended and amended and debated and have processes put in against it that would keep us from ever getting to a decision on small business health plans.

So we are trying to stay with small business health plans. I know Senators DURBIN and LINCOLN have an alternate approach. The alternate approach ought to be voted on, but the alternate approach should not be voted on to the exclusion of ever getting to a vote on this. So we don't want to have just one of them vote and one side feel very good because they got a vote for that one and the other side never gets to their vote. We are trying to find a way to make sure there are votes on both sides on the issues and that not just one side is taking the tough votes but that we do something so we can get to a conclusion for small business. Yes, we are trying to focus this on the problems of small business.

I would like to speak a little bit on the managers' amendment that is before us because there are some changes to the bill that I think the other side of the aisle will like. In most respects, this amendment corresponds very closely to the underlying bill reported out of the HELP Committee in March. It enables small businesses to pool together to save costs and increase access. It allows small business health plans and other plans to offer more affordable coverage options. It will also help streamline the current hodgepodge of health insurance regulation. However, the managers' amendment does make a number of new and important changes to the bill, most importantly in the area of premium rating.

Before I address the managers' amendment, I want to first emphasize, as I have throughout this debate, that I am eager to start sorting the amendments my colleagues might want to offer. As we start the amendment process, I look forward to debating all amendments from my colleagues on both sides of the aisle that are relevant—I mean relevant to the goal of more affordable health insurance for small business owners and their employees and their families.

I have reviewed some of the amendments Members have filed and want to offer. There are many that don't have any place on this bill and only serve to obstruct or delay passage of the bill—amendments addressing the energy efficiency of hybrid cars, Medicare benefits, hate crimes, and environmental air standards. They don't have any place on this bill. This bill is about health insurance for small business owners and their families and their employees and their families. I stand ready and willing to debate all relevant amendments to this bill.

For instance, Senator SNOWE will file an amendment on the issue of benefit mandates. Her amendment would ensure that benefits and services which have been mandated by a majority of States would continue to apply to small business health plans and other insurers. I know there is a lot of strong feeling on all sides of this issue, and I look forward to a lively and serious debate on it. I will have more to say about the Snowe amendment later.

For now, I will focus on what we have done in the managers' amendment to address the concerns raised by many Members of this Chamber. The main change we have made is related to how health insurance premiums are priced for small business. Most States do have rating laws. Those laws limit the amount of variation between premiums charged to different small businesses. Some States allow a great variation; some States allow very little variation.

During debate on this bill yesterday, I heard my Democratic colleagues make a number of speeches on this issue. They expressed their concern about how the bill, as reported from our committee, would affect the health insurance market in their States. They expressed concerns about how the rating rules in our bill might affect businesses with older workers or workers who have serious or chronic illnesses. I also heard these concerns in private conversations with a number of my colleagues over the past few weeks. I don't believe everybody should have to pay exactly the same amount for health insurance. Rules like that hurt young families and lower income workers. They get hurt because they get priced out of the affordable health insurance market.

But I have listened to my colleagues. I have also consulted with some of my colleagues on our committee and with Senator NELSON of Nebraska, who coauthored this bill with me. I value his perspective as a former State insurance commissioner. I also reviewed the bill Senators DURBIN and LINCOLN have offered. I have talked with experts in the insurance markets and insurance regulation, and they don't think the bill Senators DURBIN and LINCOLN have offered would create new and affordable options. In fact, some of those experts think that bill would make things worse, not better.

I will speak some other time in more detail on that. I prefer to go in the direction that we know can work. We know small business health plans will work because they worked in the past before the thicket of conflicting State laws made it too cumbersome to offer such plans.

Our committee heard testimony on this last year, but Senator NELSON and I looked at the Durbin-Lincoln bill anyway to see if there were some ideas we could harvest, some ideas we could incorporate.

After talking with Senator NELSON and my colleagues on the committee, we have developed an amendment that should address the concerns of most of my colleagues on the issue of rating.

The managers' amendment would do two things: First, it would permit States to limit the allowable variation in premiums to a much narrower ratio between the highest and the lowest rates as compared to the bill my committee originally reported.

Second, it would allow States to continue to require community rating of the health insurance policies. What that means is that the bill would allow States to prohibit small business health plans or insurance companies from using the health status of a group of workers as a factor in determining the group's premium.

If States want to allow health status as a factor, they can allow it; if they don't, they can disallow it. This means two things: First of all, most States would be unaffected by the new rating threshold of the managers' amendment. As a matter of fact, we estimate the rating provisions would have no impact on approximately 40 States. The vast majority of those States have reasonably competitive markets, although those markets would be even more competitive if we allow for the creation of small business health plans, allowing small business to band together across State lines to increase their leverage and to cut administrative costs. That is a huge factor.

Second, the managers' amendment preserves much of our original intent to create greater affordability for low-wage workers and for younger workers and their families, but it also allows States to retain reasonable limits on what high-risk groups can be charged. The managers' amendment sets a different threshold for allowable variation in premiums.

The new threshold is similar to the model act published by the National Association of Insurance Commissioners and updated in 2000, its most recent model, and it is what Senators DURBIN and LINCOLN used as the basis of their bill.

So under the managers' amendment, the States use community rating and could continue to use community rating. That means these States could still prohibit the use of health status as a rating factor as long as their system is adjusted to the point that it maintains affordability for low-wage workers and young people and families.

Under the managers' amendment, States would also be permitted to limit small business health plans and other insurers from setting rates that vary by more than a 5-to-1 ratio. In other words, the highest rate for a group in a particular insurance pool could not be more than five times the lowest rate. That would ensure that the insurance pool has a better and more stable balance of risks in the pool while ensuring meaningful limits on premiums for higher risk groups. This is an adjusted community rating standard used in the bill authored by Senators DURBIN and LINCOLN.

Again, just like the Durbin-Lincoln bill, the managers' amendment follows the most recent model from the National Association of Insurance Commissioners. The Durbin-Lincoln standard works out to the same 5-to-1 ratio between lowest and highest rating. So I hope my colleagues understand that here is an area where we have tried to strike a compromise, where we tried to work with them.

I should point out that most States don't use community rating. They use what is known as rating bands. These bands allow for a variety of factors to be used in setting premiums, including health status. We will allow States that use rating bands to continue to use rating bands. None of these States would be required to use community rating if they don't want to. They can continue to allow greater premium variation than the 5-to-1 ratio if they choose. It is a very important point.

The managers' amendment allows States to continue the use of two systems for rating health insurance policies. They can use either the community rating or what is known as rating bands. All the managers' amendment asks is that community-rated States follow the model set forth in the Durbin-Lincoln bill. At least if some reasonable variation in premiums is allowed, young families and lower wage workers may be able to find affordable policies. Of course, affordability would be enhanced if their State markets became competitive enough to attract small business health plans. So we are saying in 10 States it may not attract small business health plans.

I know the rating is extremely complex. This is a very difficult issue to talk about. I kind of enjoy it as an accountant. But the bottom line is very simple. First, we need to maintain a minimum level of affordability in how premiums are set across the country. Young families and lower wage workers in certain States deserve access to affordable health insurance and, therefore, affordable health care, and they deserve the ability to join together with other employees as part of a pool of small business workers through the association in their industries.

Ensuring that all the States have competitive health insurance markets will enable small business health plans to create truly national pools so they can maximize the full size of their membership as they negotiate for better benefits and for better prices.

This is a major area of compromise, and I hope my colleagues recognize it. We have taken a major concept from the bill authored by Senators DURBIN and LINCOLN and we have incorporated it in the managers' amendment. We have done this because Senator NELSON and I and the other cosponsors of the bill are working in good faith to find common ground.

While rating is the most significant issue that we revised in the managers' amendment, it is not the only one. For example, the managers' amendment includes several provisions to make it clear that the scope of the bill's preemption of State law is very narrowly tailored to only three areas. Those three areas are rating, as I have already discussed, benefits, to enable small business health plans to offer national benefit packages, and administrative functions, to reduce some unnecessary costs of health insurance regulation.

It has been a key priority for my Democratic cosponsor, Senator BEN NELSON, that State oversight authority be retained to the maximum extent possible. We have a few former State insurance commissioners in the Senate, and I know they share Senator NELSON's opinion on that. There are also a few former attorneys general in the Senate, and I have listened to them. I have also listened to some of our current attorneys general who have voiced their concerns recently.

I mention that some of their concerns refer more to the House-associated health plans bill, and it is important for people to know this is different from that bill.

We have listened and done these appropriate changes. We have added new provisions that make it very clear that this bill does not preempt, affect, or even disrupt traditional State authority regarding consumer protection, plan solvency, and insurance oversight. That stays with the State.

Most importantly, it would be crystal clear that the bill does not limit in any way a consumer's right to petition their State insurance commissioner or the State courts. That is a very important point. I want to repeat that. It should be crystal clear that it does not limit in any way a consumer's right to petition the State insurance commissioner or their State courts.

The managers' amendment before the Senate represents a significant effort to find common ground. It addresses the issue of rating, which is one of the two major concerns that Senator NELSON and I have heard from colleagues. Senator SNOWE's amendment with respect to State-mandated benefits is an attempt to address the other major concern.

So Members who have raised concerns about these two issues ought to see we are willing to work toward a compromise. There should be no reason we can't arrive at a solution over the next couple of days. Small business owners and working families I don't think are going to accept excuses.

The matter at hand is small business health plans. It is not stem cell research, it is not drug importation, and it is not Medicare. The matter at hand is about creating more affordable health insurance options for small business, and it is an issue that I think can be covered this week or a very small part of next week.

As a manager of this bill, I am willing to entertain any germane amendments. With the consent of my colleagues, I will even go further than that. I will consider relevant amendments. But stem cell research is not relevant to this bill. Drug importation is not relevant to this bill. Medicare is not relevant to this bill. What is relevant to this bill is amendments that address the 27 million Americans without health insurance who work for or depend on small businesses.

If my colleagues have amendments like that, Senator NELSON and I are more than willing to discuss them. Let's focus on the matter at hand. Let's take a meaningful step forward to give America's small business owners and working families more affordable health care.

In regard to some of the comments that have been made, as an accountant, I do remind my colleagues that this is not a case of subtraction. This insurance plan is addition. It will be bringing in newly insured people. When you go to the dry cleaners tonight to pick up your laundry, can you look that person in the eye and say: I don't think you deserve health insurance because you might not demand enough for yourself, so I saved you from yourself? Can you look them in the eye and say to the mom and pop running the business down the street from your home: You don't deserve health insurance either; you don't have it now, we're not going to make it more affordable for you; too bad, we had other things we wanted to discuss?

As you go home today, after you leave the Hill, think about the people around you, the regular people—the cab driver, the worker at the dry cleaner, the person in your neighborhood restaurant, all those people you may not notice who really make the world operate. Many of them don't have any insurance. Some may even own a little business just around the corner, be the owners of it, and still not be able to have insurance.

I am not talking about deluxe insurance, I am talking about any insurance. We are not talking about the employees at the big hotel chains or the big chain restaurants. We are not talking about the employees at Wal-Mart. We already said to them: You can form whatever benefits package you want. You don't have to answer to any State. You don't even have to have review or oversight by insurance commissioners. You don't have to meet any State requirements. We already said that to big business, and big business has done that. They haven't left out critical things. They said: Let's see, this is a competitive market. We have to be competitive. We want to have employees. And you know what. I think they included almost everything that has been talked about here. They did it because they wanted to compete.

Small business isn't any different. They need good employees. They want good employees. They know that if they are going to have good employees they have to do as much as they can afford.

Oh, yes, and when they are doing that, they can also pick up some insurance for themselves, and what they do for themselves, they do for their employees. We hear the estimates of how much this will or will not save. I would like to make a couple of comments on that. We have already seen that the big businesses, instead of paying 35 percent in administrative costs—35 percent—remember, each 1 percent of insurance costs drives 200,000 to 300,000 people out of the market. We are talking about 35 percent administrative costs. But those big businesses that we gave permission to do whatever they wanted to, theirs runs about 8 percent. Do you think they would be more competitive than the small businesses? What keeps the small businesses in business is their flexibility and how much less they make.

So I am not talking about deluxe insurance; I am talking about any insurance. Did you know that in several States there is only deluxe insurance? Did you know that in some States there may only be one insurance provider? Others have been driven out of the market. No, it hasn't been the competition that has driven them out; it could be well-meaning legislators wanting to make sure that everybody has everything they need.

There is a lot with our bodies that we ought to be doing on a regular basis. We ought to be taking care of our body like we take care of our car—well, maybe not like we take care of our car. But the way we usually take care of our body is similar to a rental car. We drive it until something goes wrong and then we take it into the shop. But there are regular services that we ought to provide for our own bodies, and we can do that.

The big companies get to do that tax deductible. It would be nice if the small businesses were able to do that tax deductible as well, and we can get into several of those issues later. We do have a plan here. We are willing to make modifications to it. We are willing to take relevant amendments. We do want to be sure that we get a vote on this bill, if we vote on an alternative measure. I think that is fair.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, let me say at the outset that I salute Senator ENZI from Wyoming. He has shown extraordinary leadership and political courage to bring this issue to the floor. The last time we had a serious conversation about health care for American families and businesses was in that one brief shining moment when the Democrats were in control and brought the Patients' Bill of Rights to the floor; otherwise, during the time that I have served in the Senate, we have run away from this issue. I salute Senator ENZI. Although I disagree with his bill, and I will explain why, I admire his political courage and vision to report a bill from his committee and bring the issue to the floor. I have said that before the press, I have said it at home, and I want to say it on the floor on the RECORD. Although we may disagree on approach, I respect him very much for being willing to bring this complex and politically controversial issue to the floor.

I think if you put it up for a vote as to when a week ends in America, we might not reach a consensus. There are some people who would argue: Why, a week ends on Friday night. That is the end of the week. Others say: No, a week ends on Sunday night. But what we have found is that Health Care Week in the Senate ends at 2:30 on Wednesday afternoon because that is when the Republican majority leader came to the floor and filled the tree, which means closed down amendments on the health care debate.

The Republican majority leader felt there were only two issues relevant to health care in America. The first was the issue of medical malpractice and preempting the States that traditionally regulate medical malpractice. For I believe the fourth time, Senator FRIST offered the medical malpractice bills at the beginning of the week, and they failed again, this time failing to even attract a majority of the Senators supporting either bill that he brought. Then the Senator moved to the health care issue before us: small business health insurance. Then the majority leader came today, having given us all of about a day and a half to consider this issue, and said that is the end of the story. No more amendments. We are not going to consider any other health care amendments in the bill before us. We are closing down the Senate when it comes to health care issues.

That is interesting because what the Republicans have done is to close down debate on stem cell research. Senator FRIST came to the floor and said: We don't want Christmas tree amendments. Christmas tree amendments—stem cell research. I don't know if Senator FRIST has been back in his State. I have. They have roundtable discussions about stem cell research. They sit at a table surrounded by men and women who have their hopes pinned on medical research, those who are suffering from juvenile diabetes and the serious problems that come with it—a mother who gets up several times during the course of the night to wake her young daughter and to test her blood to see if she needs insulin, if she needs to eat something; another family with a young man with Lou Gehrig's disease who has reached the point now where he cannot communicate. All he can do is sit in his wheelchair, this young man in his 20s, with tears rolling down his face, as his mother says: Senator, please, please do something about stem cell research. It may not save him, but it may save someone else. Parkinson's disease—to have my colleague and closest friend in Congress, Lane Evans, a young man stricken with Parkinson's, forced to end his congressional career, who had the strength to come to the floor last year in the House and beg for stem cell research and others suffering from Parkinson's and spinal cord injuries. Think of those people whose lives have been compromised and slowed down because of these injuries. All they want is a chance for a vote on stem cell research.

This President has prohibited stem cell research beyond a single line of available stem cells and has virtually closed it down as a Federal undertaking. We have decided, as a matter of Federal policy, that we will not do this research. We have been asking for over a year for a vote on the floor of the Senate on stem cell research. We were heartened when the Senate majority leader, Senator FRIST, came to the floor in July of last year and said: I may be switching my position, he said, but I am going to support stem cell research. It meant so much because we respect him, a heart transplant surgeon, a man with his medical credentials, to break from the President on this issue, on stem cell research and say he would join us in the fight. But how disheartening to hear today as the Senator from Wyoming and the Senator from Tennessee refer to debate on stem cell research as not relevant to health care. Not relevant. It may not be relevant to their lives, but it is relevant to the lives of thousands of Americans.

We in the Senate know what is at stake. If we don't bring this matter up for a vote this week on stem cell research, the chances of seeing the bill before the end of the year are slim to none. When we think of all of the families counting on us to step up for stem cell research, I want to ask you, Mr. President, isn't this worth a fight? Isn't this worth a fight on the floor of the Senate, to make sure that we get a vote this week on stem cell research, for the people who are counting on us, whose lives are compromised and broken because of disease and illness? Isn't this worth a fight in Health Care Week? Obviously, not on the other side of the aisle. They have declared stem cell research not relevant to Health Care Week.

And what else? They have decided that Medicare prescription Part D is not an important part of Health Care Week. Medicare prescription Part D, where some 9 million Americans in 5 days, if they don't sign up for this program, will face a lifetime penalty. Medicare prescription Part D is a program written by pharmaceutical companies and insurance companies, a program which has been one of the worst that has ever been dreamed up on Capitol Hill. When we want to take a few moments to fix some basics and take the penalty off seniors, the Republican leadership says, now, wait a minute. That is not relevant to a Health Care Week debate. Prescription drugs for 9 million seniors, that is not relevant to a health care debate.

Of course, we have heard Senator DORGAN of North Dakota repeatedly

asking for the opportunity to reimport drugs into the United States so that people have a fighting chance to pay for the drugs that keep them alive. He has been stopped by the Bush administration. He has fought for this opportunity to bring this issue to the floor time and again and insists on it this week in Health Care Week, and the Republican leadership has said, affordable prescription drugs coming in from foreign countries is not relevant to Health Care Week.

So, Mr. President, I think you can understand why many of us come to the floor at this point disappointed. First, we were encouraged by Senator ENZI's decision to bring this matter forward, and then when Senator FRIST said we are going to make it not just the Enzi bill, it will be Health Care Week, we finally said: Here is our chance, a chance for all of the people who have been waiting on us and who have been counting on us. Well, that chance was snuffed out at 2:30 this afternoon with Senator FRIST's procedural motion. Health Care Week turned out to be too good to be true.

It is interesting as well when we consider the basic underlying issue of health insurance. Do you know what the two competing issues are on health insurance? It is very basic. I don't have to explain it to my colleagues in the Senate, and I will tell you why. The proposal that I and Senator BLANCHE LINCOLN have brought to the floor of the Senate to make available to every business across America is exactly the same health insurance that Members of Congress have. If it is good enough for Members of Congress, we think it is good enough for American families. But I listen as Senator ENZI and Republicans stand up and talk about what a terrible idea this would be, to offer to every American the same kind of health insurance that Members of Congress and Federal employees have. Well, if it is so bad, I wonder how many of them have decided not to sign up for it themselves. My guess is they have all signed up for it.

Do you know why it is so good? It is not a government plan. It is a plan administered by the Government at less than 1 percent administrative cost that offers private insurance plans to Federal employees and their families, retirees, and Members of Congress. Private insurance offered by the Government. It is so good that it has worked for 40 years.

Now we have the Republicans coming to the floor, Senator ENZI and others, saying what a terrible idea this is, the same health insurance that protects the Senator arguing against it. You have to ask yourself why, if it is so good for us, can't we offer it to American families? Instead, Senator ENZI has come forward with a plan which makes dramatic changes, not to the health insurance we might offer to the uninsured but in reducing protection, reducing coverage, and increasing costs for people who are already insured. If you thought to yourself for a moment, that is an interesting debate on health insurance, but I am not worried about it, I already have my plan, think twice, because the Enzi bill which he brings before us is going to make your health care less valuable, less protection, and more cost. That is the Enzi plan. That is unnecessary and unfair.

Let me tell you what two organizations have to say about Senator ENZI's proposal, his health insurance plan. You might expect I am going to read something that has some political ring to it. Who is this organization that Senator DURBIN is quoting? They must have some political agenda. I would like to quote from a letter, dated May 10—today—from the American Cancer Society. The American Cancer Society is hardly a political organization. How do they describe the Enzi bill before us?

It is our view that the basic construct of this legislation is fatally flawed and therefore, we ask you to oppose it, regardless of the amendment process on the Senate floor. Consumers will be at the risk of losing important cancer-related protections such as guaranteed insurance coverage of colorectal cancer screening and clinical trial participation.

They go on to say:

It is our view that the Enzi bill will not result in increased access to quality care for most people.

That is from the American Cancer Society.

Now let me go to another letter, and you decide whether this is a political organization. It is the American Diabetes Association. The American Diabetes Association believes that:

The proposed approach in the Enzi bill is fundamentally flawed and must be opposed in all forms in order to protect your constituents with diabetes. Any preemption or weakening of State laws is a major threat to the well-being and lives of people with diabetes and should not be acceptable to the Senate.

And listen to these statistics: Every 24 hours, 4,100 people in America are diagnosed with diabetes—4,100 every 24 hours. There are 230 amputations from diabetes every day in America. There are 120 people entering end-stage kidney disease programs, and 55 people go blind every day from diabetes. We lose 613 Americans daily and 225,000 annually due to this epidemic. Diabetes continues to grow by more than 8 percent each year. And listen to this: One in three of our children will be diagnosed with diabetes in their lifetime—one in three of our children will be diagnosed with diabetes in their lifetime.

They go on to say:

. . . we cannot allow for any loss of ground in this battle.

Signed by the chairman of the board and the chief executive officer. They say:

Accordingly, we ask you to stand with us in full opposition to [the Enzi legislation], no matter which cosmetic changes may be proposed on the floor.

This is a stark and clear choice for the Members of the Senate, what we offer to small businesses and Americans presently uninsured: the same quality health insurance that protects our families as Members of Congress have or we offered them a watered down health insurance program that has been rejected by the American Cancer Society, the American Diabetes Association, the American Association of Retired Persons, the AFL/CIO, AMA, the American Nurses Association—I could go on for three pages of health groups in America that reject the Enzi approach because it will reduce coverage.

We know what the problem is. It has been a long time since we have even taken up this issue. During that period of time, we have seen the number of uninsured Americans grow from 37 million in 1993 to 46 million today—46 million uninsured Americans. But this is the wrong medicine. This Enzi bill will put the insurance companies, not the doctors, in charge of health care. People will be worse off, with less protection.

Yesterday, Senator KENNEDY and I went down to a press conference a few blocks from here. A beautiful young lady came up. She was from Cleveland, OH. She brought her guide dog with her and she told the story about how her diabetes, untreated, resulted in her blindness—young, beautiful lady. She said: I didn't have coverage for it in my health insurance, and as a result my life is much different. She said: I almost died. I am lucky to be alive and thankful to be alive. But when you talk about diabetes protection, you are talking about that young woman and others who could be just like her.

Another young woman came to speak to us and told us how she was a young mother, healthy as could be, but tired from raising those three little kids. Somebody suggested to her to get a mammogram. She thought about it because she had a history of breast cancer in her family, but she said to herself: How much is it going to cost?

They said: $250.

She said: We don't have that. I need $250 for my kids.

She said to her husband: Check the health insurance and see if it covers mammograms.

Her husband called her the next day and said: You can get the test the next day for free.

This beautiful young woman went to get a mammogram and learned within 24 hours that she had the earliest stage of breast cancer. They did a lumpectomy. She went through months of chemotherapy.

She said: I lost my hair, but I got through it all and I am here and I am alive and I am safe and I am going to be a mother for these kids for a long time to come.

So when we talk about cancer screening in health insurance, I don't think that is deluxe care. I don't think that is luxury care. I don't think that is going overboard. Whether it is prostate screening, colorectal screening, or

mammograms, that is basic preventive medicine that saves lives and spares suffering and cuts the cost of health care.

Unfortunately, many of those benefits are casualties in the Enzi approach. As I travel around Illinois, health insurance is the No. 1 issue and has been for years for businesses large and small, labor unions, individuals, families, parents whose kids reach the age of 23 and they finally realize: They are not going to be under my policy. How are they going to be covered?

Between 1993 and 2003, annual premiums Americans paid for health insurance in that 10-year period increased by 79 percent. Employer contributions to their employee insurance increased by 90 percent. These premium increases make it tough for businesses to survive and offer health care protection.

Let be me give an example of one family I know, Jim and Carole Britton. They own the Express Personnel Services in my home town of Springfield, IL. They are good folks, good hardworking businesspeople. They have 24 employees. They pay 85 percent of their employees' premiums. They want to keep doing it. They really believe it is the right thing to do.

Like many small business owners they shop for a small business policy every year because premium costs keep going through the roof. They have been forced to raise the deductible to keep premiums manageable. Last year, the deductible doubled from $500 to $1,000. To save money, Jim and Carole offered a health savings account, which many on the other side of the aisle think is the salvation, a health savings account. I won't go into it in detail, but it is a perfect health insurance plan if you are wealthy and never expect to get sick. They offered it. One of their employees decided they would sign up for a health savings account. That employee now regrets the choice because his wife is pregnant and he wishes he had better, real health insurance coverage.

To those who say solving the health insurance problem is too complicated or too expensive, look beyond the obvious. We already have the Federal Employees Health Benefit Program. It has worked for 40 years for every Member of Congress and 8 million Federal workers. Small business owners and their employees deserve nothing less.

I, along with my colleague from Arkansas, Senator BLANCHE LINCOLN, have introduced legislation to give small businesses affordable choices among private health insurance plans and expanded access to coverage. We call it the Small Employers Health Benefits Plan. We presented it to Senator ENZI. It has been a while now, a few months ago, that we said to him: Take a look at it. You know what this plan is all about. You live with it. We all live with it. We love it. It is a wonderful plan that has competition and real choice from private insurance.

We didn't convince him. I am sorry we didn't. Maybe someday we will. We will keep working on it. But let me tell you why we think it is important, why there are many advantages to the Federal employees program model. This chart spells them out.

Nationwide availability. It covers Federal employees from one coast to the other. Young and old, rich and poor, black, white, and brown, healthy and sick, every Federal employee is covered by it.

Consumer choice. There are more than 278 private insurance companies that bid for this Federal employee coverage. For these private insurance companies, they believe this is a good deal, to get in a pool of people this large.

Group purchasing discounts for small employers: In our bill, we create one nationwide purchasing pool of small employers and self-employed people, which means they can fight for premium discounts just like the Federal Government.

Low administrative costs: Do you know what it costs the Government to run the health insurance program for 8 million Federal employees? Less than 1 percent a year. Some of these plans we are talking about that private businesses have to turn to charge 25 to 30 percent administrative costs each year. You wonder why the costs go up? They are making more money, charging for administration. We don't have the administrative overhead. We use private insurance plans already there.

There is strict oversight and regulation in the Federal Employees Health Benefit Program. We know it works. We like it so much that every single one of us is protected by it.

Two economists have examined our proposal, Dr. Len Nichols of the nonpartisan New America Foundation, and Dr. John Gruber, Ph.D, from MIT. They estimate that our bill could save small businesses between 27 percent and 37 percent on health care premium costs every year, just offering to these small businesses the same health insurance deal that Members of Congress and Federal employees currently receive.

That means Jim and Carole, whom I mentioned earlier, currently offering a policy for a family of four that costs $10,000 a year and paying $8,500 of the premium, could save anywhere from $3,000 to $3,100 as employers and $400 to $500 for each employee. That is before any tax credit, which we propose in our bill, for low-wage workers.

Under our plan, premiums would not be government subsidized, but employers will receive an annual tax credit for contributions made on behalf of workers making $25,000 or less per year.

There is a big debate in this town about tax cuts. If you read the morning paper, you may have noticed the chart on the front page of the Washington Post. The new tax cut proposal from the Bush administration, when it comes to capital gains and dividend incomes, is a very generous proposal to a very small group of Americans. Let me tell you what I mean.

If you are making less than $75,000 a year, the Bush tax cut proposal, warmly embraced by the Republican majority in the House and Senate, means about $100 a year in tax breaks. There is that old $100 check they wanted to give you last week for your gas bill. Here it comes again. That is your tax cut if you are making less than $75,000.

But the same Bush Republican tax cut proposal which will come through Congress now gives to those who are making $1 million a year in income almost $42,000 in tax cuts. I don't recall receiving a single letter from a millionaire saying: Would you please give me a tax cut?

They are insistent on it. We must do this. We have to give them a break. But when Senator LINCOLN and I suggest giving a tax cut to a business that offers health insurance to low-income employees: Oh, that is a terrible Federal subsidy. How could you consider doing that?

Senator THUNE from South Dakota came to the floor yesterday and said it was going to cost us $78 billion over 10 years. Today he came and said it would cost $73 billion. We are gaining some ground. But the bottom line is there is no estimate in that range, anywhere near that range. My challenge to my colleagues on both sides of the aisle, if you believe in tax cuts, why wouldn't you believe in tax cuts for small businesses that provide health insurance for their employees? Isn't that closer to the American dream than a $42,000 tax cut for somebody making $1 million a year? I think it is fairly clear. Obviously they don't.

There are more than 26 million Americans making less than $25,000 a year working in small businesses; 12 million, 40 percent of them, have no health insurance. Is it valuable for America that these people who get up and go to work every day in the small shops and small businesses across our country have health insurance.

I go around Illionis and talk to all kinds of different groups—downstate in my home area, small towns, rural areas, the big city of Chicago. Whenever I say to people: Wouldn't it be part of the American dream that every American had health insurance, it never fails to get a round of applause. That is really an aspiration and a dream which many of us share. We can't reach that dream if we insist on giving tax cuts to millionaires who aren't asking for them and don't provide a helping hand to businesses that are doing the right thing, providing health insurance to low-wage employees.

The tax credit we propose would equal 25 percent of the cost to that business for self-only policies, 30 percent for employees who are either married or single with a child, and 25 percent for family policies. So if a family of four working for Jim and Carole in Springfield make less than $25,000 a

year, there would be an additional savings of $1,874 to $2,172.

Under the Durbin-Lincoln bill, private insurance plans would compete to offer insurance to small businesses, just like they do in the Federal employees program. This chart shows the potential savings that come from the current system and what might occur under the Small Employers Health Benefit Program that Senator LINCOLN and I will offer. Currently, many of these businesses, like the one I described, pay 85 percent of insurance costs, so on a $10,000 policy they are paying $8,500.

Look at how it drops for family coverage under the plan we are proposing—to $3,230 for family coverage. It shows the dramatic savings for each business and the opportunity for them to offer real health care.

A lot of people say: Are you talking about a government insurance plan? Let me show you the choices that my wife, Loretta, and I had when it came to health insurance this year as Federal employees and Members of Congress. Look at these plans: There are 13 plans that we had to choose from as Federal employees.

I will tell you what happened to one of my employees. She chose a plan 1 year, didn't like the way they treated her, and when open enrollment came the following September she dropped them and picked up another plan. What a luxury, real competition. You don't treat me right, you don't get my business next year. It is like shopping for a car and having some real choices.

Most small businesses and most Americans have no real choices, so when we come up with this plan, the Federal employees model plan, and those on the other side of the aisle dismiss it as unrealistic, unfair, deluxe, it is exactly the same health insurance coverage they are living with right now.

If it is good enough for us, why isn't it good enough for the rest of America? That is the bottom line.

All Federal employees receive a booklet every year about the choices that are available for coverage. If you want to take an expensive plan, they will take more out of your paycheck. For the basic plan they take less.

I have a lot of young people on my staff. Krista Donahue, my staffer on this issue, gets up and swims every morning. She picks her health plan. She signed up for a very cheap HMO. My wife and I, maybe not in the same physical condition, sign up for more coverage. That is our choice.

That is everyone's choice in the Senate and the House of Representatives and throughout the Federal Government.

What is wrong with giving that choice to America? Senator ENZI's plan does not give that choice to America. This bill we are proposing has been supported by many groups. It isn't just a matter of Senator LINCOLN and I coming together.

Look at some of the groups that have endorsed the Lincoln-Durbin plan, or the Durbin-Lincoln plan, depending on whether you are from Arkansas or Illinois: The American Academy of Family Physicians, the American Academy of Pediatricians, the American Cancer Society, the American Medical Association, the American Osteopathic Association, the American Psychological Association, Consumers Union, Families USA, Federation of American Hospitals, International Chiropractors, March of Dimes, the National Association of Community Health Centers—the list goes on and on.

And the indication is that these men and women and groups that focus their professional lives on health care reject the Enzi approach which offers less coverage and less protection and believe, as I do, that the plan being offered to Federal employees should be offered to businesses across America.

Sadly, the Enzi plan will wipe out benefit requirements.

I will concede that what I am about to say may have changed somewhat in the managers' amendment. To his credit, as Senator ENZI has realized the weaknesses of his legislation, he has added more protection. If I am going to cite something that has been changed in the managers' amendment, I apologize and will stand corrected on the RECORD. But what I am about to read is based on our best knowledge of what was in the Enzi bill. Maybe it has been changed. I want to give the Senator a chance to correct me, if I misread it.

The Enzi bill will wipe out benefit requirements, including diabetes supplies, mental health coverage, cancer screening, maternity coverage, and child immunizations for 84 million Americans. That includes almost 4 million people in the State of Illinois. The number of Americans who will lose benefit protection under the Enzi plan, S. 1955, each one of these ''stick'' pictures represents 1 million Americans who will lose benefit protection. These are not people who currently have no health insurance. These are people who are gathered here and watching this and have health insurance who think they are part of this debate. Surprise. The Enzi bill has brought you into this debate. Your health insurance is about to be reduced in coverage. The things that you thought you had signed up for, the things that you had bargained for as part of your union that you believe were covered in your plan will be reduced. The coverage will be reduced by the Enzi bill.

His belief is, if we can just lower basic health insurance coverage to a lower level, we can say everybody has it. But what good is it to have health insurance if it isn't there when you need it?

That is the point he missed. If we miss the most basic things in terms of protecting Americans and then sit back and fold our arms and say: Well, we took care of that uninsured problem, sure, we took care of it until someone desperately needs health care and can't afford it because their health insurance plan doesn't cover it.

The idea behind Senator ENZI's bill is if you provide less benefits and less coverage and less protection, it should cost less. That is right. It is reasonable. But if the insurance doesn't cover your illness, if you are left exposed to paying for it out of your own packet, what are you going to do?

One of the ladies who came to our press conference yesterday is a perfect illustration. Her husband had bought a health insurance plan that he thought was a good one, one through an association. He even signed up for a chemotherapy rider on the plan because there had been a history of cancer in his family. Guess what happened. Sadly, he developed virulent lung cancer which required a lot of treatment. They went to their health insurance plan, and they said: We are glad we bought that rider.

Then, in the fine print, there was a limitation on how much they would pay. The poor man lived for years and died an agonizing death. His beautiful young wife from California was there yesterday. When he died, she was left with medical bills of $480,000.

Is that deluxe coverage—what we heard earlier—luxury coverage of health insurance? Would you want to find yourself and your family in a situation where you needed cancer therapy to survive and your plan didn't cover it?

Unfortunately, the Enzi bill moves in that direction, and it doesn't have it. All of the benefit cuts result in about 3 percent to 4 percent savings on premium costs. These are not expensive when they are spread across large populations. They are expensive when they are borne by one family. But if there are millions of people being covered, and a small percentage need it, you spread out the cost. That is what insurance is all about. It is a point that is missed in the Enzi legislation. That is not much of a savings—3 or 4 percent—when you are talking about diabetes, maternity coverage.

Maternity coverage. I know a little bit about that, being the father of three. I can tell you that one of the toughest moments in my life was as a law student—I got married in law school. Yes. We used to do that back in the old days. Loretta was pregnant. The baby came along and she had a serious health problem. We had no health insurance. We went to Children's Hospital in Washington. God bless them. They couldn't have treated us better. They finally said after a while: You are not going to be able to afford to pay this, DURBIN. You either sign up for welfare, which you can do because you don't have any income, but get ready to go bankrupt. You won't be able to pay these bills. There is one choice. There is another choice you can consider. You can go to a clinic for people who are uninsured.

Sure enough. I had to leave my law school and cut a class, drive out to

Maryland, pick up my wife and our little baby girl and sit in a clinic for hours to get a doctor in rotation—never knowing who you would see and sure you would never see them again. They would ask you all the same questions. Let's go through the history again. You tell them over and over—you want to give them everything.

That is what life is like when you don't have health insurance.

When it comes to maternity care, you have to be careful. I will tell you why.

Twenty-five years ago when I was an attorney working in the Illinois State Senate, it came to our attention that there was a company selling health insurance in Illinois with maternity benefits, but when you read closely, the maternity benefits did not cover the newborn infant for the first 30 days of life. Do you know what that means? In our case, in my family's situation, a situation just like it, that sick baby dramatically in need of expensive care for the first 30 days wasn't covered. We put a provision in the Illinois State law which said you cannot offer maternity benefits saying you will pay for the delivery of a baby unless you cover that baby from the moment it is born. That is a requirement in law.

It makes sense, doesn't it? It would be wiped out as one of the State requirements under Senator ENZI's approach. You can buy maternity care. You may be on your own the first 30 days. Heaven forbid you are in a situation with a sick child—and I have been there. It is no fun at all. It took us years to pay those medical bills. We were glad to pay them, and they couldn't have been nicer waiting to be paid, but there were a lot of anxious moments when this father sat in that waiting room wondering if he would ever get to see a doctor for his little girl.

There was a study in the New England Journal of Medicine in the years after President Clinton required that the Federal Employees Health Benefits Program cover mental health benefits. I can't go to a town meeting in my State and mention mental health clinic benefits where I don't have the following occur. I can guarantee you that in any large group this will happen: I will say that health insurance ought to cover mental health benefits—and I think it should. Senator Paul Wellstone, that great champion, used to sit in that back row and stand and beg for health care to cover mental health benefits.

If you mention that at a town meeting in my State or any other State, do you know what happens when the meeting ends? Two or three people are going to wait for you. They will want to talk to you privately. It has happened time and again. They say: Senator, we have a teenage son with a serious mental health problem. We don't know where to turn. We can't get health insurance. There is no coverage for him.

Every time you mention mental health, you find that across America there are people in need of mental health benefits.

When it came to mental health benefits, it was one of the first casualties in the Enzi bill. About 42 States currently offer mental health benefits as part of their health insurance. And that State requirement would be wiped away in the Enzi bill.

Is that deluxe coverage? If you have a bipolar teenage son, a schizophrenic daughter, someone suffering from grave depression in your own household, is that deluxe and luxury coverage? I think it is basic. I think it is what we should be about in America: taking away the stigma of mental disease and offer mental health coverage.

We received letters from organizations such as the American Nurses Association—God bless them—the American Cancer Society, AARP, and the American Diabetes Association. They are all opposed to the Enzi watered-down approach.

In a letter to Congress, 41 attorneys general, including my own attorney general, Lisa Madigan, in Illinois, have publicly opposed this bill.

Another way the Bush-Enzi bill would make people worse off is that it sets Federal rules of how insurers can charge people. I will try to explain what I understand Senator ENZI just did.

Right now in America you can charge health insurance premiums based on a number of factors: Are you well? Are you sick? Are you young? Are you old? Where did you live? What is your injury?

You can be charged different health premiums depending on how you answer those questions. The disparity in health insurance premiums between well people and sick people can be 26 times as expensive for sick people as it is for well people.

There are nine States—most of them in New England, except for North Dakota and Oregon—that have community ratings, which means that everybody in the State of Massachusetts represented by my friend, Senator KERRY, is in the same pool, everybody just like the Federal employees pool. So everyone is charged the same premium, young and old, regardless of their medical history. Senator ENZI comes and says: We just want to change this slightly. We want to be able to say that you can charge five times as much for someone who is sick than someone who is well, even in States with community ratings—five times as much.

They tried that in New Hampshire a few years ago, increasing the premiums for sick people. They dropped their coverage, and 21,000 people were dropped. In a year New Hampshire dropped the plan, saying it is not a good idea. It wasn't a good idea in New Hampshire, and it is not a good idea in the Enzi bill.

That is what is being proposed. Let me show you a study. The Lewin Group, a nonpartisan actuarial firm, shows rates would rise dramatically for businesses with a higher number of older Americans or women of childbearing years.

This shows the average premiums for community-rated States, the average cost per contract. You can see this yellow line. What is happening because Senator ENZI is allowing this divergence and differing amounts of premiums to be charged, you can see a dramatic range of increase that could occur in any given State.

So there is no protection on the upside below 5 to 1. There could be a 5-to-1 difference in premiums charged the lowest rated person in the State to the highest rated person. It is a significant difference.

The Lewin study found that small businesses in strictly regulated States are currently paying the average of $7,738 per month for health insurance for their employees. Under the Enzi bill, businesses with a high number of older people or women of childbearing years would see their premiums increase to more than $20,000 a month, while companies that have a disproportionately high number of healthy, young people would see a decrease in their premiums to $3,096 a month.

Finally, the Bush-Enzi bill will not help the self-employed. Self-employed people are the worst off. They are forced to purchase insurance in the individual market which has the least amount of State oversight. The Enzi bill will take away what little protection self-employed people already have in benefit mandates, which means if you are on your own—you own your little business and looking for health insurance, and you at least know when you are offered a policy it has to provide the basic coverage that your State requires—Senator ENZI wipes that away. It will not give self-employed people a way to pool with larger businesses.

The Enzi bill prohibits self-employed people from being pooled with larger businesses, so they miss out on the discounts of the larger groups. Right now, we believe the realtors who are pushing the Enzi bill ought to step back and take a close look at that provision and ask themselves what percentage of the membership of realtors across America is self-employed. The coverage and protection is not there for you. This may sound good for their members until they take a look at the policy and there is no protection.

Individuals would be pooled with other individuals, so they may save on marketing costs, but they will be priced the same way they are today: individually. Under the Enzi bill, self-employed people can still be denied coverage if their State law permits it, and they can be charged exorbitant rates based on their health status, gender, age, or industry.

Diane Ladley of Aurora, IL, is self-employed and has a chronic condition called fibromyalgia, which causes

chronic pain and fatigue. She has been denied insurance in the individual market. She is currently cutting her pills in half because she cannot afford them.

The Bush-Enzi bill will do nothing to help Diane. Even if she joins an association health plan, an insurer could deny her coverage. If she is offered coverage, insurers will still be able to exclude her current condition or charge an amount so high she could not afford it.

The Lincoln-Durbin bill would allow Diane to be pooled with other small businesses in one national pool. She would have access to the same negotiated discounts as all other small businesses in the pool.

We can make health insurance for small businesses more affordable without slashing benefits or charging people who need insurance even higher prices. My bill, with Senator LINCOLN, is an example of how it can be done. It is a reasonable approach.

I will come back to my starting point as I close my remarks because I know there are other Senators in the Senate waiting to speak. This is a matter of simple justice. If Members of the Senate and the House of Representatives take advantage of the Federal Employees Health Benefit Program because they believe it is fair and right for their families, why won't they offer that same opportunity to other Americans who need health insurance? Why should we give ourselves the status of a privileged class when it comes to health insurance? Why should we say that people across America shouldn't have the same protection our wives and our families have? We ought to offer them in good faith an approach that is the same as our own. If this health insurance we use is good enough for Members of Congress, it is good enough for American families.

I yield the floor.

The PRESIDING OFFICER (Mr. COBURN). The Senator from Wyoming.

Mr. ENZI. Mr. President, I would like a chance to answer the 45 minutes of accusations that were made about my bill and also bring up a few things about the Durbin-Lincoln bill that I have not had a chance to talk about yet, but could I inquire how long the Senator from Massachusetts will speak?

Mr. KERRY. Not that long, maybe 15 minutes, something like that. Hard to say entirely.

Mr. ENZI. I almost hate to break the continuity of the debate when we are talking about some very specific things.

Mr. KERRY. I welcome it. It is not often a debate breaks out in the Senate anymore, so I am happy to welcome it. I ask, through the Presiding Officer, how long the Senator from Wyoming might think he would engage in debate?

Mr. ENZI. Probably about as long as it took Senator DURBIN to cover the fallacies and to boost his bill. I ask that I be the next to speaker after the Senator.

Mr. KERRY. I appreciate that. Maybe that will work because I will just add to some of the things the Senator will probably want to answer, and he can take it all in one bundle.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

A unanimous consent has been requested that Senator ENZI speak after the Senator. Without objection, it is so ordered.

Mr. KERRY. I thank the Chair, and I thank my colleague from Wyoming.

I listened carefully, and I hope a lot of other folks did, to the comments of the Senator from Illinois and from other colleagues in the Senate over the course of the last days.

I wish the Senate were engaging in this issue in a serious way that allows Members to debate the merits of individual approaches to small businesses being covered. Regrettably, that is not the choice of our friends on the other side of the aisle. What they have done is come in with a series of amendments, with second-degree amendments, and, in the language of the Senate, filled the legislative tree, which basically means blocked out the ability of Democrats to bring amendments, to have a real choice between plans as to how we approach small businesses. That is point No. 1. That is irrefutable and damaging to the prospects of trying to deal with the health care crisis we face.

Two years ago, when I was traveling the country as a candidate, no matter what State I went to, no matter what town or what size community or what the political definition of that community was, you always felt a profound sense of responsibility was thrown at you by the people you met from all walks of life.

I met people in town meeting halls, in VFW halls, in rope lines at rallies, in visits to factories, in visits to medium-sized businesses, large businesses. A whole bunch of folks would come up and tug at my sleeve, often with tears in their eyes, look at me, and say: Senator, you have to help us on health care. You have to do something to help us be able to afford health care. They would show me a photograph and say: Look, this is my sister, or this is my mom, and they would tell you about a loved one who could not afford the medicine they needed or who lost their health care when a factory shut down or when a business closed or moved overseas. The faces of those people stay with you forever. Their names do, too.

People—many of them Republicans, many of them conservative small businesspeople—were pleading not for a dumbing down of the system, not for an automatic reduction in coverage, but for a way to expand the ability to have the level of coverage they have today and be able to pay for it. They were looking wearily to this city for help.

I met an awful lot of poor folks who obviously do not have any health care, and the numbers are climbing. More importantly, there is a change in the fabric of our society. I met an awful lot of working Americans who are increasingly watching health care costs go up, education costs go up, energy costs go up, and their wages either stay the same or go down. That is not a sustainable equation in our country.

Increasingly, those workers are being pushed out of the middle class into the working poor or downward within the middle class itself. There isn't one of us who has not met a mother of a child who would describe situations in which she would make life choices for that child, about whether to let her kid play football or some other sport—hockey—because she was afraid she could not afford the medical care if her child broke a leg or somehow were injured.

I heard again and again stories from teachers who would tell me about kids who get no preventive care, they do not get routine exams. Schools have cut nurses, so you do not have a nurse in the school now to take care of someone.

I heard instance after instance of kids who had some form of acting-out in the classroom as a consequence of either an earache or some other chronic disorder. Some of them went to the doctor for the first time when they were 9, 10, 12 years old, and it was too late; they discovered they had a permanent hearing impairment as a consequence. I met the head of pediatrics in the State of Washington at an event we did in Seattle for children's health insurance who told me specifically of kids she had examined who had permanent hearing impairment, and now they will be in special needs education because we did not care enough to give them early intervention.

I met a lot of small business owners who would like to be able to provide their employees with health care but cannot afford it and who know the health care costs are so high that they are standing in the way of being able to hire more workers because they do not have the flexibility and the ability to be able to expand the business and try to cover people or pay even a portion of the health care.

In New Hampshire, I met a woman who had breast cancer. I got to know her pretty well. She told me how she had to keep working day after day right through her chemotherapy no matter how sick she felt because she was absolutely terrified of losing her family's health insurance if she did not show up for a day or two.

In Erie, PA, I met a man named Albert Barker who wonders how he is going to pay literally thousands of dollars in medical bills that he cannot afford. And after he suffered a heart attack and he underwent surgery, guess what. His employer just stopped his health coverage because it was too expensive because he had gotten sick. So they cut him off at the moment of need, and he was basically at that time facing bankruptcy as a consequence. His wife said at the time that she was

reduced to hoping and praying that nothing else happened.

In Council Bluffs, IA, I met a woman named Myrtle Walck who at the time did not know what she would do if the price of medicine rose any higher—which it has—and she paid a huge chunk of her Social Security, which was not very big and was her only source of income, her Social Security check, to the drugstore every month just to cover the cost of her two daily prescriptions.

In Jacksonville, FL, Renee Harris, who owns a schoolbus company that was in her family for over 50 years, was forced to sell the company because she could no longer afford to insure her workers and felt compelled to want to be able to do so.

I heard daily about workers' fears of losing coverage because they either could not afford the higher premiums, the deductibles, the copays, or they thought their employers would drop the coverage altogether.

I talked to people who told me what it was like to live knowing they were one medicine bill, one hospital visit away from bankruptcy. That is the real world we are living in today. That is the real world the Senate ought to be debating. All of these problems are in our health care system today. Yet there is so little time devoted in this Congress to finding the common ground, to finding solutions to get something done for those people who want to believe we will do something to help them.

Instead, what do we have? We have a so-called Health Week in the Senate. This is Health Week so that Senators can come to the Senate and give speeches—not legislate but give speeches. We have speech after speech in a stalemate where the whole week is going to go by, and everyone knows what will happen at the end because we are not really legislating because we are not really here to solve problems. The people I have met deserve to have a Congress that insists on a real debate, really getting the job done.

In all the 22 years I have been here, this is one of those peculiarities of a moment in American history where the Senate is about as dysfunctional as it has been in that whole period of time. Serious efforts to try to deal with problems are just not on the table.

What are we going to have? We are going to have one up-or-down vote on a flawed bill with no chance for Democratic amendments. I know the Senator from Wyoming is going to argue it is a good bill—and we will go through some of those details in a minute, et cetera—but what we have been reduced to doing here is spending an awful lot of time trying to stop bad things from happening instead of putting the competent energy of a lot of people who think a lot about these issues, some of whom have extraordinary expertise, into trying to fix them and move toward a positive health care agenda for our Nation.

Right now, we are fighting to fix the devastating changes that have been forced on the Medicaid Program. We need to overturn the rules allowing increased cost sharing that has been imposed on families who cannot afford it. And we need to prevent new rules from tossing out the early periodic screening diagnosis and treatment protections for children on Medicaid.

Who wrote to the Congress and said: ''Kids in America have enough coverage. We ought to cut out early periodic screening''? Every doctor you talk to worth their salt in this country will tell you what we need is more preventive care, wellness. We need to teach wellness in America. We need to be doing preventive care instead of treating people when they finally get sick, at a time when it is far more expensive than if we intervened early.

On diabetes alone, if we had diabetes screening for every person in America, you could probably save $50 billion. You would avoid a lot of amputations. You would avoid a lot of dialysis. And you could treat it in a far less expensive, more easy way. Are we talking about that here?

We also have to fix the Medicare prescription drug debacle and extend that May 15 deadline for signing up without penalties. Why? Because it has been confusing to seniors all across this country. Because the implementation has been exactly what a lot of people predicted. The result is a whole bunch of things that ought to be happening to reduce the cost for seniors are not happening.

A simple thing would be bulk purchasing to negotiate lower prices on prescription drugs. We ought to be simplifying the enrollment procedures. We ought to be making the benefit more comprehensive, by closing the gaps in coverage.

But the bottom line is, it would be a tragedy if all we did was try to stop these bad things from happening, when everybody knows we have a health care system that is increasingly in extremis, a health care system that is in crisis and imploding on itself in many ways.

This bill, I regret to say, because it deregulates in a selective way all of the insurance delivered in the States, is going to create chaos for people as States choose different offerings and the rules go out the window.

I might add, for a group of people who traditionally have come to the floor to defend States rights, they have, in the last years, proven themselves remarkably selective in where and when they want to protect those States rights because State after State across the country has passed a certain standard of health care. Why? Because they know it works. Because they know it reduces costs. Because they know it helps people have greater quality of care and a better quality of life. Instead, this bill is going to open up the opportunity for people to reduce the level of coverage for people.

There are a whole series of real health care initiatives that the Senate ought to be dealing with. I am convinced we can find an ethical way of dealing with the thorny issue—I recognize there are ethical considerations—but we could find, if we wanted to, an ethical way to deal with a host of in vitro embryos who, regrettably, are going to be discarded altogether, thrown out into the garbage and lost, rather than applied to the possibility of saving life. It seems to me there is a way to fully fund, in a limited way, the appropriate research of initiatives at the National Institutes of Health.

We also need to take up real legislation to get at the heart of racial and ethnic health disparities. We need to make it legal to import prescription drugs from Canada. We need to put medical decisions back in the hands of doctors and nurses and patients, not insurance company bureaucrats. We need to address the nursing shortage by fully funding all the programs under the Nurse Reinvestment Act that we fought so hard to enact.

We need mental health parity, which I heard the Senator from Illinois talk about. We need to address our growing childhood obesity problem which is going to increase the cost of health care all across the country. And we definitely need to reauthorize the State Child Health Insurance Program.

But this is Health Week, and we are going to have a Health Week on the floor of the Senate. It is not going to deal with any of those issues. It also avoids giving families and small businesses access to the same private health insurance that Members of Congress give themselves. I heard the Senator from Illinois talk about this.

I raised this all across the country in 2004. What is it about being a representative of the people, elected by the people to come here to represent the interests of the people, that empowers us to abuse that privilege by giving ourselves the best health care in the world, at less expense, with a nice Government match, bigger than what most businesses can afford, and we are not willing to allow that to happen all across the country? What kind of values does that represent for those who run around talking about values?

It seems to me we ought to stand up and make it clear that every single family's health care is as important as any Member's of Congress. We ought to be offering every single person the opportunity to at least buy into it. Why shouldn't they be able to buy into it and get the coverage? Why shouldn't we open up Medicare and let people who are 55 or older buy into Medicare early? That could happen, and a whole bunch of people would get coverage and we would reduce costs to America.

All you have to do is talk to any hospital administrator in America. First of all, they are dipping into their reserves. A lot of them are on the brink of bankruptcy. Many of them get refunded so late and with such difficulty,

it is hard to plan and come up with a business plan for the hospital. Most importantly, none of them can afford the massive investments in technology that would, in and of themselves, reduce the cost of health care and raise the quality of life.

Something like 45,000 to 50,000 to 90,000 people a year die in hospitals because of medical error. And often, that medical error is the result of pain management or pain mismanagement. The VA has a terrific system. I have been in the VA hospitals. I have seen it. Why do they have the system? Because it is the VA. It is a Government health care plan, and the Government made certain they could invest in these pain management computerized systems. The result is, they have reduced the incidence of mistaken pharmaceuticals being taken, people getting the wrong medicine, getting too much, getting it at the wrong time, getting it even when they took it already—all of these kinds of things that happen.

This week, unfortunately, instead of bringing up a bill that would grant real relief to our small businesses, we are considering a bill that 41 attorneys general of the United States have written to say is bad policy and will only exacerbate the problems in States today. Why are we doing that? Attorneys general are looking at the regulatory process. They are looking at the overall ability of a State without regard, in many cases, to the politics of it but to the law and to the implementation of what happens. And 41 attorneys general have written to say this bill is going to exacerbate current troubles. I hope the Senator from Wyoming will address all of the concerns expressed in the letter of the attorneys general of the United States.

We have also seen the numbers. The Kaiser Family Foundation reports that the number of firms offering health benefits has declined from 69 percent in the year 2000 to 60 percent in 2005. Forty-seven percent of firms with fewer than 10 employees offer health insurance, compared to 90 percent of firms with 50 employees or more.

So everybody agrees something ought to be done. The problem is, the plan offered by the Republican leadership today is not going to help the small businesses to be able to gain coverage for their employees, unless, of course, they give up a whole set of things that currently they are covered for and then without regard to what the pricing is going to be for that. It is a wholesale deregulation of insurance markets. And a wholesale deregulation of insurance markets is, in fact, going to put consumers at risk. The studies show the approach we are being offered will, in fact, have a better chance of increasing the numbers of uninsured, rather than offering small businesses a lot of the relief they so desperately need.

The proponents argue prices are going to drop once we get rid of the benefit mandates created and enacted by State legislatures. Well, first of all, that claim, frankly, does not stand up. There are two separate studies that show benefit mandates are estimated to increase health premiums by a small total of about 3 to 5 percent. Juxtaposed against the annual double-digit premium increases that we have been seeing, it is clear a benefit mandate is not at the heart of the problem. If the benefit mandate is only a 3- to 5-percent increase, but we have been seeing double-digit increases over a period of time, something else has happened.

More importantly, why do we have mandates? What happened to the right of a State to make a decision, as Massachusetts has in the last weeks, that they want to make certain every person is going to be covered and to mandate a system by which businesses have agreed and the legislature has agreed they are going to fund it and people are going to be covered?

Now, the people who have often argued about the heavy unfunded mandate hand of the Government—the people who have most objected to the Federal solution for individual States—are now going to come in and literally give this great gift to some small businesses to be able to go out and do whatever they want and take away from States the ability to guarantee a quality of care for their citizens.

Forty-nine States have passed laws mandating that insurers cover mammography services because they are proven to save lives. Twenty-seven States have passed laws requiring cervical cancer screenings because too many women are dying as a result of poor detection. Forty-six States have passed laws requiring diabetes supplies to be covered because 20.8 million Americans are living with this disease and they have a basic need for care.

So the Senate is going to come in and say: Those mandates are not important. You do not have to do that anymore. And companies are going to be able to create this unbelievable morass of different offerings which are going to confuse and, I predict, infuriate the consumers of this country, just the way the prescription drug medicine Part D program has infuriated seniors across the country.

Now, the numbers I cited about cervical cancer and mammograms and screening, those are not just numbers in a report. We have seen, every day in Massachusetts, how those things make a difference.

Kirsten Paragona of Ipswich discovered, in a routine pap test, that she had developed stage 3 cervical cancer. She was 23 years old. And because that pap test was included as a mandatory benefit in her health plan, Kirsten is alive today, with a 2-year-old daughter, instead of living without a reproductive system.

For all those in the Senate who want to talk about a culture of life, that is a culture of life. And that is a culture of life worth fighting for.

And then there is Gracie Bieda Javier of Jamaica Plain. She lost her mother to breast cancer in 1987. Without mandated coverage for treatment, Gracie's mother was unable to afford the service. And now Gracie is dedicated to helping other women avoid her mother's fate. And because Massachusetts now requires mammography and treatment services, Gracie screens and treats more than 800 low-income women a year. That is because it is mandated.

What is going to happen when you open this up to so-called market forces? People who cannot afford it are really going to get hurt. In her own words: ''[Gracie] could not think of a better way to honor [her] mother on Mother's Day than to make sure we maintain these lifesaving mammogram services.''

I think she has it right. It saves lives.

Under this bill, 2.3 million people in Massachusetts alone will lose guaranteed health benefits. So what are we going to do? We are going to go back and tell them: Gee, the Senate, in all of its wisdom, deemed that these things that the State thought were important for you—they are not important for you. And the State does not have to provide them.

Typically, the great thing about a democracy is that if there is a better idea, people get to hear it and they get to perhaps choose it. They get to debate that kind of alternative on the Senate floor and engage in a debate on the merits of each of these approaches. What is so fundamentally frustrating about this week's discussion is that differing approaches are not really allowed to see the light of day except in speeches.

Frankly, there are a lot of ways we could approach the small business issue. Senator SNOWE and I have had hearings in the Small Business Committee. We have worked for a number of years to try to narrow down options on AHPs. A lot of people don't like them because of the mandate issue. We have tried to wrestle with how do you deal with the mandates and still lower costs. There actually is a way to open regional pooling for States and allow a State that doesn't want to lose its mandates to opt out. Why can't we have that discussion on the floor of the Senate? You could create pooling. You could create a regional effort to reduce costs. But you could allow people the right to also choose to hold onto the benefits they want, if they want, and not deprive the States of that option. There were a host of other ideas that we have been working on.

I regret enormously that all of the effort that went into those negotiations and discussions is not going to see the effort of real legislation by voting on those different amendments. We also had hearings which suggested a whole bunch of different ways which we could provide and help small businesses without doing harm to the system. None of that has been incorporated or is going to be incorporated here.

In 2004, I offered America a plan that would provide every single American the same health insurance enjoyed by Members of Congress. Since that time, Senator DURBIN and Senator LINCOLN have taken that idea and turned it into a bill that creates the Small Employers Health Benefits Program which he discussed. I am a sponsor of that. Under that bill, small businesses could join a national pool and could take advantage of the same Federal administrative functions and bargaining power that is enjoyed by 8 million Federal employees across the Nation. Why should we discriminate against them? Those small businesses could have the ability to pool, to come in and negotiate less expensive health care and provide better benefits to their people and do it with the same leverage that the 8 million Federal employees do. Most importantly, it would protect the State mandates that individual States have decided they want to put in.

Republicans argue that that alternative does not provide the savings that small business owners desperately need. The facts tell a different story. We all want savings. We have to reduce the burden of health care on small business. I understand that. That is why Senator SNOWE and I have been working to arrive at a way to do so. But experts predict that premium savings for participating small businesses could reach as high as 50 percent higher in the first 2 years, if it passes. It seems to me there is a way to approach this. If you go with the idea of Senator DURBIN and Senator LINCOLN, we would actually be able to reduce those costs by almost 50 percent.

If this week was actually an effort to provide relief to small businesses, we would be discussing all of the options to provide that relief. I don't think that coming up with a precooked, one-size-fits-all, one-ideology, one-approach, one-party plan is the way to help businesses. It seems to me that what is going to happen is, a lot of our small business owners and about 25 million uninsured Americans who work for them are going to get caught up in this political show of the week. It is obvious there is a partisan disagreement in what is keeping the Senate as divided and as incapable of doing real legislative effort. And that is a shame. It doesn't have to be that way, if we mapped out enough time and actually worked across the aisle to try to find the common ground. This is one of those issues where you have to put the politics aside. That is how you are going to win one for struggling entrepreneurs.

There are a couple of places we ought to be able to find that common ground pretty quickly. First, how about for children in America? The example I gave earlier of a mother who makes a decision about a child not playing a sport or a child who comes up with a permanent impairment is replicated tens of thousands of times over across the country. We have 11 million children who have no health insurance at all. Sure, if they get extremely sick, they will wind up being taken care of in a hospital and somebody will ultimately see them, if it isn't too late. But the fact is, by that early screening and by involving ourselves early in their lives, educators and medical experts tell us that kids who are properly fed, who have good nutritional practices as a consequence of their meeting with doctors and mothers, learning about those kinds of things, do 68 percent better in school and, in fact, reduces the cost in the long run because they begin to learn good health practices as a consequence of that exposure.

Why couldn't we be using Health Week to talk about the most fundamental value of all, which is caring for our children and providing every child in America with health insurance? You would reduce unnecessary hospitalizations by 22 percent, and you would replace expensive critical care and inexpensive preventative care. Obviously, we would do much better in the classroom and much better in families if that were the case. We are the richest Nation on the planet. Yet one in four kids in America goes without immunizations. One in three children with asthma don't get the medicine they need. It is unbelievable to me that there is as much talk about family values as we hear in the political dialog, such as it is in the country, but then you have 11 million children who don't have any health care, and the country is content to let it stand.

You could insure every single child in America for less than it costs to roll back the Bush tax cut for the wealthiest people. That is the choice. Every child in America could be covered with health insurance if people earning more than $1 million a year didn't have to get another tax cut. But Washington chooses the tax break for the few who don't need it instead of health care for the 11 million who need it desperately.

A 2005 Mason-Dixon poll found the following: 82 percent of respondents think that every child in America should be covered by a Federal health program, if their parents can't afford it; 90 percent of voters believe that 11 million uninsured children in America is a serious problem and Congress ought to address it and resolve it; 79 percent agree that it is our moral responsibility to ensure health care for every child and for the Federal Government to invest in such programs.

In addition, the poll found that when voters are presented with a description of Kids First, the specifics of the bill that would provide kids with health care, 75 percent of voters support it and support its passage by a margin of three to one. They have said overwhelmingly that providing health care to kids is more important than providing the next round of the tax cuts and making them permanent.

So Americans know what we need to do. There is no more pressing need than improving health care for our children. That is why nearly 25 national organizations representing over 20 million Americans have endorsed the Kids First proposal. When I first sent an e-mail telling people about the Kids First, within 2 days, over 20,000 parents phoned in with recordings of why the Kids First Health Program is important to their families. Let me share one or two of those with you.

Jennifer from Central Islip, NY, called in and said:

> I have a child who is on medication . . . that costs me $250 or more a month. I have children who can't go to the dentist. You know, it's the worst feeling in the world, as a mother, to know that in order to afford health care, you're not going to be able to afford the home you live in.

Jordan from Reading, PA, called in and said:

> Nalani . . . my 3-year-old . . . was born with cataracts . . . Eventually chances are she will be blind. Unfortunately, times are really hard in my house and we don't have health insurance and I can't afford to give her the surgery that will fix the problem that she has. I just can't imagine growing up knowing that there was a way that you could have helped. But because nobody thought you were important enough and because your parents didn't have enough money for health insurance . . . you went blind.

With calls like this, it is extraordinary to me that Congress continues to offer a blind eye to these cries for help. This program that is being offered, I regret to say, is only going to confound and confuse and make worse the current delivery of health care in America.

I yield the floor.

The PRESIDING OFFICER. Under the previous unanimous consent agreement, the Senator from Wyoming is recognized.

Mr. ENZI. That went a little longer than I anticipated. I have now listened for an hour and 25 minutes to the other side. I ask unanimous consent that our side have that kind of an opportunity.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ENZI. I have an office that is kind of interesting. It is Phil Gramm's old office. He retired from the Senate after several years of mentoring a number of us and was a real force around here. Occasionally, when I am sitting in my office, some phrases will come by that he used. I grab them and I put them in a jar. I figure I will never have an opportunity to use them. But I think today I will pick out of the jar again. He said: When the Democrats talk about health care, they want national health care. The ship of health, they do not care who steers it, as long as it wrecks, and we can have national health care. That is a little bit about what we are talking about today, that plus a combination of saying we are not going to let anybody out there have anything unless they can have everything. That would be nice. I would like for the people of this country to have better insurance than we in the Senate have. That would be my dream.

I wish we could give them better insurance than we have.

Before I came to the Senate, I had better insurance than I have now. When the Democrats say that they want to open up the Federal employee health plans to everybody, they want everybody to have the same thing we have, they don't really mean that. They can't really mean that. I am willing to bet that if we were actually opening up that same pool and letting the Federal employee insurance be used by everybody in the country, the Federal employees would say: Whoa, not on my shift. The Federal unions would say: No, not on my shift. That is a closed pool. That isn't open to everybody. If it was open to everybody, it would be a whole different range of costs. And it is subsidized.

The Democratic alternative, S. 2382, is an open, voluntary pool purchasing agreement. That kind of an arrangement has failed nearly everywhere they have been tried. There is no evidence that they would succeed if they tried it now and would succeed where others have not. Many States have tried this. It is with very little success.

It may look like the Federal Employees Health Benefit Plan, but the Federal employees plan is a closed pool that provides premium support to all eligible individuals. The Democratic alternative is an open pool that would provide a tax subsidy to some of the eligible employers. In other words, it would be apples versus oranges.

A tax subsidy? Let's see, would everybody be able to get a tax subsidy for their health? No, you only get a tax subsidy if you buy the Durbin-Lincoln health plan, a one plan fits all for the United States.

Now, there was some discussion about whether it was $78 billion or $73 billion over 10 years. Let me tell you, they have never scored it, so they have no idea what it would cost. That is what some of the separate actuaries have looked at and said it would score. The Enzi-Nelson-Burns bill would reduce costs and increase coverage, and that is according to respected actuaries. No one can say for sure what that Democratic alternative would do—whether it is tens or hundreds of billions over 10 years.

The Durbin-Lincoln proposal eliminates the ability for national plans in that bill to offer uniform benefit packages. Why is that important? The plan I have put forth—the plan that has come out of committee—allows small businesses to work across State lines to form bigger pools so that they can negotiate effectively against the insurance companies. That is where the savings are. We talk about mandates a lot in here, but the savings come from the ability to have a uniform package so that people in adjoining States can all be bargaining for the same package and have a big enough pool to go up against the insurance companies to be sure they get a better price.

The national plan—the Durbin-Lincoln plan—would still have to meet the requirements of each and every State, even down to the specific particulars of each mandate. Did you know that there are currently 1,700 mandates in the United States? Did you know that those mandates are seldom the same from State to State? They may have the same title, but they are not the same. So how do you put together a package where you say you have to do all of them and be able to go across State boundaries to form bigger pools? You cannot. You would have to do 1,700 mandates if you wanted it to be uniform across the United States.

I need to tell you, too, that some of these mandates we are talking about are screenings. We heard about mammography over there. That is very important. I hope women get mammographies. But did you know that in Wyoming, we really emphasize at this time of year—and I will mention it because Mother's Day is coming up, and this is a huge program in Wyoming to encourage people to buy that for their mother for Mother's Day. It works well. People know exactly what they are buying and exactly how much it costs. It isn't one of many mandates that are in the package that they pay for even though they don't use it.

Somebody said that mandates only add 3 to 4 percent to the bill. No. In the State with the minimum amount in mandates, it adds 5 percent, up to Massachusetts, which adds 22 percent in mandates. Now, I am not suggesting that any of those mandates should not be done. The bill I worked on does set up the ability to have a basic plan. Would people necessarily do the basic plan? They can do the basic plan up to whatever they think is responsible coverage for the people in their association. That doesn't mean nothing; it means they can pick.

You get the impression here that if you allow a basic package, everybody in the country is going to jump on the basic package and say: I can really sock it to my employees; I don't have to provide them with anything anymore. That is not America, and that is particularly not small business America. In small business America, they know they need their employees. Of course, as somebody pointed out, sometimes the only employees are mom and pop. They would like to be insured if they could possibly afford it. So we have to find some way for them to be able to afford it. But this notion that just because there is a mandate out there, everybody will use it, and this notion that just because there is a mandate out there, if we don't require it, it will be dropped—you know, we allow big business in this country to do whatever they want. And do you know what. They provide those basic things.

Now, one of the things which has been mentioned is colorectal cancer screening. Again, the facts suggest that health plans cover important tests like this regardless of State mandate, so it is likely that small business health plans would cover them as well.

In 2004, the Government Accountability Office found that 20 States had laws mandating coverage of colorectal cancer screening tests, which are strongly recommended by the U.S. Preventive Services Task Force for people 50 years or older. Now, the GAO then surveyed 19 small employer plans in 10 of the States without laws mandating this coverage—without laws mandating that. This is an opportunity for those small businessmen, if they are the way they are accused of being here, to just drop it for everybody. Now, despite the absence of State mandates to cover colorectal cancer screening, all 19 small employer plans in those 10 States provided the benefit. Can you believe that? If you have been listening to the discussion this week, you would think they would just drop it. They didn't drop it. They said: Our employees are valuable, and we need to do whatever we can afford to to help them.

Now, how do we help them to afford it better? Let's see. If we could join up with all of the other realtors in the United States—incidentally, the realtors are coming to town next week to their regular annual meeting. As I understand it, 9,000 of them will be here next week, coming to a national convention. Oh, how I wish they would have come 1 week earlier. They could have explained their case. But we have a whole bunch of small businesses out there that really think it is important to be able to band together and get a better deal. It works.

Part of the discussion we have heard today has gone off on some other tangents. That is one of the reasons we are talking about relevant amendments. One of them that we went off on is prescription drug Part D and how, by Monday, people need to sign up for a plan. I really appreciate the coverage we have gotten to get that word out to people across America to make that decision this week. Make it this week. Don't have a penalty because you missed the deadline.

Now, for months I have listened to the Democrats say: This is terrible; this is confusing; this doesn't work; we need to do something different; we have to make it simpler for our seniors. Let's see. Let's just have one Federal plan for them to pick from. It sounds like Phil Gramm again, doesn't it? Ship of state wreck so we can have a national opportunity.

Let me tell you what happened. I was really worried about this prescription drug plan. Wyoming has such a small population—less than 500,000—and we keep hoping we will get off that mark. So far, we have never gotten a city big enough to kind of feed on itself and grow. I said that Wyoming just doesn't have any luck attracting businesses for competition, and we probably won't have any luck on prescription drugs, so I wanted to make sure there was an underlying thing that says if nobody is interested in Wyoming, the Federal Government will take care of it. Do you know what. Wyoming got 41 plans—41 of them. Competition works.

Now, that is what causes the confusion the Democrats keep talking about on prescription drugs. They say that there are too many plans out there for people to make a logical choice. That makes it confusing for seniors. If we infuriate them, we can really get them storming. They have done a pretty good job of that.

You know, I did town meetings, and I tried to help them out. Not only were they appreciative, but a whole bunch of people already signed up and were getting far more benefits than they ever dreamed of. I said: How were you able to make such a critical decision all by yourself? They said: There is this 800 number, and all I needed was to know my prescriptions and the dose and whether I want to buy them locally or do them by mail order, and I got a list of four plans that line up, line by line, that I can make a comparison on. So I know exactly what I am buying, what it is going to cost, and I know what it will be in the long run. How difficult is that?

Oh, but the telephone isn't your only opportunity. You can also go online. There is an online spot that will do the math for you, provide this same kind of list for you to make the comparison. I did it for my mom. Quite frankly, a lot of seniors are going to need help from their kids—kids who are young like me—and they will go through the process and find out how it works. There were things I had questions about, and I got ahold of Health and Human Services and got some changes to make it easier. At first, it looked as if you were signing up before you knew what you were buying, but they changed that so you could get the evaluation first.

Did you know that competition brought down the price by 25 percent even before the first person signed up? That is what those 41 companies who were competing did. Yes, the Democrats say: Wait a minute, there is this penalty and there are a whole bunch of people who don't need any drugs now, so they should not have to sign up now. That is not how insurance works. You buy insurance in case something happens to you. This is a Federal program, so we built in a benefit so that if you had something already happen to you, you can still get low-cost insurance.

In Wyoming, there is a package you can buy for $1.87 a month and avoid all penalties. It gives you assurance that you have coverage in a number of areas. And this is something that would only happen on the Federal level, too. If you come up with something that changes your whole drug prescription thing and it goes up dramatically, every November 15 to December 30 you can change plans. You can go to somebody who will provide all of the benefits you need—the cheapest possible plan. Again, you can have Medicare do the math for you.

So one-size-fits-all doesn't bring prices down. Competition brings prices down. I know that the dream of every person is not to have to sit down with every insurance agent and try to work out something or even understand what their package is. That is where the confusion in the Medicare prescription plan comes in—that possibility of having to sit down with 41 different insurance agents. How many evenings will that take you? There has to be simplification. The simplification we provide in the bill I have been talking about is the ability for your association to work across State lines, build a big pool that is competitive, and to be able to sit down and talk to all of those insurance agents so you can come up with the best possible plan for your association and to save administrative costs.

I am not talking about eliminating the mandate to save the 5 percent to 22 percent—although when they are doing those, they don't only use 25 percent of them, so maybe there is some consideration there. I am not worried about that part. That is not where the savings come in. The savings come in being able to negotiate in a competitive way and reduce administrative costs. Right now, a small businessman pays 35 percent in administrative costs. Big companies that do their own plans pay 8 percent. That is a pretty nice savings, especially if every 1 percent in costs brings 200,000 to 300,000 more people into the market. Let's find a way to bring them into the market. So 35 percent minus 8 percent is a 27-percent savings. Multiply that by 200,000 and see how many people it brings into the market.

We have small businessmen out there—22 million of them—who work in small businesses who are uninsured. That is counting the owners and the employees in the small businesses. We have another 5 million who are self-employed who are uninsured. That is 27 million people in whose lives we can make a difference because they can work through their associations to get better prices—not by eliminating mandates. They want those for their employees. They need those for their employees, to keep their employees; otherwise, they move on to bigger companies. Employees are the heart of the business, and small businessmen realize that more than big businessmen.

But there is another reason the Durbin bill won't work. He has taken away the ability of plans to form these uniform benefits on a national basis, like the national Federal employees plans can do.

So there is not going to be this national pooling because they are not going to be allowed to do what our Federal Employees Health Benefits Plan does because there would not be any insurers who would want to offer a national plan without the same freedom from State mandates that exists for national plans under—get this—the national plans under FEHBP, what we are proposing and what is referred to as the Enzi bill. I like to think about it as the small working peoples bill.

This bill would just create 50 State pools, no true national pools, and all of the 50 State pools will have all the other problems we cited. The Enzi-Nelson-Burns bill trusts small business owners to band together to negotiate for good benefits, while the Democratic alternative gives small business no say in the matter.

They say: The Federal Government is right again; we are going to do what the Federal Government does; oh, but we can't do what the Federal Government does or anything like what the Federal Government does, but that is what you have to settle for.

The Democratic alternative will create a new insurance pool that will operate under a different set of rules which creates the same opportunity for cherry-picking which is adverse selection that Democrats claim the House bill creates. You have to look because the Enzi-Nelson-Burns bill solves that. It solves that cherry-picking. It levels the playing field. It doesn't just grab the best customers from the insurance companies and move them over into the health plans. It allows the insurance companies to compete and also to reinsure, but they have to work with a bigger group.

The Democratic alternative sets up a dual Federal-State regulatory structure that would create confusion for consumers and participating insurers. I will probably cover that a little bit more later. I made a lot of notes on points I ought to cover.

There is one very important one. We were talking about childcare a while ago, and everybody considers childcare to be extremely important. We talked about newborn care. I think everybody considers newborn care to be extremely important. When they talk about eliminating mandates, they like to expand that well beyond what the bill ever allows.

There are requirements in States for who are covered persons. This doesn't change that one bit. Newborns who are covered are not touched—not now, not ever, no intention to do that. So if they are covered now, they will be covered then. It is the law.

I have several other people who would like to use a portion of this time that I just reserved a while ago. I yield time to Senator BURNS who has been very patient. I yield Senator BURNS 15 minutes.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BURNS. Mr. President, I thank my friend from Wyoming, a man who lives south of the 45th parallel from our State, for the work he has done on this legislation.

We have been asked a lot of times what drives us on this legislation. I have been on the Small Business Committee now for three terms. We tried to pass an association health plan for the last 12 to 15 years. Even Senator Bumpers, the senior Senator from Arkansas back in those days, worked on a bill, and his own side wouldn't let him complete that exercise.

The landscape has changed a little bit, and the numbers we are getting

now are much larger than they were, say, 10 years ago: 27 million working Americans are uninsured; 63 percent are either self-employed or work for a small business. For small businesses with 10 or fewer employees, 34 percent of those are uninsured. And for firms with 10 to 24 workers, 27 percent of them are uninsured.

Then I looked at my own State and looked at those numbers, and they are compelling numbers. In Montana, 60 percent of small businesses with fewer than 10 employees do not offer health insurance. That is a big number, 60 percent. Incidentally, most employers in Montana are small businesses. They make up the vast majority of our working force. They are people who run small firms that we typically think of as small business, but there is another small business—and some are a little bit bigger and can be defined as a big business—that we tend to overlook, and they are the people who live on farms and ranches across this country. They have the same desire and same needs for insurance coverage.

As I talk to my folks who live in rural Montana, ranch families simply cannot afford health insurance. Those who can, typically carry a high deductible catastrophic policy and then hope they will be able to weather the health care costs should tragedy strike. Consequently, many ranch families must work second jobs, and do, simply to get health insurance benefits.

Furthermore, very few farm and ranch owners provide their farm workers with health insurance. This isn't because they don't wish to provide that coverage. It is because providing such coverage is unaffordable. One ranch family my staff spoke with currently spends $2,000 a month for coverage of their family of four. As expensive as it is, they can't afford to go without the coverage as one of the members was in a ranch accident which confined him to a wheelchair for the rest of his life.

Consequently, these hard-working Americans are forced to rely on already burdened emergency rooms and health clinics. These small hospitals in rural Montana, some of which we define as critical access hospitals, could not have kept their doors open had it not been for a redefinition of critical access hospitals, telemedicine, and the ability for people to afford health insurance. I fear if we do not begin to seriously address this issue of the uninsured, particularly in rural areas, many of these small critical access facilities cannot survive.

I have heard their argument on the other side. Why would they put at peril health care facilities in rural America? And that is what they would be doing should we continue to do nothing. Therefore, the choice we must make this week could not be clearer. Do we prefer to give small business and individual proprietors the ability to offer their employees health benefits, or do we prefer to continue to limit their ability to offer benefits by Government regulations—mandates?

People like to have a choice. They don't want to go to the store and just buy one brand. It is an easy question for me to answer. The farmers and ranchers and small businesses of Montana—and Senator ENZI has almost the same makeup in his State as we have in our State. Agriculture plays a huge role in Wyoming and Montana. In fact, it contributes more to the GDP than any other industry. So it is not fair to those hard-working folks in rural areas to deny them the benefits that large corporations enjoy or unions and, yes, those of us who serve in this Senate. It is incumbent on us to get these business health plans in place, and now.

As we have no doubt heard, one of the major criticisms of the bill is it allows small business health plans to avoid State-enacted insurance mandates. I don't think that is quite accurate. Specifically, some of the loudest critics allege this bill will cut off coverage for mammograms, childhood immunizations, supplies, colorectal cancer screening, and many other procedures. It is not true. It just isn't true. To use a scare tactic does not do much to further the debate on how we should approach this particular problem.

Studies have shown that health care plans cover these and other services regardless of State mandates. Members of the Senate need look no further than their own health benefits package to know this is the case. Federal employee health benefits plans are not subject to State mandates. Yet these plans provide comprehensive coverage for these services and often provide better coverage than would be covered under most State mandates.

I don't like to see small business characterized as this is a way to save money at the expense of their employees. Small businesspeople are closer to their employees. They understand their responsibilities better than anybody in the world of commerce because they are small, they are a family. That is why the owner has to take the same policy as the employee. You wouldn't even have to mandate that.

I can remember I started a small business and it stayed that way. It wasn't planned, but it did. We insured our employees, and yet my wife and I carried no insurance, and we had a growing family at that time. We did it for economic reasons. But we had the responsibility to protect the folks who worked there.

Most plans cover essential services required by State mandates regardless of whether they are mandated. So why? Because it is not only good policy, but it is good business. For instance, plans generally cover breast cancer screenings regardless of State mandates because it is far cheaper than having to pay for a mastectomy. Plans generally cover screenings for colorectal cancer regardless of State mandates because it is far cheaper to catch it early. Plans cover diabetes treatment regardless of State mandates because it is far less expensive than having to pay for all the maladies that can come about if you are not treated, such as blindness and, yes, amputations.

It is far better to have childhood immunizations in your plan than pay for the more serious diseases that may develop if you are not immunized.

It just makes good sense if you want to keep the employee around and their family that you have grown to know because when you run a small business, it is a personal thing.

We have crafted this approach—and it is not a panacea to cure everything, but at least it is a step in the right direction to cover people who have no insurance today.

It is impossible for small business associations to offer uniform health insurance benefits packages affordably on a regional or national basis. It is hard. If we try to do anything around here, we try to pass legislation that is one size fits all. That is pretty tough to do. Circumstances in Maryland or Virginia are probably a little bit different than they are when you get west of the Mississippi River, especially in my State of Montana.

For instance, what is required for diabetes coverage in Montana is not the same as is required in the States of my friends from Idaho, North Dakota, South Dakota, and Wyoming. Thus, the association that offers benefits to small businesses in this region must adhere to the different mandates in each State. Having to fashion a plan to meet the mandates for each State drives up the cost. What we are trying to do is get our arms around the cost of it. It is impossible to offer a plan without first addressing cost. According to the nonpartisan Congressional Budget Office and the Government Accountability Office, these State-imposed benefit mandates raise the cost of insurance and cause countless Americans to go with no coverage at all.

Moreover, some of those mandates in certain States are for coverage procedures that the vast majority of Americans would not want and probably do not even know are offered. Acupuncture, for example, is a mandated benefit in some States. Some people may benefit from this service, but the vast majority of Americans do not. This is but one example of the hundreds and hundreds of mandates throughout this country for services many do not realize they are covered for and would not avail themselves of if they did. Yet the cost of covering this and other procedures is paid by everyone in that State due to those mandates.

It is a simple thing, insurance. I don't think I have heard it used on the floor since this debate got started. Simply put, when costs go up, coverages go down. It is a simple fact in the underwriting business.

So by allowing the businesses to band together and pool their resources, thereby giving them the same bargaining power large corporations enjoy, this bill, S. 1955, will lower cost

and improve access for millions and millions of Americans who do not have it today. This bill will not create a perfect health plan for all Americans, but that is not what we are talking about. This bill will increase the number of Americans with health insurance. This body can debate endlessly on what the perfect health plan is, but that does little good for the employees of small businesses who currently have none at all. So the choice is clear: Do we increase the amount of working American families with health insurance or do we let partisanship rule the day, as it has for too many years? The American people need better and they deserve better, and this bill will give them better as we move it along.

S. 1955 will lower health costs. All the figures we see tell us that. More importantly, it will give many working Americans affordable health benefits, something they don't have today. My farmers, my ranchers, and the small businesses in small towns across America, which are the backbone of our economy, deserve the same rights as the Fortune 500 companies, unions, and yes, even us, the Government.

It is time to act, even though it may not be perfect. Perfection should never get in the way of doing something for small businesses and their employees.

I thank my friend from Wyoming for allowing me this time.

Mr. CORNYN addressed the Chair.

The PRESIDING OFFICER. The Senator from Wyoming controls the time.

Mr. ENZI. Mr. President, I thank the Senator from Montana. I thank him for all of the work he went through during the past year as we talked with the insurance companies sitting down with us and the insurance commissioners sitting down with us, trying to work out a plan. I appreciate the efforts of those two groups and all of the associations, and I will talk about those a little bit later.

At this time I yield 15 minutes to the Senator from Texas, Mr. CORNYN.

The PRESIDING OFFICER. The Senator from Texas is recognized for 15 minutes.

Mr. CORNYN. Mr. President, I wish to express my wholehearted support for the bill that the chairman of the HELP Committee, the Health, Education, Labor and Pensions Committee, the Senator from Wyoming, Senator ENZI, has shepherded so far through this process, this small business health plan bill. I think it presents an outstanding opportunity for the Senate to do what my constituents tell me they want every time I go back home and I talk to them, and that is to have access to good quality health care.

The fact is this bill will allow small businesses to band together on a national basis and give them the leverage they need to negotiate good terms with insurance companies for their small businesses and for their employees. This bill would let these insurers bypass some of the mandates that are well-intentioned but which have the impact of driving up the cost of health insurance for employers to the point where many people can't afford it.

In my State we have the unfortunate distinction of having one-quarter of the population without health insurance. What that means is that people end up going to the emergency room for their health care, which has a couple of unintended consequences: No. 1, it costs a whole lot more than it should to treat those conditions in places like a clinic or somewhere else where they could be treated on a nonemergency basis. No. 2, it has the consequence of causing emergency rooms to have to go on divert status, and that is when people come with true emergencies to those emergency rooms and they can't be seen because the emergency rooms are full of people who are going there for nonemergency care. It literally endangers the life and certainly the well-being of that individual who needs to be seen in an emergency room. So we have a broken health care system that can be so inefficient and not serve the best interests of the American people.

What this bill does is provides a means for, as I said, small businesses to band together to increase their negotiating leverage. It is anticipated to be able to bring down the price of health insurance by about 12 percent, which will allow more and more people to gain access to health insurance so they don't have to go to the emergency room, so they have more choices, and so they have the peace of mind that comes with having that coverage in a way that allows them to enjoy the benefits that many of us have but which we take for granted.

We have an alternative that has been offered by Senator DURBIN and Senator LINCOLN, and I think it serves a useful purpose, not because I agree with the alternative proposed, but what it does is it demonstrates the competing approaches or visions or principles between this side of the aisle and that side of the aisle when it comes to providing access to health care.

It has become increasingly apparent to me that while we share the goal of access to good quality health care on both sides of the aisle, we approach it in fundamentally different ways. For example, our side of the aisle—and this bill, I think, reflects the fact that we believe there ought to be something other than a government-run health care system; that private insurance companies offering competitive plans to individuals create consumer choice. It creates competition. And we know that competition creates better service and better prices for American consumers.

The alternative being offered is a command-and-control health care system operated by the Federal Government that is neither efficient nor does it offer the sort of choice and competition, lower price and better service that would be offered through private health insurance options. Indeed, I think our friends on the other side of the aisle have, if nothing else, been consistent in their approach to health care. They believe the Government ought to dictate health care choices for the American people, whether it has to do with CHIPS, the Children's Health Insurance Program, the Medicaid Program, the Medicare Program, or whether it is veterans health care. They believe the Federal Government knows best and that bureaucrats in Washington, DC ought to make the choices that I believe ought to be reserved for me and my family when it comes to what is best for us.

As I said, this is an issue I hear about all the time when I talk to my constituents. It is, in fact, the growing cost of health care and the unavailability of health care that is one of the greatest concerns of my constituents in Texas. Rising costs, systemic inefficiencies, barriers to access, and the increasing costs of coverage represent the challenge we have to confront and which this bill directly addresses.

I understand the difficulties that small businesses have in Texas when trying to obtain quality health care coverage for their employees at reasonable prices. One employee of a small business in Addison, TX, for example, had this to say about the disparity in coverage available to small versus big businesses:

> Our February 2006 renewal premium increased by nearly 40 percent. For a group of 4 insured with no major medical issues and no increases in plan benefits, this was difficult to understand. Our course of action was to look for affordable plans with fewer benefits, but that proved to be difficult and the results undesirable. Fortunately, one of our employees decided to waive coverage and join the policy offered by a large corporation that employs her husband. Her premium under our policy would have been $4,740 a year. The price to carry her on her husband's policy was only $700 a year. Now, that is a disparity. If adequate health coverage is to be provided to employees of small businesses, it is going to be vital that small businesses be allowed to pool their employees in order to maximize their leverage and in order to minimize the premiums to which they are now being subjected.

That is exactly why I support this legislation. Because it would allow associations such as trade, industry, professional, chambers of commerce, for other small business associations to offer fully insured health plans to small businesses. I am a proud cosponsor of this legislation, and I believe this bill is an important step toward making health insurance more available and affordable to more Americans.

I thank Chairman ENZI and his committee for their hard work in bringing this bill to the floor.

The goal of this bill is to reduce health care costs and expand access by creating small business plans. As I mentioned, a recent study indicated that the price of health insurance could literally be brought down as much as 12 percent and as many as an additional 1 million working Americans insured who currently are not insured and have no alternative but to go

to the emergency room for their health care.

Recently, the Small Business Health Plan Coalition sent a letter signed by organizations that represent more than 12 million employers and 80 million workers. They wrote in support of this bill, saying it will:

> Provide workers employed in small businesses and the self-employed with access to Fortune 500-style health benefits now enjoyed by workers in corporate and labor union health plans.

This is a principle that resonates with the American people, and I must say that the American people have every right to be frustrated at Congress's unwillingness to step up and deal with this problem. And woe be it to those politicians who stand between the American people and their desire to see health coverage expanded and access increased. Almost 90 percent of voters, including 93 percent of Republicans and 86 percent of Democrats, in recent polls state that they favor allowing self-employed workers and small business employees to band together to negotiate lower insurance costs.

It is time for the Senate to act. In 2005 alone, health care costs rose three times faster than inflation—and even faster than that for many small businesses. Many small firms had to simply cut benefits or eliminate health care coverage entirely. Only 41 percent of firms with 9 or less employees offer health benefits, compared with 99 percent of larger firms.

We all know that small businesses are our Nation's chief job generator, our No. 1 job creator. They deserve to be treated fairly. But by themselves, these small firms and self-employed people have almost no leverage against insurance companies to try to negotiate fair prices and fair plans.

As it stands now, if they want to join other small employers and purchase insurance through national associations, they have to deal with an enormous array of State-level health insurance regulations and benefit mandates. It goes without saying that many of the mandates that are ordered by State legislators to be included in insurance policies in their States are passed with the best of intentions, but they have the unfortunate effect of raising the price of the insurance to the point where many people simply cannot afford it.

It makes no sense to say that everyone must have a Cadillac with all the bells and whistles when all some people want or can afford is a basic model of a similar vehicle. Big businesses, for the most part, do not have to deal with these regulations. The Congressional Budget Office and Government Accountability Office and others have found that State-imposed benefit mandates raise the cost of health insurance and, in effect, represent an unfunded mandate on employers.

Small business health plans will have a strong incentive to offer the best policies possible for their members. After all, that is what the competitive market is all about. Small businesses will have to compete with large businesses for employees. And when employees decide where they want to go to work, they will look at not only the salary they will be offered but the benefits that will be offered, including the health coverage that is available. This is simply a case of the market working and allowing individuals the maximum freedom to choose what is best for themselves and their families.

In order to remain competitive and attract a talented workforce, I believe small businesses would want to have the ability to offer high-quality health benefits, the same opportunity that large companies currently enjoy. Right now, small businesses effectively have the choice of offering expensive plans with all the required mandates, whether employees will actually even use those services or simply not offering insurance at all. That policy in my State is part of what has been responsible for 25 percent of the people of Texas not having health insurance. It must change.

This is not a complete panacea, but it will provide dramatically better and expanded coverage to the people of my State and the people across this country.

Under the Enzi bill, every small business owner will have the opportunity to choose a comprehensive plan, but they will also have other, more affordable, high-quality choices, too. This will improve access for millions of Americans who currently do not have any insurance at all. I believe this legislation is a good step in the right direction toward increasing the affordability and access to health care that all Americans deserve.

More can certainly be done, and I certainly believe that while this is an important step, we should not stop here. We should continue to increase the number of choices available to the American people—things like consumer-oriented health care, which provides greater transparency and provides information to consumers so they can determine where to go for their health care services based not only on price but based on outcomes—things like health savings plans, which would give people greater access and greater control over their health care decisions and allow them to determine how their health care dollars will be utilized rather than having to buy high-priced plans that contain attributes that they frankly don't need or don't want and which cost them additional money.

Certainly, more could be done, but I urge my colleagues today to support this important legislation because I think it represents a dramatic and long overdue improvement over the status quo.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

(Disturbance in the Visitors' Galleries)

The PRESIDING OFFICER. The Sergeant at Arms will restore order in the gallery.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I do have several things I need to cover. I think I have another speaker or two on their way down. People are talking about being able to offer amendments. They can offer amendments. We want to have discussion, debate; we want to cover objections, answers, proposals on this bill, and we are willing to do anything that is relevant.

There has been a lot of talk about needing to talk about drug reimportation. That is important—at least a 3-week topic. Prescription drugs, that one best wait until after Monday until we see what the exact problem is before we do it. And stem cells, that is probably another 3-week debate.

It took us a year to be able to get this one to the floor so we could talk about small business health plans.

I need to make some comments in regard to a couple of the letters that were read earlier because I am aghast at what was in the letter. The American Cancer Society, as part of that, said: No matter what is done to the Enzi bill, don't vote for it.

That means that should we have an amendment that does everything that is done across the United States for cancer at the present time, they are still urging people to vote against it? It is a little early to say that. It is a little early to say there are not going to be any changes because we will have votes. It may require cloture in order to stay with germane ones instead of the ones that I mentioned and also to make sure—I want to have a vote on the Durbin-Lincoln bill. But I want to have a vote on my bill as well. I think we both ought to have them.

If we release the Durbin-Lincoln one for a vote now, then they can put all kinds of blockages on there so I can't ever get to a vote. And the only vote that we will have had will have been theirs.

We are trying to have some fairness, and so far we have not been able to get to that point.

Another one was the diabetes letter. Again, it said: No matter what you do to the Enzi bill, vote against it. That means, if we instituted every single thing that is being done for diabetes in any State in the Nation, they are still suggesting that they will vote against the bill? Wow. I mean, I have never run into anything such as that.

We looked at the diabetes thing and we said: How do we do this? Because out of the States that do it, there are no two that do it alike, so how do we get these agreements across State lines so they can pool into bigger pools and be able to negotiate against the insurance company so they can bring down rates through negotiation and they can bring down rates by eliminating administrative costs? We are not talking about bringing down rates by eliminating mandates. We are allowing

them to have some flexibility in the mandates so they can come up with a common package, and I am sure that it would include that, just as I did the thing on colorectal cancer. All 19 places that they have been allowed to do that, they included that, even though it wasn't a mandate. They were excluded from that.

I also wanted to put into the RECORD an editorial from the Arkansas Democrat Gazette. It was in the ''Opinion'' section. It says:

Ever face a really tough decision like where to attend college, or whether to take that new job, or should you go with the lasagna or the meatloaf for lunch? So you get out the yellow legal pad and make a list of the pros and cons, right? Well, maybe not for the meatloaf vs. lasagna bit. Some things are a simple gut decision.

But it helps to compare and contrast. And it sure helped to compare and contrast the two bills now floating around the U.S. Senate to make it easier for small businesses to offer health-insurance to their employees. One bill is co-sponsored by Arkansas' senior Senator, Blanche Lincoln.

You could find the comparison on page 2A of Wednesday's paper. There was Senate Bill 1955 (sponsored by Mike Enzi of Wyoming) on one side, and Senate Bill 2510 (Blanche's bill) on the other.

Both sounded fairly similar.

Both promised to make it simpler for businesses to band together and buy cheaper health insurance.

Both promised to save businesses money and cover more folks.

Then we got down to the bottom, to the very latest, biggest question, and, boyohboy, talk about a pro and a con.

The question: What would it cost the Federal Government?

The answers: Nothing for the Enzi Bill.

For the Blanche bill, oh, somewhere in the ritzy neighborhood of between $50 billion and $73 billion over 10 years.

When an estimate for new government spending has a margin of error of some twenty-three billion dollars, you know that new program is just gonna bleed money.

What's worse, or at least as bad, is that Senator Lincoln's bill creates a national health program that'll be under the administration of the federal Office of Personnel Management.

Translation: We the American Taxpayers will be in charge of the care and feeding of yet another bloated bureaucracy.

Why? Why do we need another federal program under federal so-called management adhering not just to federal rules and regs but all the state rules and regs, too? (It gives us a headache just thinking about filling out those insurance forms.)

We suppose it's because some politicians, who may have the best intentions in the world, can't imagine a health plan that doesn't have the government deciding what should and should not be offered at every single bureaucratic level. Thank goodness that isn't required of private employer plans. Can you imagine the red tape? Perish the pencil-pushing thought.

Senator Enzi's proposal, unfortunately entitled the Health Insurance Marketplace Modernization and Affordability Act, takes a freer-market approach. His bill would let small businesses band together and get better deals on health insurance through trade associations.

Now for the devilish detail: Senator Enzi's bill would be regulated by the feds but largely exempt from individual state mandates. The better to offer these plans nationwide and keep costs down.

Remember, the idea is to help small business, not burden them with more state regulations.

Besides, it's nothing new. Major companies like General Motors long have been granted exemptions from state laws regulating insurance—it's called an ERISA exemption, because they have employees all over the country. They couldn't very well insure their employees from sea to shining sea while abiding by every queer detail of every law in every state. Especially when employees move or get transferred and want to keep their insurance.

But won't the absence of state regulations lower standards? Not if the small businesses offering the insurance want to keep their employees. It's in businesses' interest to have good health insurance for their workers, or their workers will go somewhere else. It's how the free market works.

Think of these small-biz health plans like charter schools. They'd be free of, to quote Senator Enzi, ''the current hodgepodge of varying state regulation.'' That way, small businesses across the country can band together and negotiate group health insurance on their terms. Which would be more affordable for the businesses, the employees and, unlike the Blanche bill, the taxpayers.

If we gotta have a federally regulated Small Business Health Plan, we sure don't need one as costly as Blanche Lincoln's. And, yes, we gotta have a Small Business, etc. Because what we've got now isn't working.

Look at the numbers: Of the more than 45 million uninsured Americans, 60 percent are employed by small businesses or are in some way dependent on those businesses. But it's getting harder for a small business to offer health plans because insurance premiums cost so much these days. Since 2000, the cost of health-care premiums for employers has gone up almost 60 percent, including some 11 percent in 2004 alone.

Pass the Enzi Bill and, according to a study by a Milwaukee consulting firm, small businesses would save 12 percent on health insurance premiums. Even more important, some 900,000 uninsured folks would finally get coverage.

Hey, sounds like a plan. Blanche Lincoln's bill, meanwhile, sounds like an expensive, bureaucratic pain in the pocketbook.

Mr. ENZI. I would like to have you see the small business organizations that are supporting the Enzi-Nelson bill. There are a couple of hundred of them here—12 million employers, 80 million workers.

I would like for you to see the small business organizations that are supporting the Durbin-Lincoln bill. Oh, there are two. OK.

I want to share a letter from the National Association of Insurance Commissioners as well. They are writing in response to our May 2 request for a review of S. 2510 Small Employers Health Benefits Program sponsored by Senators DURBIN and LINCOLN.

I ask unanimous consent the letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MAY 9, 2006.

Hon. MICHAEL B. ENZI,
Chair, Committee on Health, Education, Labor and Pensions, Washington, DC.

DEAR CHAIRMAN ENZI: We are writing in response to your May 2, 2006, request for our review of S. 2510, the Small Employers Health Benefits Program Act, sponsored by Senators Durbin and Lincoln.

The authors of S. 2510 sought the input of the NAIC when drafting their bill and we appreciate their willingness to work with and consider the views of insurance regulators. Like your bill, S. 1955, the Durbin/Lincoln bill does not include the option of self-funded association plans, instead requiring coverage to be purchased from carriers that are licensed in and regulated by the states. This is a significant improvement over association health plan legislation, such as S. 406. The bill would also preserve state rating rules and benefit mandates, thus maintaining state authority over health insurance regulatory policy.

We are concerned, however, about the practical impact this legislation would have. S. 2510 creates an unlevel playing field by requiring plans sold through the Small Employer Health Benefit Plan (SEHBP) to meet different rating standards than those required of plans not sold through the SEHBP. By setting different rules for different carriers, S. 2510 could create an unworkable market in some states.

For example, if state law allows carriers in the general market to charge small employers with healthier, younger workers significantly less, and the federal law requires carriers in the SEHBP to have only a modest variation in rates, the SEHBP carriers will be selected against. In fact, few carriers would want to participate in this program in states with such rating disparity.

S. 2510 does attempt to ameliorate this problem by providing subsidies for those that participate in the SEHBP. We agree that these subsidies will help, but they are not sufficient. We believe that states are best suited to establish rating rules for all carriers—creating two sets of rules would be harmful to the workings of the small group markets. This could also limit the ability of states to develop innovative programs to address the growing health care crisis.

Finally, both S. 2510 and S. 1955 will not affect the underlying and primary causes of skyrocketing health care costs that are making health insurance increasingly unaffordable for millions of Americans. However, we do applaud you and Senators Durbin and Lincoln for your efforts and we hope our dialogue will continue and yield real solutions.

Sincerely,

CATHERINE J. WEATHERFORD,
Executive Vice President and CEO;
ALESSANDRO IUPPA,
Superintendent of Insurance, State of Maine, NAIC President;
WALTER BELL,
Commissioner of Insurance, State of Alabama, NAIC President-Elect.

Mr. ENZI. The experts on S. 2510, the Durbin bill, from the National Association of Insurance Commissioners, write:

S. 2510 creates an unlevel playing field . . . could create an unworkable market in some states. . . . Few carriers would want to participate in this program. . . .

Again, people can read the entire letter, and I am sure they will find that very enlightening. There is a lot more detail there.

Last, I ask unanimous consent to have a letter from the National Association of Health Underwriters printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MAY 10, 2006.

Hon. MICHAEL B. ENZI,
Chairman, Senate Health, Education, Labor and Pensions Committee, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ENZI: We're very pleased that the Senate will spend this week working on important health issues. The issues to be addressed are critical to the health of America.

One of the most important issues to be addressed this week is health insurance market reform under S. 1955. Our members work on a daily basis out in the real health insurance markets of America. We are in a unique position to be able to observe which markets work better than others and would like to commend everyone who has worked so hard on this legislation to produce an end product that will make health insurance more affordable for small employers. S. 1955. has been modeled to produce a competitive market and a level playing field. Markets with these characteristics are always the strongest and produce the most affordable products.

We are in particular pleased that reform did not go in the direction of S. 2510, Small Employers Health Benefits Program Act of 2006. Under the auspices of creating a more competitive environment, S. 2510 creates the worst kind of unlevel playing field by providing subsidies in the form of reinsurance and a risk corridor only to health plans offered in one purchasing vehicle within the small employer market. It is very important that all plans operating within a special market segment play by the same rules. This ensures the financial integrity of all market players and results in more product availability within that market. S. 2510 does just the opposite. The subsidies it provides are not available to plans that offer coverage in the small employer market outside the purchasing pool and it would provide a significant competitive advantage to carriers operating in the pool, versus those that offer coverage outside the pool. Under this anticompetition model, there would soon be very little choice outside the pool as carriers would be forced to exit a marketing environment where they could not possible operate competitively. This would force more and more people to purchase coverage within the pool, and the cost to government for the subsidies would increase even more.

There is, of course, a reason for the subsidies. Rating rules inside the pool would be considerably more restrictive than they are in the majority of states today, so the pool could not be competitive in many areas without the subsidies. And although the subsidies are for a limited period of time, the unlevel playing field created under this scenario would likely result in no other coverage being available outside the pool for consumers to select once the subsidies to plans operating inside the pool stopped and costs returned to a higher level. And although the subsidies would at that point stop, the rating structure and other mandate provisions inside the pool would continue and the cost of coverage would be predictably high. The ultimate result would be an increased number of people being priced out of coverage and ultimately, more, rather than fewer people would be uninsured.

We do appreciate the positive direction you've taken with S. 1955, and the extreme efforts you've taken to listen to everyone's concerns and respond in a reasonable way. My staff and I look forward to working with you toward achieving enactment of your bill. Please let us know how we can help.

Sincerely,

JANET TRAUTWEIN,
Executive Vice President and CEO.

Mr. ENZI. Again, it is a much more extensive letter. I hope people will take the time to read the RECORD, but it is from the National Association of Health Underwriters. These are the experts on health insurance. They look at this stuff all the time.

It says:

''2510 creates the worst kind of unlevel playing field;'' ''the cost of coverage would be predictably high;'' ''an increased number of people being priced out of coverage;'' and, ''Bottom line: More rather than fewer people would be uninsured.''

That is the National Association of Health Underwriters.

I wish to have some time to go over the good comments, too. But I have been joined on the floor by the majority whip. I will relinquish a few minutes for him to say a few words.

The PRESIDING OFFICER. The Senator from Kentucky.

Mr. MCCONNELL. Mr. President, I thank my colleague from Wyoming. I congratulate him for a superb job in crafting this important measure to deal with what many of us think is one of the most pressing problems confronting our country. I have talked to a lot of people in my State, and right up there with gas prices today, they raise the issue of affordability of health insurance.

I have heard from workers who fear that their employer may have to cut back on their coverage. I have met with employers who are concerned that high health care costs prevent them from investing in their businesses and creating new jobs. It would be safe to say I am confident that most if not all of our colleagues have had similar experiences in their own States.

These are real concerns. In every sort of noon-time civic club engagement I have, this is the first thing people bring up. Health premiums have increased nearly three times the rate of inflation, and the percentage of employers offering health care benefits continues to decline.

This is a particular problem for our small employers and entrepreneurs. These are the people who create the majority of the new jobs in our country. Sixty percent of the working uninsured—those Americans who have jobs but don't have health insurance—are either self-employed or they are employed by small businesses.

The sad truth is, it is too darn expensive for many small businesses to provide health coverage to their employees in our country today.

There are a lot of reasons for this.

First, small businesses don't have as much negotiating clout with insurers when they are negotiating premiums as large businesses do. It makes sense. That leaves them stuck, of course, with higher costs.

Also, employees in small firms must absorb a larger share of their plan's administrative costs because there are fewer employees to share those costs.

Third, small businesses must typically purchase care in the uncompetitive, expensive, small group market.

Add all of these factors up and small business health care costs become too expensive for many small businesses to afford.

Small business, as we all know, is the engine that drives the American economy. We must allow them to band together so they can buy health insurance at lower costs so that our people and our economy can keep moving full speed ahead. I commend the HELP Committee for reporting a bill that will do just that.

Finally, I commend Chairman ENZI who has done a magnificent job in moving this legislation forward.

It addresses the unique challenges facing small businesses by allowing them to join together across State lines to offer insurance to their employees. This will give them the needed purchasing power to get a better deal on insurance policies.

Enacting the Health Insurance Marketplace Modernization and Affordability Act will address many of these problems all at once. It will reduce health care premiums. It will increase the number of Americans with insurance. It will reduce the Medicaid rolls. And, most importantly, while doing all of this, the bill will not increase the burden on the taxpayers.

That is not just my opinion; these are the findings of the nonpartisan experts at the Congressional Budget Office. Their cost estimate for S. 1955 shows that the bill will reduce health care premiums in the small group market by 2 to 3 percent. That is important because we know that with every 1-percent change in premiums, 200,000 to 300,000 Americans are able to afford insurance.

So do the math. According to the Congressional Budget Office estimates, 700,000 Americans who would be uninsured under current law—who are currently uninsured—would be covered under the Enzi proposal; 700,000 Americans who would be uninsured under current law, would be insured under Chairman ENZI's proposal.

By helping small businesses expand coverage for their employees, CBO estimates that 135,000 Americans, who without the Enzi bill would be on Medicaid, would now receive private insurance under the Enzi bill. Clearly, this is the way to go.

Most importantly, and unlike the Democrats' alternative, the bill accomplishes this without increasing the burden on the Federal taxpayers. In fact, the Enzi-Nelson bill will save the taxpayers $3 billion over the next 10 years. Nearly 1 million Americans get better health coverage, and the taxpayers will save the $3 billion I referred to over the next 10 years. This legislation is good, strong medicine.

My colleagues across the aisle have called the plight of small business a ''distraction.'' But this situation that affects the economic engine of our country—the small businesses—is a real problem, not a distraction, and the problem is not getting better on its own. It ought to be addressed.

In 4 of the past 5 years, small businesses paid double-digit increases each year in health insurance premiums. At that rate, more and more employers will be forced to scale back or drop coverage altogether for their employees. The Enzi bill is the first step in righting that crisis.

Again, I commend the HELP Committee for reporting the bill that addresses the challenges facing small businesses.

I also note the tremendous contribution made throughout this process by Senator TALENT, who has been a tireless advocate for small business health plans during his tenure in the House and during his 4 years here in the Senate.

This is an important piece of legislation that will address a very significant problem facing many of our small businesses—the high cost of health insurance.

I urge our colleagues to vote to invoke cloture and to support the Enzi bill. It would be an important step in the right direction for Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I thank Senator MCCONNELL. I appreciate all of his effort and help. I appreciate the Senator bringing up Senator TALENT. I need to mention Senator SNOWE as well. They were the original sponsors of associated health plans on this side. They asked for a hearing. We held a hearing. After the hearing, people on my committee were saying, Golly, this is a problem for small business. What can we do to solve it?

It was also obvious from the discussion that there were some difficulties with the true AHP approach which we modified in the meantime. That is how we got to the position we are now in.

Mr. MCCONNELL. Mr. President, if the Senator will yield for one question, I have heard the Senator talk about the process by which he developed this legislation. Does he have any idea how many hours he spent consulting with the various entities across America that care about this and trying to move this legislation to this point?

Mr. ENZI. Mr. President, I don't have any idea. I spent a lot of hours and my staff people spent a lot more hours. Senator NELSON's staff and Senator BURNS' staff worked on this for so long that I actually thought maybe their staff people worked for me, too.

I was pleased spending days on end and sitting down, understanding all of the parts of this and getting it to work.

Another important part of this, Senator DURBIN asked me to talk to him about his plan. I made an appointment that same day and met with Senator DURBIN and Senator LINCOLN. We tried to work some of the principles which they had into this format. Eventually, we were kind of invited to leave by staff. We need to resolve more of that.

Mr. MCCONNELL. Mr. President, I say to the chairman that this has been a laborious and meticulous effort on his part. He has headed this up, and he has led us in an extraordinary way, and I, on behalf of all Members of the Senate, commend him for this accomplishment.

Mr. ENZI. I thank the Senator.

Mr. President, as an accountant I have to remind people that this bill is not a case of subtraction. This insurance plan is an addition. It will bring additional insurance to people. There are 27 million people out there who are uninsured. This will bring a number of them into the market. It will also allow people who are already insured to increase the amount of insurance which they have because they will be able to save some dollars. I am sure they will put that back into insurance and into more benefits for people. So it is an addition, not a subtraction, and it will bring in newly insured people.

One of the things I ask people is, when you go to the dry cleaners tonight to pick up your laundry, can you look that person in the eye and say, I don't think you deserve health insurance because you might not demand enough for yourself? So I am going to save you from yourself. Can you say to the mom and pop who are running the business down the street from your home, You don't deserve health insurance?

As you go home today, as you leave the Hill, think about the people around you, the regular people, the cab driver, the worker at the dry cleaner, the person at the neighborhood restaurant, all of those people who often you may not notice, the real people who make the world operate. Many of them do not have any insurance. Some may even own the little business around the corner and still are not able to have insurance. We always assume that if people own a business, they make a lot of money. There are times that the employees make a lot more than the owner of the business. They always have to pay themselves last.

As Senator BURNS said, when he was in business he provided health care to his employees, but he couldn't afford it for himself and his wife. But you do that to keep employees. I am not talking about deluxe insurance, I am talking about any insurance.

When people get the kinds of screenings that they would like to have, or even get the screenings they would like to have, and then find out there is a problem, if they don't have any insurance, they can't get anything done unless they pay for it.

We are not talking about the employees at the big chain hotels or the big chain restaurants. We are not even talking about the employees at Wal-Mart. We already said to them you can form whatever kind of benefit package you want. You do not have to answer to any State. You don't have to have review or oversight by the insurance commissioners.

Those are all things we provide for in our bill. You don't have to meet any State requirement. So instead of 35-percent administrative costs, you only pay 8-percent administrative costs. I am not talking about deluxe insurance, I am talking about any insurance.

Right now in several States, there is only deluxe insurance. Did you know that in some States there may be only one insurance provider because others have been driven out of the market?

I hope people will take a close look at this bill. I hope the other side will offer some amendments which are relevant to this bill and let us work through the bill. I hope, if the only way we can maintain germaneness is through cloture, that they will join in cloture because there are thousands of businesses out there that need insurance. They need hope. They want to ensure their employees. Think about that—27 million uninsured.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware.

Mr. CARPER. Mr. President, while he is still on the floor, I say to my colleague from Wyoming, I think from all of us, I thank him for taking an earlier position on the health plan bill that passed the House. In my view, and I think in the view of lot of us, it was badly flawed. Thanks for the Senator's efforts over an extended period of time, along with our colleague, Senator NELSON of Nebraska, to take that product and make it better, and for your willingness to work I think in conjunction with Senator SNOWE to improve on it further, to be responsive to the concerns that a lot of us are raising, I wanted to go on the record.

As I said yesterday—and I will say it in front of my colleague—I find that he and Senator NELSON of Nebraska are two of the most thoughtful Members we have in the Senate. It is a pleasure working with you.

One of the disappointments that I find around here is sometimes even when we appear to agree on things, it is hard to get anything done. In this case, there appears to be pretty good agreement that if we could somehow find a way to harness market forces, we could bring down health care costs for small business and their employees and find a way to pool the purchasing power of those small businesses and our employees could maybe bring down health care costs and get a better selection of options from which to choose.

There has been a fair amount of discussion today and the days leading up to this debate over mandated coverage that certain States offer. I will give an example of one State in our experience with respect to mandates.

Before I came here, in my last job I was Governor of Delaware for 8 years. Roughly 10 or 12 years ago we learned, to our alarm and dismay, that Delaware had the highest rate of cancer mortality in the country. We also learned at the same time that while we had the highest rate of cancer mortality in the country, we did not have

the highest rate of cancer incidence. In fact, we were at number 20 or so.

We looked at those numbers and sort of scratched our head about them to figure out why we were No. 1 in cancer mortality—which is the last place you want to be—and number 20 or so with respect to the incidence of cancer.

We pulled in some people a lot smarter than me to look over those results and asked: What is going on here? Why the high cancer mortality number, particularly in light of the fact that cancer incidence is more like the middle of the pack?

After assessing the situation for a while, they said: We conclude—and we are fairly sure of this—the problem is, in your State, in Delaware, you do not do a very good job of early detection and treatment of cancer. If you want to bring down your cancer mortality number to be closer to your cancer incidence number, you have to do a better job of early detection and treatment.

We took that charge seriously. We went to work in three areas: The first of those, Delaware at the time, was one of the higher ranking States in terms of incidence of smoking, tobacco usage. We said one of the things we want to do is reduce the use of tobacco products. We decided to start with young people to reduce the likelihood young people will start smoking and continue to smoke. We made it more difficult for them to have access to tobacco products. We also reduced the opportunities for people to smoke indoors, an effort that continued under my successor.

The second thing we did was, with respect to expanding the opportunity for people to find a health care home by expanding opportunities for people to participate in Medicaid and the SCHIP Program for young children, partnership between the State of Delaware and the Federal Government as other States participated, too.

The third thing we decided to do was to say maybe we ought to have health insurance plans in our State offer as part of their package screening for certain kinds of cancer. For example, mammography screening for breast cancer, colorectal screening, cervical cancer screening, and a couple of others. We did all those things roughly 10 years or so ago. Every year we have had an opportunity to find out how we are doing with respect to cancer mortality and cancer incidence.

I have a chart. Delaware is small, so rather than use 1 year's numbers we look at 5 years. We have a 5-year rolling average. We went back to 1989 to 1993, when Delaware was No. 1 in cancer mortality. In the next 5-year period, 1990 to 1994, we were No. 1. In 1992 to 1996 we were No. 1, and so on. During the 1990s and into the decade we start out No. 1. We were the first State to ratify the constitution and our State slogan, which is ''We are the first State.'' We like to think it is good to be first. This is one thing we do not want to be first in.

The State that was No. 1 in cancer mortality for too many years started to drop by 1997 when we fell down to No. 2, and we continued to drop so that by the year 2000 we were down to No. 5.

I am happy to report standing before the Senate today that in the most recent numbers which I think run up through 2003, we dropped out of the top 5. We might still be in the top 10, but we know we are not in the top 5, and certainly not No. 1. We are heading in the right direction. I will not be happy until we are No. 50.

I would like my colleagues to consider that all of our States are different. Delaware is different. Wyoming is different from Oklahoma. We all have different priorities. We had a real problem in Delaware. We still have a significant concern with respect to cancer mortality. We developed a good game plan and we implemented that game plan. And lo and behold, it is working. It is actually working. We want to make sure it continues to work.

Reducing cancer mortality is like the Navy guys changing the course of an aircraft carrier, turning an aircraft carrier. The same is true as we try to reduce cancer mortality. It is a slow process. It is not an easy process. It takes time. If you stick with it, you can turn aircraft carriers. You also can bring down cancer mortality numbers.

How does this relate to the debate today? It relates because an earlier version of the association health plan legislation passed by the House any number of times does not let us do in Delaware what has proven to be successful in reducing cancer mortality. Even with the efforts of Senator ENZI and Senator NELSON, as this bill came to the floor, it did not let us continue in Delaware requiring the screenings for mammography, screenings in colorectal, prostate, and cervical cancer. It does not help us do those things.

With the amendment that may be offered or suggested by Senator SNOWE, we can do some of this stuff, not all of it but we can do some of it. Particularly the breast cancer screenings would be allowed to continue, maybe one of the others.

The reason I bring this up, I want to keep in mind that States are different. What we have focused on in Delaware is what works—what works to reduce unemployment, what works to improve student outcomes, what works to get people off of welfare roles, what works in a variety of things. This is a multipronged approach that worked in reducing cancer mortality.

Let me talk more about the Enzi-Nelson preliminarily with respect to the Lincoln-Durbin proposal. They actually share some things in common, as I said earlier. They both say: Health care costs are a major problem in this country. They are a problem for little businesses; they are a problem for big businesses.

As we watch my generation aging and look to the future, when the boomers are in full retirement—and I might add, the generation of the Presiding Officer is in full retirement—we will see Medicare, Medicaid, and Social Security which today account for roughly 8 percent of gross domestic production, by the time our generation is in full retirement, 25 or 30 years, I am told that Medicare, Medicaid, and Social Security may well consume something like 16 percent of gross domestic production. The amount of spending for those three programs alone is roughly equal to 16 percent of our gross domestic production as a country.

If you look back over the history of our country, in the last 50 years or so we spend as a percentage of gross domestic product something like 18 or 19 percent of gross domestic production to run the whole Government. If we are looking at 25 years or 30 years down the line where we are spending 16 percent of gross domestic production just to run three programs, with nothing for the environment, nothing for housing, nothing for defense, nothing for homeland security, nothing for education, that is a scary prospect.

So the concerns we have about finding a way to constrain the growth of health care costs are not just a concern of small or large business but a great concern for those in the public sector who worry about how to continue to fund and offer benefits through Medicare and Medicaid.

Senator ENZI took a few minutes to talk about the Durbin-Lincoln proposal. The proposals are similar in a couple of respects: One, they say rising health care costs are a major concern. They are a concern not just for government, for big business, but a concern to small businesses.

Wouldn't it be great if we could find a way to somehow combine the purchasing power of a lot of small employers across the country and their employees, much as we do for Federal employees? All Federal employees do not work for one employer. We work for hundreds of agencies. The Senate is an agency. The House is an agency. We have the courts around here that are separate courts and agencies.

Throughout the country we are, in a way, sort of like small businesses. We talk about being three branches of Government, but we actually are, in a sense, small employers. There are big employers among us, bigger agencies, such as Defense, but there are a lot of small agencies that are much like a small employer.

What we have done to be able to constrain the growth of health care costs for Federal employees is to find a way, working with the Office of Personnel Management, to pool our purchasing power, to get a whole lot of health insurance products available to be offered to us, to give us the opportunity to shop among them and figure out what works for each of us best, what we can afford, the kind of benefits we are looking for, and then we can pick

and choose. We end up with a great cross section of product to choose from. Given the kind of purchasing power we have, we are able to constrain the cost of coverage. We have to pay something, I think it is about 25 percent of the cost of our coverage. But it is, frankly, a lot lower premium than otherwise it would be if we did not have the purchasing power pool.

When you add active Federal employees and Federal retirees, you add in all the families, we are talking about a lot of people, maybe as many as 6, 7, 8 million people, and it gives us a chance to have a real impact on what is available in terms of coverage and how much that coverage is going to cost.

Senator ENZI raised a question about the cost of the Lincoln-Durbin plan. The Lincoln-Durbin plan is different from where it was initially introduced, as I understood it. There is a tax break in their plan from which the cost arises.

He mentioned the cost over 10 years as much as $50 or $60 billion. It is a tax cut for smaller businesses that offer coverage for their employees. The reason there is a cost associated with the Durbin-Lincoln plan is because of that tax cut. Ironically, some of my colleagues have suggested that is one of the few times they recall our Republican friends being opposed to a tax cut. I know there are tax cuts they are opposed to, but that is the reason there is this cost. It is considerable.

In the conversation we had earlier this afternoon, I was sharing with my friend, Senator ENZI, it involves Senator LINCOLN, myself, Senator SALAZAR of Colorado, and a number of folks from the business community who were gathered around just to have a good discussion about the problems we face in trying to look for some common ground.

I said to Senator ENZI when I came to the Senate a bit ago, we had a side bar conversation while another colleague was speaking. It is too bad that conversation we had with the business community in Senator LINCOLN's conference, too bad we did not have that 12 months ago or 12 weeks ago. He shared with me a conversation that occurred maybe 9 months or so ago that involved him and some of my colleagues on this subject.

Senator ENZI is good, as are Senators DURBIN and LINCOLN, in reaching out to the other side and trying to find common ground. We need to find common ground. I remain convinced I am one of the people who, like Senator ENZI, sees the glass half full even when it is almost dry. As to this issue today, I think the glass is at least half full.

I cannot help but think, given the good will on both sides, that if guys like me and gals like Senator LINCOLN and guys like Senators NELSON and ENZI and DURBIN put it in their minds, we could find a way to further reduce the differences between our respective proposals.

I do not know what is going to happen when we vote. I guess we are going to vote on cloture tomorrow, I am told. I am not sure what is going to happen. I don't know if the debate will basically continue or, because of that, sort of end for now. If it does, I hope the discussion actually will begin in earnest, and discussion, certainly, with the principals on both sides who have interests in this issue, and that out of that discussion we come to a more satisfactory resolution.

One of the problems we have on our side—and I think Senator ENZI has heard this before—is sometimes, even when we pass what we think is a pretty good bill in the Senate, and we go to conference with a much different bill from our friends in the House, when the conference is created between the House and the Senate, we, as Democrats, are not always full participants in those conferences, and what comes out at the end of the day does not look a whole lot like what we passed in the Senate, or at least not enough. That is going to be a concern. And I just need to say that.

But having said that, we will cast our votes tomorrow and see what happens with respect to them. But I would say to my friend Senator ENZI, my hope is that if we do not come to resolution and this is an issue that continues to be outstanding. It is too important just to let it die. I hope we will have an opportunity—whether it is tomorrow or next week or the weeks after that—to find a common ground and get something done.

Mr. President, I brought these charts. We might as well use them. Actually, I think for a guy from Delaware they are actually pretty interesting. I do not know what these numbers look like in Wyoming. But when you look at the leading causes of death in my State—this chart goes back to about, oh, Lord, a dozen years or so. In the early part of the 1990s, about 32 percent of the folks who died in our State died from heart disease, about 26 percent died from cancer, 6 percent died from strokes, 4 percent died from chronic lower respiratory disease, 4 percent died from accidents, and 3 percent died from diabetes, and 25 percent died from ''all others.''

Keep in mind, in the early 1990s, cancer was right around 26 percent, heart disease was 32 percent.

Let's see what it looked like a decade later. Heart disease was at 32 percent, now it is down to 29 percent; and cancer, which was at 26 percent, is now down to 24 percent. The rest are pretty much the same, although ''all other'' is gaining. In fact, ''all other'' is in first place now, whatever ''all other'' is.

We are real pleased to see the drop in the number of cancer deaths. Does that sound like a lot over a 10-year period of time, to drop from 26 percent down to 24 percent? It is not. But as I said earlier, it is a little bit like changing that aircraft carrier. The numbers have dropped. We are convinced we are doing something right, and we want to continue what seems to be working.

I have a couple of other charts, and then I will close. This is a chart that goes back to the beginning of the 1980s—1980 to 1984—and up to 2002. The red numbers are the cancer mortality rates for the country, and the numbers above are cancer mortality rates for Delaware, starting in the early 1980s and going to the early part of this decade.

As you can see, the gap by around 1990—the early 1990s—the gap right here, was pretty large, back here, but it is even larger here. That is when we started doing something different, changing up our game plan in Delaware. And we are still above the national average here, but it is about half of what it was a decade or so ago. So we are convinced we are on the right path.

One more chart. My staff thinks this is not a very good chart, and maybe it is not. I kind of like it. Let's see if I can get it straight. We look here at the percentage of the reduction in cancers. It dropped between the early 1990s and the early part of this decade. The mortality rate of all cancers in Delaware went down by about 13 percent—a drop in all cancers.

The cancer mortality rate in the United States during the same period went down about 7 or 8 percent. The drop in the lung cancer mortality rate in Delaware, over the last decade, was, again, by about 13 percent. In the country, it went down by about 5 percent, in this same period of time. Colorectal deaths went down in our State by over 15 percent over that 10-year period of time, and down about 12 percent in the country. Breast cancer deaths in Delaware went down, in the last decade or so, by about almost 20 percent. In the country, it went down by about 12 or 13 percent.

And for guys like us—Senator ENZI and my colleague, the Presiding Officer—this is a real attention getter. For prostate cancer, the mortality rate in our State, in the last decade, went down by almost 50 percent, in Delaware, as compared to the rest of the country, which was about half that, roughly 25 percent.

I think that is a pretty good chart, and I am glad it was made up for us to look at.

The point I want to make is, actually sometimes we have these mandates, along with other things I mentioned earlier, and some positive things do happen in our respective States.

We are pleased with the progress we have made, and we have a long way to go in Delaware. We want to make sure we have the tools to be able to continue in that vein.

I have said my piece. I look forward to seeing how the smoke clears and what things will look like after tomorrow. We will just take it from there.

I yield back my time. Thank you, Mr. President.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will not be very long. I will be very brief. I

want to speak about the bill that the Presiding Officer, the Senator from Wyoming, has brought forth from the HELP Committee.

I have the honor of serving with the chairman on the HELP Committee. I think he has done a great job crafting this bill, which will offer more people the ability to afford health insurance in America.

We have heard reports about how many uninsured Americans are in our country today. The fundamental point is that a lot of Americans simply cannot afford to buy health insurance. And, many uninsured Americans are employed by small businesses. I have built, owned, and operated two animal hospitals, veterinary hospitals. As a small business owner, it is very difficult to afford to buy health insurance, not only for yourself, but, obviously, for your employees. One of the reasons it is difficult to buy health insurance relates to purchasing power. When you have a small number of people, it is difficult to go to insurance companies and negotiate effectively for good prices. If you have 20 employees versus a company that has 20,000 employees, the company with 20,000 employees has a lot more buying power and, therefore, can negotiate prices down more effectively than the smaller company.

The bill before us today establishes small business health plans, which will allow small businesses, such as the veterinarians, the restaurant owners, and the physical therapists to band together through their associations, and negotiate for health care coverage at prices they can afford. What this means is that a lot of people who are currently uninsured can become part of the insurance market. There is also a side benefit for the people who already have health insurance. A lot of people who are currently uninsured are young, healthy people who happen to want some type of health insurance coverage. If we bring these individuals into the health insurance market, they will help spread out the risk, which lowers costs for everyone else.

Now, we have heard criticism from the other side of the aisle saying that we are not maintaining the mandates that a lot of States have put forward. Opponents say that some people are going to be without coverage for mammograms, cancer treatments, and other services.

These same people today have no health insurance coverage whatsoever—isn't basic coverage better than no coverage at all? We would love to offer and be able to afford to offer everyone every type of service possible. But the reality is that a lot of people cannot afford health insurance plans today because insurance coverage has become too expensive. One of the reasons for this is that small businesses cannot pool together across state lines. Another reason has to do with mandates.

We talk about a lot of different proposals that can lower the cost of health care for hard-working Americans. Everybody campaigns and tells their constituents: We have to do something about the high cost of health care. We must do something. Let's act.

We have an opportunity to act now in the Senate. There is a good bill before us. We need to act on this bill so that uninsured Americans can come into the insurance market.

This bill is estimated, by an actuarial firm, to lower the cost of health insurance for small employers by as much as 12 percent. This is a significant number. Every dollar you lower the cost of health insurance makes more and more people able to afford it.

It is time for us to enact legislation that is actually going to be good for the American people, a proposal that will allow more people to be able to afford health care coverage.

Mr. President, the bill before us today goes a long way toward making health insurance more affordable for small business owners and employees. I encourage this Senate to get behind this legislation. Let's move it forward, work out the legislative differences with the House, and send a bill to the President that will help Americans afford health care insurance today.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, first of all, thank you for taking my stead in the Chair this evening so I could participate in this debate. I have been in the Chair 2 hours and 30 minutes and have heard quite a range of things.

Health care is a problem that affects the whole country today. We are going to spend in our Nation $2.3 trillion this year. The largest amount of money we are going to spend on anything in our country, we are going to spend on health care, and one out of every three dollars we spend does not help anybody get well.

We ought to ask ourselves—with 45 million people truly not covered in an insurance product, with the cost of health care rising double digits every year, with the cost of drugs skyrocketing, with the cost of hospitalization, emergency care skyrocketing—how is it we are spending all this money, with $1 out of every $3 not helping somebody get well, and costs are going through the roof?

It is because we have some real structural problems. This bill is meant to address a small portion of that. It is not the end-all, answer-all to our problems in health care. We all realize that. But this is something we can do in the short term that will make available an opportunity for costs to be controlled in a small area of our economy that will have impact and will create accessibility.

I would say we all in this body want everybody to have access to health care. The question is, Who pays for it? Right now, in terms of Medicare, our grandchildren are paying for it because it ran a $120 billion deficit last year. In other words, we borrowed $120 billion to run Medicare last year because that is the amount of money we did not have coming in from Medicare premiums.

The whole question on how we address health care is going to be: How do we get a better system that will give more people access, that does not waste that $1 out of $3? That is what we have to be concerned with. We have the brains, we have the science, we have the facilities, but something is wrong. What is wrong is there is not a competitive system out there where we allocate scarce resources based on quality and value and price.

This bill will move a little bit in that direction. There are going to be a lot of areas where we move. The one thing I have heard from the other side that I agree with today is, we ought to be emphasizing prevention. I agree with that 100 percent.

We have 19 different agencies in the Federal Government that have something to do with prevention. We are going to be introducing a bill that pulls all those together into one and has a leader who is emphasizing prevention and what we can teach the American people about saving money, preventive health care. As grandma used to say: An ounce of prevention is worth a pound of cure. And it works every time.

We know we can prevent diabetes. We can stop 50 percent of diabetes just with education, but we don't have it. We are wasting resources and duplicating resources. We have opportunity costs from programs that are designed to do it and don't do it well. Others do it much better, but we are still funding the ones that don't do it well. There are lots of problems we have.

I want the American people to understand that the choice that has been outlined by those who oppose this bill today isn't a choice of whether we have to have mandates. It is a choice of somebody who has no care now, no mandate, versus getting some care. If we do our job on prevention, then we will be educating the American people. But the ultimate health care responsibility in this country isn't the Congress. It isn't the States. It is the individuals who make choices about what is going to impact their lives and what value they want on their health care. That is why HSAs, although they have been blocked, need to be expanded vastly. They need to be funded better. They need to have an application for chronic care, and they need to have a tax deductibility to bring you up to the level of that so that we put everybody's skin in the game, so you know you are going to make a choice based on what is valuable to you.

Everywhere else in this country, we have trusted markets to allocate scarce resources. We are a little timid about how they are doing it in oil, but the fact is, the market is scarce, and the price is up. As soon as either demand decreases or supply increases,

the price will come back down, or some other form of energy is going to be there to supply it, such as agrifuels.

We have to trust the market to help us because we can't afford what we have promised. We can't afford what we promised in Medicaid, in Medicare. The money is not going to be there in 10 years. It is going to start winnowing away. So what are we to do? Continue to create a charade for the American people that says yes, we can, or start with one small step with this bill which offers availability through group purchasing, expanded purchasing power, lowering the overall risk to a million people? Why would we not want to do that?

Is it perfect? No. There isn't a bill we pass that is perfect. But this is a step in the right direction, although it does walk over some State mandates, I agree. But the problem is, Medicaid walks over State mandates every day. Medicare walks over State mandates every day. They set a mandate.

We have two choices in health care: the Government is going to run it all, or we go to the private sector where we really trust the market to allocate and protect those who need the help, those who can't help themselves. Those are the only two choices we have on health care. If you think we have problems now, wait until the Government runs it all.

I am a physician. I have practiced since 1983. That is 23 years. I have delivered 4,000 babies. I have done every kind of operation you can think of. I have seen a system decline based on how insurance has been applied to it and copying the mandates of the Federal Government. So we are in a mess on health care. Let's get out of the mess. Let's start with this, but let's don't stop there. Let's start with prevention. Let's make sure there is competition in the pharmaceutical industry. We don't have it.

As a practicing physician, there is no competition in the pharmaceutical industry. Drugs that do exactly the same thing and are priced the same way, nobody wants an increased market share. The Federal Trade Commission ought to be asking why. Why don't they want increased market share? I believe there is collusion on sharing of markets in the pharmaceutical industry so that they can keep the prices high. We need worldwide competition on pharmaceuticals. If we will do that, we will get a lot of bang for our buck.

There is even collusion when it comes to the generics. The FDA has created this wonderful system which enhances no competition for 6 months to 18 months for the first person who comes out with a generic. What is that all about? That is taking away from the market.

There are lots of problems, but this is a good start. It is not perfect. Is it as good as we can get? It probably is right now. But it starts us down the path on what we need to do to fix health care in this country. That is competition.

We need transparency. We have seen recently hospitals not wanting to give their rates, doctors not wanting to give rates, Medicare not wanting to publish rates. Why not? Let people know what they are supposed to be getting charged. Let's have a little open sunshine on the health care industry.

Let's talk about the 19 percent of every dollar that goes into the health insurance industry that never goes to help anybody get well. Let's talk about that. Let's create real competition in the health insurance industry. The more people get into it, the more competition we will have.

I thank the Senator for filling in for me so I could take the time to address the Senate. Our goal is making sure everybody has access to care and doing it in a way that our children can afford to pay for it because we are not paying for it today. We need to be mindful of that as we make those decisions. This bill starts with that.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BURR. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. COBURN). Without objection, it is so ordered.

Mr. BURR. Mr. President, as you spoke on this bill, you inspired me to come back over for another opportunity to talk. To put in context why we are here, you have to talk about where we have been this week. We started this week focused on exactly what you raised, and that was the inflation factors that go into health care.

On Monday, we were slated to consider two different proposals. One was a proposal that limited the liability that all medical professionals have, and we have seen liability premiums rise at a rate that is unsustainable for doctors across the country. That bill was quickly questioned as to whether we would bring it to the floor. Some argued that there was no need to; it is not a problem. We were forced to have a vote on whether we could proceed to consider the bill. We didn't vote on the bill. We didn't offer amendments on the bill. We had a vote on whether we could proceed, which requires 60 Members of the Senate to support. We didn't get 60 votes. The American people didn't get cost reductions because some in this body chose not to extend the privilege of debate and the voice of the American people in the amendment process into that bill.

We turned around and we introduced another bill. The bill's coverage applied to those specialists who are OB/GYNs; in other words, individuals who deliver babies, something that is vital in this country.

I know the Presiding Officer is, in fact, an OB/GYN. He delivers babies. He delivered babies throughout his career in the House of Representatives. He would leave the House, he would go home and deliver babies on the weekends so that he could keep his practice alive. He doesn't have the luxury now in the Senate. That is a shame because he was good.

There are communities all across this country that have lost their OB/GYNs, not because they became U.S. Senators but because they can't afford liability insurance anymore. They have been forced to leave rural America and go to urban America where they are under the umbrella of coverage of a large medical institution, in all likelihood affiliated with an academic institution.

What happened on Monday night when we took up liability limitations for those across this country who deliver babies? We didn't get the opportunity to debate it. We didn't get the opportunity to amend it. We had a motion we had to vote on to proceed. Because 60 Senators didn't agree to move forward, that died a quick death. Two bills that addressed substantive ways to cut the cost of health care died in a matter of 1 hour on the Senate floor because people didn't think it was important enough to address things that are inflationary to the cost of health care.

I said shortly after that I was going to come back to the floor because I thought it was important for my colleagues on the Senate floor and people in the gallery and across the country to hear real stories from real Americans.

In North Carolina, we have a lot of people who are suffering today because they lack insurance. So the third part of Health Care Week is to take up a bill that allows small businesses—really the heart and soul of America—to purchase as associations, as groups, to negotiate en masse because they don't get the luxury of the benefits of large corporations to leverage the cost of health insurance. For that reason, many small businesses today can't afford to provide health care and to keep the doors open of their businesses. So they choose to hire folks and to employ them and to pay them but not to extend health care benefits. Those are numbers that are counted in the national uninsured population.

In North Carolina, we have 671,000 small businesses. Small businesses make up 98 percent of the firms in North Carolina. Women-owned small businesses have increased 24 percent since 1997. Hispanic-owned small businesses have increased 24 percent since 1997; Black-owned small businesses, 31 percent; Asian small businesses, 74 percent. Are they any better off because of the categories they are in to provide health insurance for their employees? No, because they are caught in the same problem. They don't employ enough people to negotiate like the larger corporations.

In North Carolina, there are 1.3 million uninsured individuals, and 900,000

of those uninsured individuals are in families or on their own with one full-time worker. One full-time worker is in that house either with a family or is the individual in the house. The opportunity with this one bill is that we will have 900,000 people who potentially have the opportunity for the first time to be covered by health insurance.

Many run to this floor, and they talk about what we need to do as a Congress. They don't really mean we need to pass legislation that creates an affordable health care bill. What they mean is they would like for the Federal Government, through taxpayer funding, to produce a benefit we pay for for anybody who is without health care.

I think we have the right approach. The right approach is to make sure that small businesses can band together, that they can negotiate with the private insurance market, that they can offer a benefit, for the first time for many of them, to their employees, and the retention of their employees is better because that benefit is now extended.

Do you realize that the most expensive benefit that is offered by a business today is health care? It is not retirement, not any of the things that historically we have looked at. The health care benefit is the single most important thing.

I heard the Presiding Officer talk about the future and the fact that our children are the ones paying for Medicare today.

That is, in fact, right. Three things control our competitiveness in the world, and they are health care, energy, and labor. But I guarantee you, when we bring up energy, we are going to be blocked from proceeding because we will try to bring down gas prices and try to come up with things that bring stability in energy. Some would rather see nothing happen on the Senate floor.

I have an individual who is in the appraisal business in North Carolina who wrote to me and said that small businesses need help with insurance. That is in big letters. He says he is now paying $986 per month for his wife and himself. This is for only 60 percent coverage and a $2,500 deductible. He says he knows people with group insurance paying $600 for 80 percent coverage and a $250 deductible, and many of those have dental insurance as well. He said his policy provides none. ''Please help me out.''

This came from a store owner, and it says that as a small business owner, it is important to enable some economy of scale in allowing franchises to obtain more affordable health insurance.

The economies of scale is exactly what we are on the Senate floor to debate. I might add at this time that this debate really didn't start until several hours ago because on the third bill—this bill—we had to vote on a motion to proceed, which we won this time, and we had to delay some 30 hours before we could engage in the amendment process and general debate.

This comes from an individual from Hickory, NC. She said that as a parent and an employer, she knows the importance of having affordable insurance and the financial devastation that occurs when you have no coverage. Unfortunately, there has to be a tradeoff. She says she has only one of two options to keep her doors open: either her employees have no insurance or they receive a livable wage. When there are no viable alternatives for employers to purchase reasonably priced insurance, the losers are her employees.

What are we here debating? We are debating a change from today's policy. What is the choice employees of small business have today? It is a choice between nothing and nothing. That is unacceptable. That is why the chairman, Chairman ENZI, has worked so hard to carefully craft a bill that doesn't bypass those who are charged today with regulating insurance, every State insurance commissioner. But it incorporates them fully and allows products that can be created that, for once, are affordable. Sure, they don't have all the bells and whistles. They don't cover the full scope of coverage that every insurance product has today. But when your options are nothing and nothing, isn't it reasonable to believe that we can have a debate about creating something and nothing? Isn't that, in fact, why we are here?

In South Carolina, there is a textile company, a small business owner in Greenville who says that providing health insurance is becoming an unbearable hardship for small businesses such as hers. She is a widow, self-employed, and her health insurance is an expense she can hardly afford. Like many of her employees, she has a $5,000 deductible, and her monthly premium constantly increases 35 to 40 percent every 6 months. Most would say that is impossible, but I have her name and her address, I have the city in which she lives, and I have her company name. She wrote to me.

It is individuals who are turning to the U.S. Senate now. The House passed it. They are saying: Please produce something for us.

Here is one from Alabama. It is not all North Carolina. This is an owner of a nursing services company who said that the cost to cover one employee is $225 a month, and it is $617 for full family coverage, which is up 6 percent over last year. She recently lost a long-term employee to a larger company because that company could afford to pay 100 percent of the employee's health care costs. She thinks it is simply unfair that we don't do anything.

Janice is from Kentucky. She is the owner of an elevator company. She was hit with an astonishing 60-percent increase in health care premiums in 2002. There are a lot of similarities in the last letter. Some might have thought that is impossible. It is not.

Here is another one. Some of this increase in cost was passed down to employees because her company simply could not absorb all of the costs. If this trend continues, which she fully expects, they will have to drop the coverage she has provided for employees for years.

The writing is on the wall. We need to do something to relieve the pressure for small business in America or the uninsured rolls will increase. The rolls will not decrease because these small business owners cannot afford to continue to supply health care as a benefit.

Here is one from Mississippi. As a new small business owner in Mississippi, he finds it harder every day to make sense of why he pays three times as much for family health insurance as he paid when he worked in the same industry for a large company. He says there needs to be a way for his company to offer his employees similar high-value health insurance that he was offered when working with the big guys at a reasonable rate. Small businesses are at an immediate disadvantage simply because they are small, he said.

I talked earlier today about my election to the House of Representatives, when the Presiding Officer and I came in. I came from what I considered to be a small business, but it was over 50 people. We had adequate health care. I paid 25 percent, and the company paid 75 percent. I got to Washington as a Member of Congress. I found that my choices for health care increased in number, but I thought it was probably most prudent to choose, in fact, the same plan I had in the private sector, the same company, the same plan. I paid the same 25 percent, the Government paid the same 75 percent. What was the one difference? The one difference, now that I was part of 2 million people who worked for the Federal Government, was that my premium went up $50.

You see, there are some that will argue that the only way to solve the health care crisis in America is to have the Government take it over. If you want to solve small businesses' problems, let the Government negotiate a health care plan for them. Well, my experience with the Government negotiating health care is that it costs me more money. I would be willing to bet that most will find that to be the case. Incredibly, nobody is calling my office saying: I wish you guys would negotiate for me, or I wish the Government would take this over. Don't provide me choices, just give me one. I don't want to choose.

This is from Larry in Mississippi, who owns a small company. He has little buying power and few affordable options for health care. It is similar to what has happened in so many States, where one insurer controls more than 75 percent of the small-group market. This lack of competition resulted in an 80-percent increase in the last 2 years for his John Deere dealership.

I will tell you what, if there is anybody I would work hard for to find him

a deal on health insurance, it is a John Deere dealership. He increased the deductible from $250 to $2,500. He says that if he doesn't receive relief soon, he will be forced to drop all insurance coverage or lose his business. So he has an option: He can close the door, and everybody who works for him would be out of business.

You see, we are here because today the choice that small businesses and their employees have is a choice between nothing and nothing. All we are here to do is to suggest that we engage in this bill and that we have an up-or-down vote about something. Nobody will see this as a silver bullet that solves the health care crisis, as the Presiding Officer said earlier. That will take a much more in-depth engagement, a much more difficult debate on the Senate floor. We really will bring in the experts as we try to provide the changes that are needed so our children have the same benefits we have. But it doesn't make me too optimistic if we cannot solve this simple thing that so many small businesses are experiencing today.

Here is one from Virginia, not too far from us. The owner of a small industrial service firm is facing a crisis trying to provide health insurance for employees. His small business, with 20 employees, has struggled for the past 10 years to provide a health benefit plan. He has been able to continue to provide this insurance only by reducing coverage, raising individual office fees, and asking his employees to pay a higher share of the monthly premium. Underwriting penalties for small groups and rising medical costs and increasing mandates from government are collectively squeezing his small business to the point where meaningful health coverage will simply not be affordable.

I thought our job was to try to bring more people under the umbrella of coverage. I thought that was the objective, to try to create new products, create more affordable products, make sure that health care is not just more affordable but more accessible.

Here we are on the Senate floor with one of the most carefully crafted bills I have ever seen—a bill that a group of actuaries from a well-respected firm found would reduce health insurance costs for small business by 12 percent in today's dollars. That is $1,000 per employee. Is somebody in this institution telling me that small business employees across the country don't want to save $1,000 or that they don't want to have the opportunity to have less of their out-of-pocket money go to health care coverage or that we should ignore a well-respected actuary?

By the way, the actuary also found that S. 1955 would reduce the number of workers who are uninsured by about 8 percent, or 1 million people. This would automatically bring a million people under the umbrella of coverage. That hits home to me because I have 1.3 million uninsured in North Carolina. I have 1.3 million uninsured individuals, and 17 percent of North Carolina's population is uninsured today; 16 percent are uninsured nationally in this country.

Do you realize that only 205,000 of those 1.3 million uninsured are part-time workers? There is this belief that that number includes all part-time workers. If we could just make sure Wal-Mart supplied health insurance, this would all be over. No. The majority of mine—1.1 million—in all likelihood work for small businesses. They are uninsured. And 900,000 of them certainly are in a family where they could have a chance at health care coverage if, in fact, we pass this bill.

The Congressional Budget Office has also looked at the bill, and they found similar numbers of newly uninsured Americans. If S. 1955 were signed into law, CBO estimates that nearly 750,000 more people would have private health insurance than under current law. I guess that is the key. I guess some don't want there to be private health insurance. When we leave the marketplace alone, when we set it up so it is fair, it is amazing what competition does.

As a gentleman from Mississippi said, when one company controls 75 percent, where is my negotiation point? We are talking about letting national associations band together. We are talking about potentially shopping for national coverage, with national firms, but letting the State insurance commissioner regulate the product. I am not sure there is a downside to that, unless the downside is that we have now brought more individuals under the umbrella of coverage and this issue begins to diminish from a standpoint of the politics that comes along with health care.

Mr. President, I am going to end for the evening. I will not end for the debate, though. I still continue to get letters into my office that are real stories about real people. I think many times real people are forgotten on the floor. We get so wrapped up in the debate of issues that we forget that everything we do here affects somebody in this country or in the world.

Each time we stop long enough—maybe this weekend; I am not sure we will finish this bill this week; I hope we do—we figure out who these uninsured are. Maybe everybody will take an opportunity to go to a small business if they haven't visited one in their State, and they can ask those small business owners: What is the health care market like for your employees? I have a feeling what they are going to hear is what I have shared with you from real businesses, real owners about real people who can't afford what is available to them today.

There are in North Carolina 671,000 small businesses that desperately want a choice of something. Today all they have is nothing versus nothing. Their employees have nothing or nothing. Not a very good choice.

I am glad we are on this bill. I am glad the 30 hours is over. I commend Chairman ENZI for legislation that is incredibly well crafted. It is focused exactly where it needs to be, and that is to make sure plans are not cherry-picking, to make sure that regardless of the money that is available, there is a health care option so an employer and their employees can decide whether it is, in fact, affordable.

At the end of the day, it is my hope that Members of this very historic institution will remember the folks back home who sent them here, that they will remember the next generation we are obligated to represent, that we have an obligation today to make sure individuals who want to be covered have an affordable option to be covered, to make sure we fix some of the problems so the next generation, our kids, don't fight the same challenges we fight today.

I am convinced this debate will continue, and at the end of the day, I am convinced the American people will win regardless of what the intent is of some in this institution.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. DEMINT.) The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, something is wrong when 45 million Americans, 8 out of 10 of them in working families, cannot afford access to quality health insurance. This past weekend I met a woman in Des Moines who has been without health insurance for herself and her daughter since her husband died several years ago. She works hard as an administrative assistant in a small law office. She lives, like many Iowans, from paycheck to paycheck. She cannot afford private health insurance and she makes too much money to qualify for the State's Children's Health Insurance Program or Medicaid. This has consequences. She has not had any screenings or preventive care in years. Her daughter does not go to the doctor regularly, despite the fact that their family has a long history of diabetes and cancer. She knows she is at risk but cannot do anything about it. What happens to her if she gets sick?

Many people believe the United States has the best health care system in the world—the best treatments, the best medical technology, the best pharmaceuticals. But this is a cruel joke to the uninsured, including more than 8 million children, because they are forced to make do with substandard care or none at all. The result is a paradox. The United States has a world-class health care system, but we fall behind most industrialized countries when our general health outcomes are

measured. In 2000, the World Health Organization ranked our health care system 37th in outcomes that our health system provides. Just this week, CNN reported a new study which found that the U.S. ranked next to last in infant mortality among industrialized countries.

Bear in mind again that health insurance is not just about seeing a doctor when you are sick; it is about prevention as well. If you have insurance, you are more likely to have a relationship with a doctor or health care specialist who knows you and your health history. You are more likely to have access to preventive care so that chronic disease can be prevented in the first place. Without health care coverage, minor illnesses turn into major ones and small incidents turn into chronic conditions. Once this happens, it becomes almost impossible to afford quality health insurance without restrictions on benefits.

That is why this debate is so important. This week we are considering a major overhaul of the insurance system in an effort to help provide health care coverage to small business owners and their employees. I applaud the goal, but this particular legislation before us now is sorely lacking and will not provide access to quality health care at affordable prices.

I oppose the bill before us for the following reasons:

First, the bill eliminates consumer protections found in current State regulations, including in Iowa. In Iowa, under the bill, 840,000 consumers would lose coverage for diabetes testing supplies and education, emergency services, mammography screenings, State mental health parity, and well child care. They would also lose guaranteed access to dentists, nurses, nurse practitioners, and other providers. Iowa does not have a laundry list of coverage services. Iowa State regulations guarantee quality insurance. But S. 1955 would do away with the compromises that were worked out at the State level to guarantee quality.

Secondly, the supporters of this bill argue that the bill would lower insurance premiums for small businesses. What they don't tell you is that it comes at a cost. Many people, especially those who are older and sicker, would see their insurance premiums increase under the legislation, even with the changes found in the managers' amendment. CBO found that insurers will charge significantly higher premiums to those who are sicker, older, and otherwise less favorable to insurance companies. They will do this in order to reduce health insurance premiums for small firms with workers who have relatively low expected costs for health care. Imagine the shock of business owners all across America, including many I have met with recently in Iowa, when they are billed for the first insurance premiums under the new bill.

So keep in mind, of course, you can always get cheaper insurance, but what does it cover, at what cost, and what are the premiums going to be for the person who is covered?

Third, and importantly, this bill would undermine State efforts to guarantee coverage for preventive services. As I have often said many times, we don't have a health care system in America, we have a sick care system. If you are sick, you get care. But we spend precious little money and we have very few incentives for keeping people out of the hospital, keeping them out of the doctors' offices, and keeping them healthy in the first place. This bill would make it worse. In short order, insurers would offer stripped-down policies that do not cover preventive services. The result would be the elimination, as I said, of cancer screenings, well child care, mental health services, access to certain physicians or nurses or other providers such as chiropractors, for example, who might give you good care and keep you from getting a chronic condition, something that might cause you to have an operation in the first place. So importantly, this would mean elimination of benefits for everyone, not just small business.

Americans should have access to quality, affordable health care coverage. Coverage that is stripped down is not sufficient, and we shouldn't settle for it. People's lives, their livelihoods, their ability to contribute to society will all be undermined if they are not healthy.

I met with small business leaders in Iowa. Of course they want relief from high insurance premiums or from not even being able to get policies at all for their workers. We all do. Small business is the backbone of my State. And they need—they need—to have some kind of insurance coverage for their workers. With regard to this bill, what I have said to them is, don't think it is this bill or nothing. I also ask them: Are you willing to lose access to quality health insurance? Just check with the American Cancer Society. We have cancer societies in our small towns and communities all over America. People who run small businesses contribute heavily to our local cancer societies. But here is what the American Cancer Society said:

> In one stroke, this bill would erase all that state legislatures have done to prevent and more effectively treat cancer by ensuring access to life-saving screenings for breast, colon, and prostate cancer, cancer specialists coverage for evidence based off label drug use, clinical trials, and proven smoking cessation services.

That is from the American Cancer Society about this bill.

I ask all my friends; I ask anyone who has had a history of cancer in their families: Would you want insurance that doesn't cover screenings for breast cancer or colon cancer or prostate cancer?

How about the American Diabetes Association. We know that diabetes is hitting people younger and younger all the time. We have to do something to prevent diabetes. But here is what the American Diabetes Association said about this bill:

> We must ask ourselves how people with diabetes will be able to pay for a disease that costs an average of $13,243 per person to manage. Unfortunately, it will be our emergency rooms and Medicaid system that are forced to pay.

I ask my friends who are diabetic or who have family members with diabetes: Would you want insurance that doesn't cover diabetes-related services?

Those are just two examples, but there are many others. So, again, it is not this bill or nothing. There is a better option out there that will guarantee coverage for these services and at the same time provide small business access to quality insurance.

One realistic solution that I support would be to give small businesses the option of joining a program modeled after the Federal Employees Health Benefits Program. That is the program that covers us here and we love it, believe me. All Senators, all Congressmen, Supreme Court Justices, all our Post Office people—anybody who has anything to do with the Federal Government belongs to the Federal Employees Health Benefit Program. It is great coverage. Why shouldn't small businesses have access to the same kind of program we have?

That is why I have joined with Senators DURBIN and LINCOLN to introduce S. 2510, the Small Business Health Benefits Plan. Here is why this bill is superior to the bill we have before us:

First, it would create a larger purchasing pool, a nationwide pool, rather than the fragmented pools that will be created under S. 1955. A national pool would reduce insurance rates for everyone.

A few years ago, before I came to this place, I sold insurance. There is a principle in insurance that we all know: The more people in the pool, the cheaper it is for everybody. It is one of the fundamental principles of insurance. The more people in the pool, cheaper it is for everyone. So you want a big pool when you are dealing with health care.

S. 1955, the bill before us, sets up thousands and thousands of small pools. But the Federal Employees Health Benefit Plan is one big pool. So if you have that national pool, insurers will be able to offer a range of plans such as we have now. Every year we have open season and I can choose from—I don't know, I didn't count last time—maybe about 18 different plans. But the Office of Personnel Management would negotiate the rates and benefits offered under the plans.

Should they do that? OPM has been negotiating with private plans for decades. They have consistently negotiated better rates for Federal employees than have been achieved in the non-Federal market.

All the Senators here, all those who love the free market system—you will hear speech after speech praising the

free market system, but everyone here belongs to the Federal Employees Health Benefit Plan, and OPM is the one that manages the rates and negotiates the rates in these plans. As I said, they are better than anything that has ever been achieved in the non-Federal market.

Second, our bill offers a tax credit to small employers that would help offset the cost of premiums for employees if they make $25,000 a year or less. S. 1955 doesn't do this. There are no tax breaks for small businesses in S. 1955. There are more than 26 million Americans making $25,000 or less working in small businesses. Of those, 12 million, or 40 percent, are totally uninsured. That is what we want to get at.

I will be glad to go to any small business with those who are advocating S. 1955. We will take S. 2510 and we will take S. 1955, we will lay it out there and let the small business owner decide which one they would want to have. I would love to see that happen. I tell you I know what would happen: They would pick S. 2510, the one I am talking about, the one that would give them a tax break for covering and would provide quality insurance.

Third, our bill does not preempt State consumer protection laws. S. 1955, the bill before us, would do away with the guarantees I discussed, the guarantees of preventive services such as breast cancer screening, mammography, cancer, prostate screening, things such as that. By contrast, our bill would keep State insurance laws where they are. The insurance would cover mammograms, cervical cancer screening, diabetes testing supplies, immunizations, and on and on.

If you are a small businessperson and you happen to be watching this session and you are listening to my remarks, you are probably saying: Senator HARKIN, that all sounds good. Why don't you get S. 2510, the bill you are talking about, up for a vote?

Welcome to the unreal world of the Senate, when we are not allowed to do things such as that. We have S. 1955. The majority leader has, if you will pardon the expression, filled the tree. That is sort of gobbledygook around this place which means they have blocked us from offering any amendments, and then we are supposed to vote on cloture on the bill, which means debate comes to an end on the bill and you can't file anything that is not germane.

Tomorrow night we are going to be asked to vote for cloture on it? I am not going to vote for cloture on that. If you want to have an open Health Week here and you want to bring out S. 1955, leave it wide open so we can offer S. 2510 and we can have a debate on it and have up-or-down votes. I am all for that. I think the small business community in America ought to know that we are not being allowed to bring up our bill for amendment and discussion. I think our bill would pass. I think the small business community would support it.

But as I have understood, being out in Iowa last weekend and as I talked with small business owners, they have sort of been led to believe it is S. 1955 or nothing. And of course they will take S. 1955. If I thought that was all there was, I would probably take it, too. But that is not the option before us. We have better options than S. 1955. We have the option of S. 2510, the bill I spoke about, introduced by Senator DURBIN and Senator LINCOLN.

Again, it is unfortunate—not for us. It is not unfortunate for us. We have great health care coverage. We have great health care coverage. It is not unfortunate for us but unfortunate for the small business owners and the 25 million Americans who work for small businesses—12 million who do not have any insurance at all. This is what is unfortunate. It is unfortunate that this bill has been brought up in a way that makes it impossible for our side to amend it.

Besides getting a vote on our bill, I was prepared to offer a series of amendments that focused on preventive care. I think if we are going to have a Health Week and we are going to have a bill, I want to start focusing on preventive care. We know it saves money. But we can't do that, either.

Count me as one who will not vote for cloture on this bill tomorrow, but count me as one who wants to have an open debate and amendment on a health insurance program that will be beneficial to our small businesses. I am sorry we are not going to be able to do it now.

Again, we are supposed to have a Health Week. Yet tomorrow I guess we will take all day tomorrow talking about the tax reconciliation bill, and then we are not going to be here Friday. What kind of Health Week is this? What kind of Health Week is it when we are not allowed to offer amendments and debate preventive health care, offer a different bill for the one before us?

I think the small business owners of America now know what is going on. I have heard from some who basically have been supportive of S. 1955 and they are backing off of it. They are saying no, we would rather have your bill, we would rather have the one that provides us with some tax credits so we can go out and join a bigger pool like the Federal Employees Health Benefit Program; so we can join a big pool and we can have preventive services; we can have the State mandates that are there now that cover quality. They would rather have that bill.

But I am sorry we probably will not be able to get it done this year and I think, as I said, that is not just unfortunate for us—heck, we have the best health care coverage. We have great health care coverage. The health coverage we have ought to be available to every American out there.

I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, one of the difficulties around here is the process we have to use. Another one is that nobody listens to anybody's debate. We have covered this in some detail earlier today, that relevant amendments would be accepted. The Durbin-Lincoln bill ought to be voted on. But it should not be voted on and then S. 1955 precluded from getting a vote. That is one of the possibilities in the organization and the rules that we have around here, that we could wind up voting on that one and skipping the vote on S. 1955 and saying: Look, all these people voted against that; that means they don't like health care for small business. But they wouldn't have gotten to vote for the one that they might have liked.

I went through a number of the reasons why S. 2510 has some problems. I object to people saying we ought to give everybody the same health care the Senators have. We ought to give them better health care than the Senators have. The only problem is we can't do either of those things. The bill that is on the floor by Durbin-Lincoln doesn't do either of those things. It is a different plan that uses kind of the same structure so we build the same kind of bureaucracy, except a lot bigger bureaucracy to handle all the people in America, and it limits all of the pools to each State because they will have to meet all of the mandates of each of those States instead of what we have in the Federal plan which is a national level of mandates.

We have our own level of mandates. We don't go by what the States do. But that is not what is in that bill. In that bill they would still have to go State by State, and if you go State by State, you can't form the kinds of pools that we need to be able to have the clout to negotiate a better price and to bring around the administration.

People say you want to get rid of mandates so that will save money. No. Every experiment, every minilab that has happened out there where small business people have been given the opportunity to band together and to do something, they have covered those mandates. They didn't give those mandates up.

How do you save money with this thing? Small businesses pay 35 percent for their administration. Big business, which we already excluded from all mandates, we excluded them from Federal control, we excluded them from State oversight and consumer protection, which is in my bill—it still has the State oversight and consumer protection in there—we gave the big businesses the wave on all of those things. They still kept the mandates. But where they saved the money is in administration. It costs them 8 percent to administer their plans. So 35 percent minus 8 percent means they save 27 percent over what a small businessman will do. And every 1 percent we can save on insurance brings 200,000 to 300,00 people back into the market.

That is why we want to have associations to be able to offer plans under State consumer protection, under the insurance commissioner's oversight.

But with some kind of a blended plan, they can cross State lines and have a uniform package, and they can have a big enough group so they can negotiate. That is what 1955 is about. We need to have a vote on that as well.

As far as mandates, Senator SNOWE is putting in a bill that will cover those basic things people are talking about.

The letter that the Senator read from—the American Diabetes Association—I talked about that a little bit earlier today. One of the difficulties we had in trying to do something with diabetes is that 42 States—it may even be 47 States—are doing something with diabetes, but no two do it alike.

Again, how do you blend across State boundaries unless you can get some kind of basic package? I know they will cover diabetes. Under the Snowe amendment, they will for sure.

The distressing part of their letter was, no matter what changes are made to the Enzi bill, defeat it. That is not a very reasonable approach by any disease group. That means that if I have an amendment that said find out everything that is done for diabetes and do everything for diabetes that is done anywhere, they would still be suggesting voting against my bill. I don't think that is a reasonable approach by any group.

The American Cancer Society wrote pretty much the same letter and said pretty much the same thing.

We are not trying to subtract, we are trying to add. We want people who are uninsured to come into the market, and we want people who already have insurance to be able to get more and better insurance for the same dollar. That is what employers are able to afford. We are trying to come up with a system such as that.

The only thing about filling the tree—which I agree with the Senator is gobbledygook—the only thing with that is to stick to small business health insurance.

There are another dozen things on insurance and health care that we ought to be debating. Each of them would take about 3 weeks to debate. At this point in the season, we are not going to get 3 weeks to debate anything. I am lucky to put together a few days to be able to talk about this. I hope to make more progress on that.

I have been working hard with everybody to try to come up with some kind of mechanism that will work. That is where we are on the bill. If we could do the things that are relevant to this, or also germane after cloture, then we could stay on the bill a little longer and keep working on it. If we don't get cloture, we are probably done with this discussion for the whole year. That will probably be the end of health care for the year. People have to keep that in mind when they are voting on cloture.

Even individual mandates can be brought up one at a time and put into the thing, or at least be voted on. The desire is not to keep votes from happening but to stick to small business health plans.

These folks have been asking us for 15 years for a change and some way to handle it. They have been encouraged several times because eight times the House has passed the association health plan. That was very exciting for them. They said I think we can get it. It never made it out of committee on the Senate side because there are some problems with the basic plan that the House passed.

When I got this chairmanship, I said we are going to do something to change this. We are going to find out what the objections are and see if there isn't a way to get something done that will get relief for the small businessman. The insurance companies were convinced that we were going to do something, so they sat down with me. The insurance commissioners had concerns, and they have always been one of the stakeholders. They sat down with me, and they had their representatives sit down with us days on end to work on some kind of a compromise. This is one.

Nobody is raving about it except the small businesses because they see it as an answer—not the final answer, not the total answer, but an answer—that moves closer to what they can afford to do. Again, it isn't by cutting mandates.

Mr. HARKIN. Mr. President, will the Senator yield?

Mr. ENZI. Yes.

Mr. HARKIN. He is a gentleman, and a good friend. I know he is serious about this because he is a small business owner himself.

As I said earlier—and I want to make sure we are clear—that under this gobbledygook, the filling of the tree—no one understands what we are talking about out there—because of the way the bill is laid down, the majority leader, under the rules of the Senate, today offered amendments to the bill so that we can't offer amendments. There is no way we can now offer amendments. If cloture is invoked tomorrow, then we have 30 hours on the bill, and that tree could stay filled. So we can never offer an amendment to this bill. We would then have a final vote on S. 1955 without being able to offer any amendments. Is that not so?

Mr. ENZI. Not quite.

Mr. HARKIN. Inform me.

Mr. ENZI. Even during the course of today and any other debate we have on this bill, we have said if there is a relevant amendment, we would consider taking that up and voting on it. One exception we have on that is the difficulty with Durbin-Lincoln. If we vote on that, that might be the only vote we ever get because the other side can block any further votes from happening because you would have to have unanimous consent to have a vote. So we would be blocked from ever having a vote on our bill.

Mr. HARKIN. That is the problem with this whole cloture process. Why didn't we try to reach a time agreement and an agreement on how many amendments would be offered? As I understand it, our side was willing to do that. Then we would not have this problem of cloture where we are precluded then from offering amendments.

As the Senator pointed out, if S. 2510 is offered, I don't know what would happen after that. The Senator said it wouldn't be offered. This whole thing with the cloture has screwed up everything.

Mr. ENZI. No, I wasn't suggesting that S. 2510 would pass. I was saying that a lot of Democrats would vote for it and it would fail. Then there will be no further votes on it. You folks could all say we voted for small business and the Republicans didn't vote for small business. It would be because the Republicans wanted S. 1955 with a few amendments which can be offered by both sides. That would happen postcloture. The only thing that happens postcloture is amendments have to be germane. That means they actually would have to apply to the bill. The Durbin-Lincoln bill is germane. Many of the things people talked about would be germane. What wouldn't be germane are some of the long-term debates and things people would like to do, namely the stem cell debate which we are going to have a debate on. They promised a vote on it. We don't know how much debate there would be with that; prescription drugs, Part D, and those would not be germane to the bill. Each of those would take about 3 weeks to debate.

Mr. HARKIN. I say to my friend, I think if agreements were made with this side and the other side, we could agree on time limits and structures without having this on us.

I also say to my friend, I think we should take 3 weeks to debate health care. We have been wasting so much time around here doing nothing. Now tomorrow we have tax reconciliation. So my friend from Wyoming is getting a day cut out of his deal. I think we ought to take 3 weeks to debate health care around here. It wouldn't bother me any.

Mr. ENZI. The Senator certainly is not the only one. I would love to have a lot of time. We have had a lot of bills that came out of committee already that could be brought up. We have some more that are going to come out next Tuesday. A lot of those I think would pass here by unanimous consent. I would love to have some agreement. The Senator knows how hard it is to get 1 week around here. We spent 3 days getting cloture to proceed. That is to proceed; that wasn't to actually do any votes on the bill. So we were offered the moment, but between the two sides we didn't get the moment.

Mr. HARKIN. I ask my friend, what was the vote on the motion to proceed?

Mr. ENZI. It was 98 to 2.

Mr. HARKIN. Then there was no problem with that.

Mr. ENZI. If there was no problem with it, why did we have to wait 3 days to get the vote?

Mr. HARKIN. We didn't have to wait 3 days to get the vote.

Mr. ENZI. I am talking about time limits and that sort of thing. Those requests were made between leaders to come up with some tight time agreements. It is beyond my pay grade.

Mr. HARKIN. It is beyond my pay grade, too. I wasn't involved in that.

Mr. ENZI. There were a lot negotiations to try to stick to small business and have some kind of a mechanism where the votes from both sides could be done. But there was not any agreement on that, so we are stuck in this kind of a situation where small business may be penalized once again.

Mr. HARKIN. That is a shame.

Mr. ENZI. If we get cloture, we could have a lot of debate on the small business stuff, not all of other ones. If we could get in a situation where we started doing these things a little quicker, with more time agreements, some of the more difficult ones could probably get some floor time. I am for that.

Mr. HARKIN. If we get cloture, we have 30 hours. Every Senator gets one 1 to speak. That is putting handcuffs on people; 30 hours, run the clock out. One person can get up and offer an amendment and that could be the only amendment we would have for that 30 hours. That is the way things work under cloture. It is not a good way to proceed. I think that is why some of us are upset. We want to help small business. I think there is a fair debate to be had between S. 1955 and S. 2510, with amendments. But somehow we are told that we are going to do this in 1 week. Monday is shot. We didn't do anything Monday. We had two votes Monday night. Tuesday, Wednesday, and then Thursday, tomorrow, is tax reconciliation. Health Week is 2 days. I don't think that is fair to small business, either. I think it is worth taking a couple of weeks around here to do it, and to do it right.

I thank the Senator for yielding.

Mr. ENZI. I am with the Senator.

Yes, it would be nice if we could wrap up something for small business. I think there is a plan there. I think there is a way to get there. I don't think it is going to happen without the cooperation of both sides in either coming to some time agreements or passing cloture.

We will have to wait and see what happens. I would wait until the end of next week to have a vote on either of them as long as we can do amendments. And I am excited about doing amendments. There are always perfecting things. No bill is perfect when we finish it. Even after conference it is never perfect. But it is usually much better than when we started. We need to have that process.

I thank everyone for their participation today.

Mr. FEINGOLD. Mr. President, I wish to speak today about the Medicare Prescription Drug Program. I opposed the final version of the legislation that created the Part D drug benefit, the Medicare Modernization Act, because I believed that it would not provide adequate relief for Medicare beneficiaries. I was concerned about the structure of the program, and worried that it would negatively affect Wisconsinites and other Americans who must quickly and affordably access prescription drugs. I have been trying to fix some of these problems since the program was enacted, but supporters of the program have been unwilling to consider these reforms. Instead, they have allowed these problems to remain, and the results, since the benefit was implemented in January, have been disastrous.

I have heard from a number of Wisconsinites who found the prescription drug plan enrollment process exceedingly confusing. Many people had difficulty finding a plan that would cover their prescriptions, while others could not get through to Medicare representatives to ask questions about the enrollment process. There have been breakdowns in the entire information process, and these failures by the insurance companies and the Centers for Medicare and Medicaid Services have sometimes completely blocked beneficiaries from accessing essential medications such as insulin, antipsychotics, and even immunosuppressants.

We can't afford to wait any longer in improving the Part D program so that it can better serve its beneficiaries. We need to minimize the negative effects of Part D's implementation problems and high costs. As part of this effort, I strongly support S. 1841, Senator BILL NELSON's, Medicare Informed Choice Act. This plan would allow beneficiaries extra time to navigate this confusing system by extending the enrollment period through the end of 2006. In addition, it would allow a one-time penalty-free change of programs for beneficiaries who have made a mistake in choosing their prescription drug plan.

Supporters of the Medicare prescription drug benefit have touted it as the vehicle that would supply affordable, easily accessible prescription drugs for seniors. The program has so far fallen far short of that goal. The outcry that I have heard from pharmacists, beneficiaries, and health care providers over the past couple months makes clear that the implementation of the program has been a disaster. This program has not provided either affordable or easily accessed drugs to many Medicare beneficiaries. Instead it has presented providers and beneficiaries with frustration, confusion, expensive medications, and sometimes no medications at all. It is unacceptable for individuals to go without life saving medications. Yet this is what has been happening in Wisconsin and across the country since this program commenced.

Since the beginning of January, I have received panicked phone calls from people in my State saying they were unable to receive drugs that they had been routinely getting at their pharmacy every other month. At the same time as I was hearing from people suffering from pain because they did not receive their pain medications, I read press releases from the Centers for Medicare and Medicaid that expressed satisfaction with the launch of the program, and boasted of the millions of participants in the program. There may be millions participating in the program, but too many of them cannot receive their drugs and too many pharmacists are unable to comply with the complicated regulations in the program. CMS should be focusing its efforts on addressing this emergency rather than disseminating public relations messages.

I have written Secretary Leavitt and Dr. McClellan repeatedly to express my concerns about Medicare Part D, including the approaching deadline. I hope that the administration will soon realize that it cannot continue to ignore these problems or hope they go away on their own, and that significant changes in the program are needed to better serve beneficiaries. I think it is time that CMS remember who this plan is supposed to serve: the people, not the drug and insurance companies.

We cannot sustain a great nation if we do not care for our elderly, sick, disabled, and home-bound. These are the people this drug plan is supposed to be serving, but they have been dismally let down. Let us make a simple change to the drug plan that will provide immense help to this group—extend the May 15 deadline. I urge the majority leader to bring up S. 1841 for a vote before the deadline passes.

Mr. OBAMA. Mr. President, over the past year and a half, I have spent a few days every month holding townhall meetings around my home State of Illinois. I have now done almost 50 of these in cities and towns all over the State.

After I give a short presentation, I open the floor to questions from the audience. And without fail, one of the first questions asked at every townhall is about health care. Too many hard-working Americans can't afford their medical bills or health insurance premiums. Too many employers are finding it difficult to offer the coverage their employees need. And sadly, too many people in the world's wealthiest country have no insurance at all.

When Senator FRIST declared the second week in May as ''Health Week,'' I naively assumed that maybe, just maybe, we would actually begin a real discussion about health care in the United States. I thought we would talk about serious and meaningful ways to address the health care problems faced by average Americans—important problems like: the 45 million Americans without health insurance; the worsening epidemic of chronic diseases, including asthma, obesity, and diabetes; the persistent and pervasive problems with patient safety and health

care quality; or the status of emergency and pandemic avian flu preparedness.

I know that I am not the only Senator who has been disappointed. A number of my Democratic colleagues have mentioned other pressing, critical issues on the floor this week, including stem cells, the looming enrollment deadline for Medicare Part D, and drug importation.

Yet so far we have had only a sham discussion on medical malpractice, revisiting the same old bills that have been rejected in the past that do not represent any real attempt to compromise and find solutions to the problems that many of our doctors and patients face.

And now, the Senate has turned its attention to the Enzi small business health plan. I know that small businesses need help in providing health care coverage to their employees. Small businesses are paying the price for this Congress's refusal to seriously embrace comprehensive health care reform, to expand coverage and contain costs.

Yet this bill is not the solution, and it is not part of a solution. In fact, some have described it as the antisolution.

In my opinion, any health coverage reform bill that passes the Congress should meet, at a minimum, three criteria: First, it may sound crazy, but I think a health coverage bill should actually expand coverage. The Enzi bill has been estimated to expand coverage to less than 1 million of the 45 million uninsured Americans. This is laughable.

In fact, some States will actually see an increase in the number of uninsured. In New York, for instance, 28,000 people could lose their health insurance coverage because of this bill.

Second, a good health reform bill should ensure comprehensive, quality health care. Over 200 health professional and patient advocacy groups have expressed their opposition to this bill, because it will promote health plans that won't offer the basic health care services that we all depend upon and take for granted, such as maternity care, mental health services, diabetes care, dental care, and so forth.

I have rarely seen such a large number of groups come together as swiftly, as vociferously, and as united as these groups have been against this bill.

Third, a good health reform bill should have a positive effect on the health insurance market. Will the market be stabilized and strengthened, or will it be weakened and fragmented? Again, the Enzi bill does not pass muster. Over 40 attorneys general have expressed serious concerns about this bill's preemption of State protections and laws and its restrictions on State oversight and regulation.

This so-called health week makes a mockery of the efforts of those who are working to achieve real health care reform. While we in Congress are squandering precious time on this bill, our States are moving ahead, exerting leadership because Congress has failed to act.

Illinois is in the process of implementing a program called All Kids, which will ensure that every child in the State is covered by health insurance. And we all know that Massachusetts just passed a sweeping, universal health coverage bill, negotiated and passed in bipartisan fashion.

In contrast, the last major health insurance reform passed by Congress was in 1997, when the SCHIP program was created. Even though the number of uninsured has continued to rise, almost 10 years have gone by without a serious congressional effort to address this crisis.

This is wrong. The Durbin-Lincoln amendment, which I have cosponsored, is a good example of how we can meaningfully expand health coverage without sacrificing the quality of care received.

The central tenet of the amendment is that small business employees should have access to the same health insurance coverage that members of Congress and other Federal employees receive themselves.

The health care problems facing our country are serious ones, and the solutions will not be easy. But we need to have a serious debate about this issue—a debate that addresses the whole problem and isn't just about scoring political points in an election year.

The American people expect as much, and I hope this failed attempt at a ''health week'' is not the last chance we will have to talk about an issue that is the chief financial concern of millions upon millions of people in this country.

Mr. LEAHY. Mr. President, for all of the recent talk from the majority about up-or-down votes, and allegations of Democratic obstruction on amendments, I find it astounding that the Republican majority has locked up Senator ENZI's bill and will not allow amendments to be offered. We now face exactly the type of obstruction the majority has decried so loudly. On a bill for which Senator ENZI has urged full debate, the Republican majority has now decided the Senate and the American people we represent should not get the benefit of the full legislative process. For example, I am being prohibited from offering an amendment to help prevent medical malpractice insurers from bid rigging, price fixing, and other anticompetitive behavior that hurts doctors and patients. For another, we are prohibited from offering an amendment to extend the arbitrary deadline for seniors to sign up for prescription drug benefits without a penalty. Why not provide our seniors more time and assistance in examining the prescription drug provisions that have frustrated so many? Seniors did not grow up in the computer age and many are not trained accountants who can sift through the confusion. They should not be penalized by an arbitrary cutoff date which could easily be extended.

This week, the Senate has already refused to proceed to legislation that would have abridged our citizens' access to justice when they are injured by medical errors. Those bills purported to lower medical malpractice insurance costs when, in fact, it is not payouts that have led to rising insurance premiums. The Senate has done the right thing by rejecting these bills once again.

The debate that preceded the votes demonstrated that capping medical malpractice awards is not the way to lower insurance premiums, which we all agree are unfair to the men and women who devote their lives to the care of others. There can be no disagreement that exorbitant insurance costs make it harder for medical professionals to do their jobs. Health care providers, like all Americans, deserve fair treatment in the marketplace. We also know that the insurance marketplace is unique, because unlike other business interests, insurers are not subject to some of the most important Federal antitrust laws.

High malpractice insurance premiums are not the result of malpractice lawsuit verdicts. This myth has been repeatedly discredited. They are the result of investment decisions by the insurance companies and of business models geared toward ever-increasing profits. But an insurer that has made a bad investment, or that has experienced the same disappointments from Wall Street that so many Americans have, should not be able to recoup its losses from the doctors it insures. The insurance industry should have to bear the burdens of its own business model, just as the other businesses in the economy do.

High malpractice premiums for doctors can occur because there is nothing stopping insurers in a soft market from collectively raising rates and stifling competition. Any other business would be prohibited from this activity, and I have heard no arguments as to why the insurance industry should be treated differently. The insurance industry is special because it is exempt from most Federal antitrust laws. The McCarran-Ferguson Act permits insurance companies to operate without being subject to those laws, and our Nation's physicians and their patients have been the worse off for it. Using their exemption, insurers can collude to set rates, resulting in higher premiums than true competition would achieve—and because of this exemption, enforcement officials cannot investigate any such collusion. If Congress is serious about controlling rising premiums, we must objectively limit this broad exemption in the McCarran-Ferguson Act.

The amendment I wanted to propose modifies the McCarran-Ferguson Act with respect to medical malpractice insurance, and only for the most pernicious antitrust offenses: Price fixing, bid rigging, and market allocations.

Only those anticompetitive practices that most certainly will affect premiums are addressed. I am hard pressed to imagine how anyone could object to a prohibition on insurance carriers' fixing prices or dividing territories.

After all, the rest of our Nation's industries manage either to abide by these laws or suffer the consequences. If medical malpractice insurers are certain that malpractice lawsuits drive their rates, then there should be no reason to object to bringing their business within the reach of the same Federal laws that apply to all others.

Many State insurance commissioners police the industry well within the power they are accorded in their own laws, and some States have antitrust laws of their own that could cover some anticompetitive activities in the insurance industry. My proposal, which I wanted to offer, is a scalpel, not a saw. It would not affect regulation of insurance by State insurance commissioners and other State regulators.

But there is no reason to perpetuate a system in which Federal enforcers are precluded from prosecuting the most harmful antitrust violations just because they are committed by insurance companies.

This amendment is a carefully tailored solution to one critical aspect of the problem of excessive medical malpractice insurance rates. I am sorry that I was stopped by the Republican leadership and could not offer this narrowly drawn legislation as a positive step towards improving the American health care system, which would help ensure that doctors and patients are treated fairly.

Mr. KENNEDY. Mr. President, the Senate is currently considering legislation proposed by Senator ENZI that would profoundly change health care coverage. The proposal has been modified from the version approved by our committee.

It is important for the Senate to understand fully the impact that this legislation would have on millions of Americans. I have requested an analysis of this modified proposal from Professor Mila Kofman of the Georgetown University Health Policy Institute.

I ask unanimous consent to have this analysis printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

GEORGETOWN UNIVERSITY,
May 10, 2006.

SENATOR EDWARD KENNEDY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR KENNEDY: This is a response to your request for an analysis of the proposed rating structure in the Manager's Amendment to S. 1955. This also addresses your question on how the proposed amendment compares with the current NAIC model law on small group rating:.

In general, the proposed Manager's Amendment would not improve the bill. Under the new proposed rating structure there would be no new protections for consumers and a significant loss of existing state-based protections in the area of premiums. This loss of protections will adversely impact people with medical needs, older workers, and women of child-bearing years. This will also have a negative impact on ''micro'' groups (employers with fewer than 10 employees) because insurers will be allowed to charge these groups higher rates solely on the basis of the employer's size.

Here is a brief summary of how the proposed amendment would work:

Associations: The amendment clarifies that associations certified as small business health plans (by the U.S. Department of Labor under Title I of the bill) would enjoy a complete carve-out from small group rating state pools in both adopting and non-adopting states. Each certified association would be allowed to have their own premium rate not tied to the rest of the small group market. This would segment the small group market. Assuming associations attract healthy businesses (there are many ways that the bill would allow associations to ''cherry-pick'' healthy people), any restrictions on rates in the rest of the small group market would be undermined. Rates between association coverage and coverage outside the association could vary broadly. For a discussion of this, please see attached paper ''Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change.''

In adopting states, the bill clarifies that premiums within an association may vary using the same standards that would apply in small group market (see discussion below). This would be at least 500 percent variation in rates for businesses covered by the association or if the state allows, variations in rates could be even greater.

In non-adopting states, it is unclear whether the rating standards in the bill would even apply. If they apply. then a variation in premiums of 500 percent would be allowed for businesses covered by an association (so some employers would pay 5 times more than others for the same coverage within an association).

Small group market: In adopting states, insurers are required to vary rates by at least 500 percent (called ''total variation limit''). This means that states can allow insurers to have greater variations in rates. Using age. health, claims. and duration factors. variations of at least 300% are required. Note that insurers must use age, health, or both and may use duration and claims experience. The option is given to insurers. If a state wants to adopt this approach and become an ''adopting state.'' it must allow insurers to use age and health. This requirement essentially eliminates community rating and adjusted community rating by allowing insurers to adjust rates based on health. Allowable factors included in the 500 percent minimum required variation are: industry. geography. group size, participation rate, class of business. and wellness programs. Note that gender is not listed. The bill is unclear whether gender rating is prohibited or is added to the 500 percent variation.

At renewal, the same rules would apply. This means that premiums may increase at least by 500 percent if a smaIl business has high claims the year before.

In non-adopting states (generally states with greater protections for consumers). the language in the bill is ambiguous. The proposal says ''The plan may not vary premium rates by more than 500 percent].'' The term ''plan'' is not defined. If the term ''plan'' means an ''insurer,'' then one possible interpretation is that premium variations are limited to 500 percent (if insurers chose to follow this new tederal standard). What is clear. however, is that adjusted community rating and pure community rating would be preempted.

Renewal rates would limited to trend plus 15 percent to reflect claims of small business.

Importantly, in non-adopting states insurers would have a choice of whether to follow a state's existing laws or the new federal one. As a way of example, in DC, which has no rating laws, assuming DC chooses not to adopt the bill's rating structure and is therefore a non-adopting state. Insurers are not likely to use the rating restrictions in the bill.

The proposed rating structure varies significantly from the NAIC model law for small business health insurance premiums. By way of background. the National Association of Insurance Commissioners (NAIC) in the early 1990's adopted and since replaced a model law that provided for rate bands that permit premium variation up to 200 percent based on health status. The old model, which is the basis for the original bill, allowed further premium variation based on age, gender, industry, small business group size, geography, and family composition. Rates based on adjustments for these factors had to be actuarially justified but were not limited except for industry, which was limited to a 15 percent variation. The old NAIC model act permitted a wide variation in rates, allowing for a price difference of 26 to 1, or more. This means that for the same policy an insurer could charge a business or a person $100 per month or $2600 per month depending on risk and other factors. Higher rates under the model would be permitted as long as there was actuarial evidence to support wider variations.

Shortly after adopting its original model with rate bands, the NAIC replaced it with a model law for small groups that requires adjusted community rating, prohibiting premium surcharges based on health or other risk characteristics (like claims experience and durational rating). The current NAlC model act limits premium surcharges based on age to 200 percent; it prohihits insurers from varying small group premiums based on gender of people in the group or an employer's size. Today 12 states follow the current NAlC model act. Ten states require all insurers to use community rating or adjusted community rating for all small group policies. Two others, Michigan and Pennsylvania, require Blue Cross Blue Shield plans (their largest insurers) and HMOs to use adjusted community rating. The proposed amendment would preempt these state rating protections.

Please let me know if you need additional information. Thank you for the opportunity to address your questions.

Very truly yours,

MILA KOFMAN, J.D.,
Associate Research Professor.

CLOTURE MOTION

Mr. FRIST. Mr. President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The assistant legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the pending modified substitute amendment to Calendar No. 417, S. 1955, Health Insurance Marketplace Modernization and Affordability Act of 2005.

Bill Frist, Johnny Isakson, Sam Brownback, John Thune, Thad Cochran, Wayne Allard, John Ensign, Richard Shelby, Larry Craig, Ted Stevens,

John McCain, Lamar Alexander, Norm Coleman, Judd Gregg, John E. Sununu, Pat Roberts, Craig Thomas.

ORDER OF PROCEDURE

Mr. FRIST. Mr. President, I ask unanimous consent that on Thursday, May 11, immediately after the time for the two leaders, the Senate begin consideration of the conference report to accompany H.R. 4297, the Tax Relief Extension Reconciliation Act; provided further that 8 hours remain out of the statutory time limit and that it be equally divided. I further ask consent that following the vote on the adoption of the conference report, and notwithstanding rule XXII, there be 60 minutes of debate, equally divided, between the chairman and ranking member of the HELP Committee or their designees prior to a vote on the motion to invoke cloture on the modified substitute to S. 1955, the small business health plans bill, with no intervening action or debate, and the live quorum waived.

The PRESIDING OFFICER. Is there objection?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, may I inquire of the majority leader, at this point, are we closing down debate on this bill?

Mr. FRIST. Mr. President, through the Chair, on the small business reform bill, we will have 1 hour prior to the cloture vote. And during the day tomorrow, I expect people will be coming to the floor talking, as well, on small business health plans.

Mr. DURBIN. If I may ask through the Chair to the majority leader, as I understand the procedural position we are in, earlier today the majority leader filled the tree, as we say, to preclude any further amendments. And now, as I understand it, the majority leader has filed a cloture motion, which basically means we are going to bring this to a close without further amendments, without further debate, one up-or-down vote on cloture?

Mr. FRIST. That is correct. Someone could offer an amendment tomorrow prior to the cloture vote, if they so desire.

Mr. DURBIN. If I might ask the majority leader through the Chair, I asked earlier today if we would be allowed to bring up the stem cell research issue, which the majority leader has expressed his support of, and whether we could bring that up for a vote this week while we are on Health Care Week so we could address this issue of medical research.

I would like to ask the majority leader through the Chair if we could bring it up before cloture or after cloture?

Mr. FRIST. Mr. President, through the Chair, the interest in stem cells will be debated in the future, at a time that is mutually set by the Democratic leadership working with the Republican leadership. Stem cells can be discussed but will not be voted upon before this cloture motion.

Mr. DURBIN. I thank the majority leader.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that there now be a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

FINAL PASSAGE OF H.R. 4939

Mr. ENZI. Mr. President, I wanted to take this opportunity to discuss why I made the difficult decision to vote against H.R. 4939, the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Hurricane Recovery.

The United States is involved in operations overseas while dealing with natural disasters such as Hurricanes Katrina and Rita. On May 4, 2006, I voted against a $109 billion spending bill that was $17 billion more than what the President originally requested. Of course, on occasion, times call for emergency spending, but this bill goes far beyond what anyone would call emergency spending.

Many items in this bill do not constitute ''emergency'' spending. The bill would funnel millions of dollars to a road in Hawaii, millions of dollars in grants for research not related to emergencies, and still millions more to subsidize the volunteer work program AmeriCorps. Are these projects necessary? Possibly, but they are not an ''emergency.'' These spending proposals should go through the annual authorization and appropriations process. Congress must tighten the definition of what qualifies as an emergency. The use of supplemental spending bills must be saved for the true emergencies. True emergency funding is being bogged down with nonessential projects that have no business being in an emergency supplemental spending bill.

We must not saddle our children, their children, and their children's children with debt that we incurred because we did not properly restrain our spending. My very first speech in the Senate Chamber was on the need for a balanced budget. In 1997, I said that the Federal Government must learn to live within its means. Without any restraint on spending, we are simply adding onto our Nation's enormous debt. Unfortunately, this is still true today.

I recently visited American troops stationed in Kuwait. I always have and will continue to support our troops. I appreciate the sacrifices they make and the sacrifices of the families, friends, businesses and communities they leave behind.

Our American service men and women should have the financial resources they need to fight this crucial war on terror. This bill should be about voting to provide financial stability that allows the U.S. Government to support our troops and our veterans into the future. It is unfortunate that other nonemergency spending projects made their way into an important bill that included vital funding for our troops. I wish that the Senate would have followed the President's proposal and only included funding for real emergencies.

HONORING OUR ARMED FORCES

LANCE CORPORAL STEPHEN R. BIXLER

Mr. LIEBERMAN. Mr. President, I rise today to pay tribute to LCpl Stephen R. Bixler of Suffield, CT.

Corporal Bixler, a member of the 2nd Reconnaissance Battalion, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC, was killed in action on May 4 while conducting combat operations against enemy forces in Anbar Province, Iraq. He was struck while on foot patrol by an improvised explosive device on his second tour of duty in Iraq. Corporal Bixler is fondly remembered as a quiet but strong leader with strength of character and self-assurance unusual for someone of his age. As an Eagle Scout and former senior patrol leader in his Boy Scout troop, Corporal Bixler enjoyed helping others. He joined the Marines shortly after graduating from Suffield High School in 2003 and served in Haiti prior to his tour in Iraq. He was well received and respected when he proudly visited his high school, where he had been admired as he excelled at academics and athletics, to talk to students about his experiences. He was a true patriot and defender of our great Nation's principles of freedom of justice. Corporal Bixler served as an example of the potent American spirit, which permeates this Nation's history.

I am both proud and grateful that we have the kind of defender exemplified by Corporal Bixler serving in the Persian Gulf. Our Nation extends its heartfelt condolences to his family. To his father, Richard, his mother, Linda, and sister, Sandra, we extend our profound gratitude for sharing this outstanding Marine with us, and we offer our prayers and support.

STAFF SERGEANT MARK WALL

Mr. GRASSLEY. Mr. President, I rise today to honor the life of a truly brave American who has passed away while defending our country. SSG Mark Wall died April 27, 2006, in Mosul, Iraq, where he was serving his country as part of Operation Iraqi Freedom. Staff Sergeant Wall was assigned to C Company, 2nd Battalion, 1st Infantry regiment in Fort Wainwright, AK. He was deployed to Iraq in August of 2005 and served near Mosul. I would like to extend my deepest sympathies to his parents, Arthur and Helen Wall, his two brothers and his sister.

Mark Wall graduated from Alden High School in 1997 where he participated in basketball, football, track, chorus, and band. He was a Boy Scout, attaining the rank of Eagle Scout in 1997. He also participated in 4–H, garden and photography projects, and FFA. Staff Sergeant Wall joined the Iowa National Guard in February of 1997. He attended classes at Ellsworth Community College studying agricultural business and worked as an electrician's helper before joining the Active-Duty Army in May of 2000.

I understand that Mark had a passion for the outdoors and took advantage of that passion while he was in Alaska, prospecting for gold, hiking, fishing, and skiing.

I would like to again give my condolences to the family of SSG Mark Wall. He served his country with pride and passion, and we are all saddened by his loss. I would like my colleagues in the Senate to take a moment and remember the life of Mark Wall and remember the tremendous sacrifice he gave for us and our great country.

SITUATION IN DARFUR

Mr. FEINGOLD. Mr. President, I join the American public and the international community in congratulating the signatories of the recent peace agreement signed in Abuja, Nigeria on May 5, 2006. I hope that this peace agreement marks a dramatic turning point in bringing about a solution to the genocidal conflict that has ravaged the Darfur region of Sudan. The administration deserves to be commended for getting the Sudanese government and the Sudan Liberation Army to the table and for maintaining a commitment to completing this peace process. This does not mean, however, that we or the international community can return to complacency, satisfied that we have done our part. Quite the contrary.

At this point, it is essential that the peace agreement be expanded to include those parties that have not yet signed. Those without a stake in the current political power and wealth sharing agreements will have few incentives to help build peace in the region, and will most likely be spoilers to the peace agreement. These parties must be encouraged to join and abide by the accord. Additionally, it is critical that the international community, working with the African Union, the United Nations, and regional partners, develop a comprehensive strategy to ensure that the peace agreement is implemented and adhered to by both the Government of Sudan and the Sudan Liberation Army. The Darfur region is facing an extremely fragile period. Now is the time to show international resolve for quelling the remaining instability throughout the region and for kick-starting all of the elements of the peace agreement. We must also move quickly to institute and strengthen mechanisms and systems to ensure that the parties to not backslide in to full-scale conflict.

In addition, we must strengthen the peacekeeping capabilities of the African Union and ensure that it has the capacity to help monitor and enforce the peace agreement. The African Union has worked hard to execute its broad and far-reaching mandate with limited resources and experience, and it will need support to be a contributor to establishing a lasting peace in the region. We must also work to introduce a United Nations peacekeeping mission into the region as quickly as possible. I applaud President Bush's decision to send Secretary Rice to the United Nations to seek a resolution authorizing a U.N. peacekeeping force in Darfur. I supported the recent amendment to the fiscal year 2006 emergency supplemental appropriations bill adding $60 million to fund a U.N. peacekeeping force in Darfur, matching similar legislation in the House. With this clear message of support from the U.S. Congress, it is now up to the administration to work with our friends and allies at the U.N. to reach agreement on a resolution authorizing a peacekeeping force, and exert robust diplomatic pressure on those who would try to block it.

We must not forget the massive humanitarian tragedy that is still unfolding. Even as the peace deal was being finalized, the U.N. World Food Program, WFP, announced that it would have to cut rations by over 50 percent in Darfur beginning in May. Many of the over 2 million refugees who have been forced from their homes and their livelihood are on the brink of starvation, and this already massive tragedy could yet take an even more devastating turn. Systematic gender-based violence against women and girls continues unabated and basic safety and security continue to be denied to Darfurians. Humanitarian organizations trying to work in the region face increasing difficulties in fulfilling their mission, and safe areas have diminished to unprecedented levels. The situation, in short, remains disastrous and the lives and well-being of millions hang in the balance. If anything, we must increase our efforts to protect the region most vulnerable, and to support Darfurians in this fragile period. Failure to do so could have a negative impact on the peace agreement.

Looking ahead to the implementation of the peace agreement and to establishing peace in the region, it will be critically important to address the crimes against humanity that have been committed, and to take a stand against the cycle of impunity and injustice that we have seen occur over the last 3 years. Those who commit crimes against humanity must know that the world is watching, and that they will be held accountable for their actions.

In conclusion, we have reasons to be optimistic. We must not ignore, however, the fact that now the hard work begins.

A MONTANA VISIT

Mr. BAUCUS. Mr. President, I am proud to rise today and announce a historic event in my home State. For only the second time in the history of Montana, our great State will welcome the President of Ireland. President Mary McAleese has displayed courage, intellect, determination, and passion as she has guided her country for nearly a decade. During this time her country has experienced unprecedented growth, quickly rising to the upper echelons of nations.

President McAleese will make an inaugural pilgrimage to a city whose history has been intimately tied with Ireland's for more than a century. In 1882, a lone Irish immigrant, driven by the work ethic instilled in his homeland and his desire to succeed, made a discovery that would forever change the face of Montana, the West, and America. The city was Butte, MT, and the man was Marcus Daly. Three hundred feet into the belly of the Earth, Daly set off an explosion that unearthed a revolution. Before his amazed eyes lay one of the riches veins of copper the world had every seen, and with it the unknowing hopes of millions of Irish immigrants.

Butte, and its neighbor to the northwest Anaconda, quickly became thriving metropolises turning these mining communities into a virtual mosaic of nationalities and ethnicities. When walking down the street, one could hear the chatter of Eastern Europeans, smell cooking from the Middle East, or view native dress from Scandinavia. But above all was the voice of the Irish. The Irish made Butte their own, easing their longing for their native Eire by molding the city to reflect the land from their past. The streets were vibrant with festivities straight from the homeland; these hard-working immigrants, ranging in professions from doctors to lawyers to miners and gandy dancers, populated this young bustling city and gave it the feel of an island thousands of miles away.

As the years passed, the pride of the Irish continued to ring strong, and with it the city of Butte. Butte quickly became the heart of Montana, and shaped the figures whose names would forever be remembered in the lore of our State. Names like Mike Mansfield and Burton Wheeler will be etched in the hearts and minds of Montanans for many years to come, and with them the tradition of the Irish.

Today, Butte remains a vibrant city, as the new generation of Irish-Americans listen to the whispers of their ancestors and continues to uphold the proud tradition of being Butte Irish. With the same values that turned this sleepy community into the heartbeat of the West, the people of Butte continue to thrive and the city remains as strong as the immigrants who first settled it.

As President McAleese is embraced by the spirit of this magnificent city and by the residents who carry on the

proud tradition of hailing from Butte, I say: may the road rise to meet you, may the wind be always at your back, may the sun shine warm upon your face, the rains fall soft upon your fields and, until we meet again, may God hold you in the palm of His hand.

THE HONORABLE STEPHEN M. McNAMEE

Mr. KYL. Mr. President, it is with great pride that I rise today to honor a respected jurist and dedicated public servant upon the occasion of his stepping down as the Chief Judge of the United States District Court for the District of Arizona.

The Honorable Stephen M. McNamee earned his bachelor of arts in history from the University of Cincinnati in 1964. He received his master of arts degree in 1967 and his juris doctor degree in 1969 from the University of Arizona.

Judge McNamee began his professional career as an assistant U.S. attorney, a position he held from 1971 to 1985. During that time, he was chief of the civil division in Tucson, chief assistant U.S. attorney, and first assistant U.S. attorney.

In 1985, President Reagan appointed him U.S. attorney for the District of Arizona. He made prosecuting violent crime within the 21 Native American communities in Arizona a top priority, particularly the prosecution of those who victimize Native American children. He also implemented model collection procedures for fines and penalty assessments of Federal defendants—the source of funding for the entire Victims of Crime Act program. Additionally, he testified before congressional committees on behalf of the Department of Justice regarding a variety of issues from terrorist threats to the southwest border, to child abuse and neglect on Indian reservations, to theft of Indian artifacts from archeological sites, to the reauthorization of the Victims of Crimes Act of 1984. At the behest of Attorney General Richard Thornburgh, he helped organize the first major conference to bring together American and Mexican criminal justice officials.

In 1990, he was appointed to the Federal bench by President George H.W. Bush, and in that capacity he developed a similar program to bring Mexican and U.S. Federal judges together to learn about each other's processes and procedures. As the chief judge of the District of Arizona, Judge McNamee managed a burgeoning docket. Since 1999, the filing of criminal cases went up 80 percent and civil case filings went up 59 percent. Nevertheless, under his leadership, the number of cases pending for 3 years or more has declined nearly 20 percent.

Judge McNamee has been an active liaison to Congress for the Administrative Office of the United States Courts and the Federal judiciary. He was appointed to the board of directors of the Federal Judges Association and has served on several Ninth Circuit and District of Arizona committees addressing a wide range of issues, from capital cases to racial, religious, and ethnic fairness to security issues.

As a distinguished member of the community, Judge McNamee has been the recipient of almost two dozen international, national, and State commendations and awards. He exemplifies the highest standards that we have come to expect from our judiciary, and we thank him for his service.

GREEN MOUNTAIN COFFEE ROASTERS: TOP CORPORATE CITIZEN

Mr. LEAHY. Mr. President, it gives me great pleasure to congratulate Mr. Bob Stiller, president and chief executive officer, and the 600 employees of Green Mountain Coffee Roasters on their selection as the Nation's top corporate citizen by Business Ethics Magazine. In the best traditions of Vermont, Green Mountain Coffee Roasters is about more than making a profit—they are about fostering a strong commitment to corporate social responsibility.

Through the company's support of organizations like the Rainforest Alliance, a non profit dedicated to protecting ecosystems, and Coffee Kids, an international nonprofit seeking to improve the quality of life for children and families in coffee-growing communities, Green Mountain Coffee Roasters has been a pioneer in the fair trade coffee movement. The company has also taken its socially responsible mission into the halls of our government, when, in 2002, Green Mountain formed a joint alliance with the U.S. Agency for International Development aimed at improving the livelihoods for those in improvised coffee growing regions.

Green Mountain has maintained these strong corporate ethics while continuing to build a robust earnings record. In 2005, the company reported revenue of $161.5 million, with net income of $9 million, a 15-percent increase over the year prior. And in the first quarter of fiscal year 2006, Green Mountain's fair trade coffee represented 26-percent of total sales, an increase of 68-percent compared to the same period last year.

I commend this outstanding Vermont company and ask unanimous consent that the Business Ethics article naming Green Mountain Coffee Roasters as the Nation's top corporate citizen be printed in the RECORD, along with a recent editorial from the Burlington Free Press.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From Business Ethics Magazine, Spring 2006]

100 BEST CORPORATE CITIZENS FOR 2006—CELEBRATING COMPANIES THAT EXCEL AT SERVING A VARIETY OF STAKEHOLDERS WELL

''We take them coffee picking, and they do some hand sorting of beans in the hot sun,'' says Winston Rost, Green Mountain Coffee Roaster's director of coffee appreciation, describing the annual trip he leads of a dozen employees, visiting coffee-growing cooperatives in Vera Cruz and Oaxaca, Mexico. With a newfound appreciation for how hard the work is, some roasters say they'll never spill another bean again, Rost adds. This kind of attention to the human element of business offers a hint at why Green Mountain Coffee of Waterbury, Vt., is No. 1 this year on the list of the 100 Best Corporate Citizens.

Since its founding in 1981, the company has been socially and environmentally active, ''but it wasn't all that extensive or organized at first,'' recalls CEO Bob Stiller. Green Mountain upped the ante in 1989 when it formed an environmental committee and created a rainforest nut coffee to support the Rainforest Alliance, a non-profit dedicated to protecting ecosystems. The company has grown increasingly active in the countries where coffee is grown and has been a pioneer in the fair trade movement, which pays coffee growers stable, fair prices. But the biggest change came in the early 1990s when the company began sending its employees on trips to see where the coffee is grown. Many employees ''said it changed their lives,'' Stiller adds.

Green Mountain, with 600 employees, saw 2005 revenue of $161.5 million with net income of $9 million, a 15 percent increase over the year prior. Since 1988, it has donated more than $500,000 to Coffee Kids, an international nonprofit seeking to improve the quality of life for children and families in coffee-growing communities. Through the Coffee Kids program, the company supports a micro-lending facility in Huatusco, Mexico and a sustainable sanitation system in Cosaulan, Mexico. It also has provided financial support to the FomCafe cooperative's quality control training program, which helps farmers earn higher profits for coffee.

In 2006 Green Mountain will release its first corporate responsibility report. ''We are focusing on measurement so we can understand the economic and social impact of the company and create indices so we can better focus those efforts,'' Stiller says. ''Just the process of getting all that information in one place is valuable,'' notes Michael Dupee, vice president of corporate social responsibility. ''It makes you think about and gain insight into what's working and what's not, so even if you never published anything, it's worthwhile.''

In 2004 the company expanded from one executive in social responsibility to three. Besides Dupee's position, there is a director of sustainable coffee and a vice president of environmental affairs. Some 45 percent of Green Mountain's coffee is purchased farmer-direct, which cuts out the share middle men take. And 20 percent of coffee sold is certified fair trade, which incorporates principles of environmental sustainability and respect for cultural identity, while guaranteeing growers minimums of $1.26 per pound when commodity prices might be far lower. Consumer interest in fair trade is growing, Stiller says, ''because through their purchases they are wanting to make a difference in the lives of growers.''

Efforts like these have earned Green Mountain a spot in the top 10 on Business Ethics' list for four years running. Its meticulous attention to corporate social responsibility conveys well what the 100 Best Corporate Citizens list is about. The best-managed firms today—in this era when societal expectations of business are rising—can no longer focus solely on stockholder return. Companies that aim to prosper over the long term also emphasize good jobs for employees, environmental sustainability, healthy community relations, and great products for customers.

Seeking to put numerical ratings on service to these various stakeholder groups, the 100 Best Corporate Citizens list uses data provided by KLD Research & Analytics of Boston. It employs statistical analysis to identify those major public U.S. companies that excel at serving a variety of stakeholders well, using eight measures of service: stockholders, community, governance, diversity, employees, environment, human rights, and product.

[From the Burlington Free Press, Apr. 29, 2006]

WATERBURY COFFEE FIRM DESERVES HIGH PRAISE

Vermont should take pride in the accomplishments of Green Mountain Coffee Roasters Inc., the Waterbury company named the nation's top corporate citizen by Business Ethics magazine.

For this company, which employs 600 people, the human dimension clearly matters. Employees, the local community and coffee workers in far-away places have benefited from Green Mountain Coffee's refreshing divergence from the standard of bottom-line business.

In its annual ''100 Best Corporate Citizens,'' Business Ethics magazine praised Green Mountain Coffee for its corporate social responsibility, in particular its commitment to fair trade, a Free Press story said. Fair trade ensures coffee growers are paid fairly with a guaranteed minimum price. Sales of the company's fair trade coffee have done extremely well, especially with a lucrative deal signed last fall with McDonald's restaurants in the Northeast.

Not only are the company's ethics admirable, Green Mountain also makes money—a winning combination that other businesses should heed for long-term success.

Within the organization, employees receive a firsthand education on the product they handle. Every year, a group of U.S. workers travel to coffee-growing areas in Mexico to experience the hard labor of picking and sorting beans. According to the magazine's Web site, the annual trips have given these employees a real appreciation of the work done in Mexico. It can be a life-changing experience.

The magazine, which has compiled the corporate citizens' list for seven years, has included Green Mountain Coffee in four of those years, including a second place last year. Chittenden Corp. was the only other Vermont business on the list, coming in at 26th place. The bank also deserves recognition.

To compile the list, eight measures of service are considered by Business Ethics: stockholders, community, governance, diversity, employees, environment, human rights, and the product, the magazine's Web site said.

There are many companies in Vermont that take their social responsibilities seriously. In 1990, Vermont Businesses for Social Responsibility was created by a group of businesspeople who shared the belief that companies have a duty to their employees, the environment and their communities as well as to their stockholders. Last month, the organization named Green Mountain Power of Colchester its ''Large Company Leader of the Year'' for the company's socially responsible approach to business. It's an impressive award, and a rare one for a utility.

With companies like Green Mountain Coffee, Chittenden Corp., and Green Mountain Power in our midst, the bar has been set high for other companies in the state and across the country. Bravo to them for leading the way.

ADDITIONAL STATEMENTS

HONORING JANE HUNN

● Mr. BAYH. Mr. President, I rise today to pay tribute to a remarkable science teacher, Jane Hunn, from Tippecanoe Valley Middle School in Akron. Last week, Jane was honored with the 2005 Presidential Award for Excellence in Mathematics and Science Teaching, the Nation's highest honor for teaching in these fields.

Jane is the only winner from Indiana and one of just 100 middle and high school teachers nationwide to receive this prestigious award. This award is an extraordinary honor to Jane. It recognizes her hard work and dedication to her students and their academic achievement.

Now more than ever, education is the key to greater personal opportunity. Here in Washington, I have fought to ensure that education is available and accessible to all our Nation's students. However, the real, heroic work is done on the ground, in our schools, by teachers like Jane.

Jane has concentrated on including hands-on learning in her classroom as a way to challenge and inspire her students. In her own words, she ''would much rather put the students in the active role of discoverers than be the fountain of knowledge. They really own their discoveries when they do activities and put together their own findings.'' By allowing them to take an active role in their own education, Jane has made science accessible to every student regardless of his or her learning ability.

Through countless hours of work both inside and outside the classroom, Jane has demonstrated her commitment to ensuring the success of future generations and to encouraging the curiosity and development of our Hoosier youth. I am sure that hundreds of Akron students both past and present, along with their families, join me in expressing my sincere gratitude for her efforts.

On behalf of the State of Indiana, I thank Jane for her dedication to her profession and our young people, and I am proud to enter her name in the CONGRESSIONAL RECORD of the Senate.●

AWARD TO DR. PHILIP GOLD

● Mrs. BOXER. Mr. President, today I rise to congratulate Dr. Philip Gold on receiving the Rabbi Norman F. Feldheym Award. The Rabbi Norman F. Feldheym Award was established to pay tribute to those members of Congregation Emanu El who have conspicuously and exceptionally reflected Rabbi Feldheym's qualities of love for and loyalty to the synagogue, service to the community, and the personal traits of humility, loving kindness, care, and love. Dr. Gold receives this award as part of the ceremonies marking the 115th anniversary of the founding of the congregation.

Dr. Philip M. Gold has been an extraordinarily devoted leader of Congregation Emanu El through his service as a member of its board of directors since 1990. He served as secretary, second vice-president, vice-president, and, from 2000 until 2002, he served as the president of the congregation.

During his remarkable tenure with Congregation Emanu El, Dr. Gold has masterfully guided it through a period of leadership change. He has been an inspirational leader of the congregation with a deep love for Judaism, participation in worship and education, and an exemplary commitment to Jewish values and their application to contemporary society.

In addition to his immense contributions to Congregation Emanu El, Dr. Gold is a highly respected physician and teacher, and he has been recognized by his colleagues as a leader in the field of medicine. He has served as the president of various medical organizations, and he has received numerous awards for his work and achievements.

As his family, colleagues, patients, and fellow congregants would attest, Dr. Philip M. Gold is a truly deserving recipient of an award that honors the importance of integrity, character, ethics, humility, and love for others. Throughout his life, Dr. Gold has consistently embodied the best ideals of human values.

I congratulate Dr. Philip M. Gold on receiving the Rabbi Norman F. Feldheym Award and wish him continued success in his future endeavors.●

100TH ANNIVERSARY OF NORTH AUGUSTA, SOUTH CAROLINA

● Mr. GRAHAM. Mr. President, I rise today to recognize the 100th anniversary of North Augusta, SC. Preceded by the settlements of Hamburg and Campbelltown, North Augusta was founded on the north bank of the Savannah River in 1892 by James U. Jackson, whose development company planned the city's original layout. Officially chartered a town on April 11, 1906, North Augusta remained small and mostly residential until the early 1950s when the Savannah River Site was built. Thereafter, the town tripled in size, becoming a city. During the next half century, as new subdivisions were constructed around the city, commercial development flourished. Today, North Augusta is known for its first-class recreational facilities, community league sports teams, and caring people. It is a city that prides itself on responsive government and a strong sense of community. With a healthy respect for its past, an emerging riverfront, and careful growth, the city's future is bright.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

ENROLLED JOINT RESOLUTION SIGNED

At 10:22 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the Speaker has signed the following enrolled joint resolution:

H.J. Res. 83. An act to memorialize and honor the contribution of Chief Justice William H. Rehnquist.

The enrolled joint resolution was subsequently signed by the President pro tempore (Mr. STEVENS).

At 11:33 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3829. An act to designate the Department of Veterans Affairs Medical Center in Muskogee, Oklahoma, as the Jack C. Montgomery Department of Veterans Affairs Medical Center.

H.R. 4204. An act to direct the Secretary of the Interior to transfer ownership of the American River Pump Station Project, and for other purposes.

H.R. 4902. An act to award a Congressional gold medal to Byron Nelson in recognition of his significant contributions to the game of golf as a player, a teacher, and a commentator.

H.R. 4912. An act to amend section 242 of the National Housing Act to extend the exemption for critical hospitals under the FHA program for mortgage insurance for hospitals.

H.R. 5037. An act to amend titles 38 and 18, United States Code, to prohibit certain demonstrations at cemeteries under the control of the National Cemetery Administration and at Arlington National Cemetery, and for other purposes.

H.R. 5311. An act to establish the Upper Housatonic Valley National Heritage Area.

The message also announced that the House has passed the following bill, without amendment:

S. 1382. An act to require the Secretary of the Interior to accept the conveyance of certain land, to be held in trust for the benefit of Puyallup Indian tribe.

The message further announced that the House agrees to the amendment of the Senate to the bill (H.R. 1499) to amend the Internal Revenue Code of 1986 to allow members of the Armed Forces serving in a combat zone to make contributions to their individual retirement plans even if the compensation on which such contribution is based is excluded from gross income, and for other purposes, with amendment.

At 6:19 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4297) to provide for reconciliation on the budget for fiscal year 2006.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3829. An act to designate the Department of Veterans Affairs Medical Center in Muskogee, Oklahoma, as the Jack C. Montgomery Department of Veterans Affairs Medical Center; to the Committee on Veterans' Affairs.

H.R. 4204. An act to direct the Secretary of the Interior to transfer ownership of the American River Pump Station Project, and for other purposes; to the Committee on Energy and Natural Resources.

H.R. 4902. An act to award a Congressional gold medal to Byron Nelson in recognition of his significant contributions to the game of golf as a player, a teacher, and a commentator; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 4912. An act to amend section 242 of the National Housing Act to extend the exemption for critical access hospitals under the FHA program for mortgage insurance for hospitals; to the Committee on Banking, Housing, and Urban Affairs.

PETITIONS AND MEMORIALS

The following petitions and memorials were, laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–292. A resolution adopted by the House of Representatives of the Legislature of the State of Michigan relative to funding fully the Select Michigan Agriculture Program through the United States Department of Agriculture; to the Committee on Agriculture, Nutrition, and Forestry.

HOUSE RESOLUTION NO. 181

Whereas, the Michigan Department of Agriculture introduced the Select Michigan campaign in the Grand Rapids area to encourage Michigan residents to purchase locally grown and produced foods. Recently expanded to the Detroit area, the program uses posters, banners, and stickers in Michigan grocery stores and farmers' markets to identify locally grown food products. Since 2001, the Select Michigan program has highlighted the numerous Michigan-grown products available in the state, including apples, asparagus, blueberries, cherries, chestnuts, corn, dry beans, honey, maple syrup, peaches, and strawberries; and

Whereas, access to fresh and nutritious food products is vital to the health and well-being of Michigan residents. Michigan farms, which are second in the nation in the diversity of agricultural products grown, provide residents with a wide variety of locally grown fruits and vegetables. Identifying and marketing these products to the local population enables residents to support Michigan's agricultural industry, which contributes significantly to Michigan's economic well-being. The impact of Michigan's agriculture on our economy is estimated to be $60.1 billion annually and growing; and

Whereas, in 2001, a one-time block grant of $3.75 million from the United States Department of Agriculture provided support to launch the Select Michigan program. The program is able to continue due to a unique funding partnership involving the private sector and the federal government. However, to ensure all Michigan residents have access to fresh and nutritious locally grown food products and allow the Select Michigan program to expand to encompass the state, full funding of this program by the federal government is necessary: Now, therefore, be it

Resolved, by the House of Representatives. That we memorialize the Congress of the United States to fund fully the Select Michigan agricultural program through the United States Department of Agriculture; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States Senate, the Speaker of the United States House of Representatives, and the members of the Michigan congressional delegation.

POM–293. A concurrent memorial adopted by the House of Representatives of the Legislature of the State of Arizona relative to enacting a 2007 Farm Bill that is supportive of the specialty crop industry; to the Committee on Agriculture, Nutrition, and Forestry.

HOUSE CONCURRENT MEMORIAL 2001

Whereas, the fruit, vegetable and tree nut production in the United S1ates accounts for $35 billion in farmgate value, or 33 percent of farm cash receipts, and with the addition of nursery and greenhouse production, overall specialty crops account for 51 percent of farmgate value; and

Whereas, in Arizona, fruit, vegetable and tree nut production represents a $1 billion industry representing over 35 percent of Arizona's farm cash receipts; and

Whereas, the fruit, vegetable and tree nut industry is a critical and growing component of United States agriculture, deserving of full and equal consideration as other agricultural sectors in the Farm Bill; and

Whereas, the fruit, vegetable and tree nut industry does not seek direct program payments to growers, but rather places its emphasis on building the long-term competitiveness and sustainability of United States fruit and vegetable production; and

Whereas, government investment in the competitiveness and sustainability of the United States fruit and vegetable industry will produce a strong return on investment for all of America, not just farmers, by expanding access and availability of safe, wholesome, healthy and affordable fruits and vegetables. The Farm Bill will be a critical component in reaching the mandate of doubling fruit and vegetable consumption called for in the USDA/HHS 2005 Dietary Guidelines; and

Whereas, with the government's mandate that domestic producers meet the very highest standards in environmental regulation, labor and other areas comes the responsibility to help those producers achieve cost-effective compliance through government investment in this agriculture industry to create a fair, level playing field with international competitors who do not face the regulatory burdens of United States producers; and

Whereas, without appropriate assistance, United States fruit, vegetable and tree nut production will relocate to less restrictive foreign growing areas; and

Whereas, a thriving and competitive United States fruit, vegetable and tree nut industry will support strong growth in export markets and improve our agricultural balance of trade in order to realize the goal of increasing exports; and

Whereas, it is critical that federal policy and resources support efforts to remove the many existing international trade barriers that continue to block United States fruit, vegetable and tree nut exports. Wherefore your memorialist, the House of Representatives of the State of Arizona, the Senate concurring, prays:

1. That the United States Congress recognize the importance of the specialty crop industry in the development of the 2007 Farm Bill.

2. That the United States Congress support the priorities of the specialty crop industry in the 2007 Farm Bill.

3. That the Secretary of State of the State of Arizona transmit copies of this Memorial to the President of the United States Senate, the Speaker of the United States House of Representatives and each Member of Congress from the State of Arizona.

POM—294. A joint resolution adopted by the Legislature of the State of Maine relative to memorializing the Secretary of the Navy to honor the gift of 1,000 acres known as the Brunswick Commons bestowed in 1719 by Pejepscot Proprietors to the Town of Brunswick forever and return it to the town at no cost; to the Committee on Armed Services.

JOINT RESOLUTION

We, your Memorialists, the Members of the One Hundred and Twenty-second Legislature of the State of Maine now assembled in the Second Regular Session, most respectfully present and petition the Honorable Gordon R. England, the Secretary of the Navy, as follows:

Whereas, nearly 300 years ago, in 1719, the Pejepscot Proprietors donated 1,000 acres of land in the township of Brunswick to be laid out as a ''general perpetual commonage to ye town of Brunswick forever''; and

Whereas, the Town of Brunswick accepted the gift in 1774 and laid out the 1,000 acres that would come to be known as Brunswick Commons. In 1783 a deed was conveyed to the town selectmen, and the land became property of the town forever; and

Whereas, an 1816 survey was recommended by the Town Commons committee as the correct survey of the land, and in 1891 granite monuments were placed to mark the boundaries of the deeded land; and

Whereas, the Federal Government took the majority of Brunswick Commons to build the Brunswick Naval Air Station, which served this nation well during World War II. Five of the original granite markers of the Brunswick Commons are within the boundary of the current base; and

Whereas, the base was deactivated after World War II in 1946 and recommissioned in 1951 and has been active since that date, providing support to the United States military as a vital part of America's defense system; and

Whereas, Brunswick Naval Air Station was targeted for decommissioning in the latest round of federal base closings, with the direction that the base be sold to the highest bidder instead of returning the land to its original use as described by deed; and

Whereas, the original deed clearly meant for this land to be for the common good of the Town of Brunswick and, while the subsequent use of the land for Brunswick Naval Air Station was important for our national security, the Town of Brunswick and the people of Maine feel strongly that, since the Federal Government no longer has need of this land, it should be returned to its original source; and

Whereas, the Town of Brunswick declared in 1968 the full 1,000 acres of the Brunswick Commons to be an Historic Landmark, and the Town of Brunswick and the people of the State of Maine seek to make the original Brunswick Commons whole again, at no cost to the Town of Brunswick: Now, therefore, be it

Resolved, That We, your Memorialists, on behalf of the people we represent, respectfully urge and request that Secretary England do all in his power to see that the land deeded to the people of Brunswick be returned to the people of Brunswick at no cost, now that the Federal Government no longer wants this historical tract of land; and be it further

Resolved, That suitable copies of this resolution, duly authenticated by the Secretary of State, be transmitted to the Honorable Gordon R. England, the Secretary of the Navy, the President of the Senate and the Speaker of the House of Representatives of the Congress of the United States and each Member of the Maine Congressional Delegation.

POM–295. A resolution adopted by the Senate of the Legislature of the State of Hawaii relative to authorizing and appropriating funds to allow all members of the armed forces reserve component to access the TRICARE program; to the Committee on Armed Services.

SENATE RESOLUTION NO. 92

Whereas, Army National Guard members are fulfilling commitments in Iraq, Afghanistan, Bosnia, and the Sinai, with members of the Hawaii Army National Guard having recently served in Iraq and Afghanistain; and

Whereas, presently almost half of all service personnel deployed in Iraq are members of the reserve components of the United States armed forces, including members of the National Guard and Army, Navy, Air Force, and Marine Corps Reserves; and

Whereas under present law, for every ninety day period on active duty, a member of the reserve component receives one year of cost-share TRICARE health benefits if the member agrees to serve that year with a reserve component; and

Whereas, while well-intentioned, this measure does not go far enough to solve the problem of medical readiness that exists in the reserve component and can affect the mobilization and deployment of intact reserve component units; Now, therefore, be it

Resolved, By the Senate of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2006, that the Congress of the United States is urged to authorize and appropriate funds to allow all members of the reserve component to access TRICARE health benefit coverage on a cost-share basis, without restrictions; and be it further

Resolved, That certified copies of this Resolution be transmitted to the President of the United States Senate, the Speaker of the United States House of Representatives, the Secretary of Defense, members of Hawaii's congressional delegation, the Governor, and the Adjutant General.

POM–296. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to taking such actions as are necessary to amend the Stafford Act to allow the use of emergency funds under the Federal Emergency Management Agency for stabilization and restoration of barrier islands; to the Committee on Banking, Housing, and Urban Affairs.

HOUSE CONCURRENT RESOLUTION NO. 62

Whereas, the Stafford Act is the federal act which authorizes uses of federal emergency funds under the Federal Emergency Management Agency (FEMA), with such authorized uses including re-establishment of vital and necessary infrastructure such as utilities, roads, levees, and other hurricane protection structures, hospitals, and facilities needed to house public agencies responsible for necessary public services; and

Whereas, coastal communities are dependent on the protection that barrier islands provide from storms originating off the coast, including the winds and storm surges associated with storms; and

Whereas, the storms from which the barrier islands soften the blow for coastal communities are not only hurricanes but include severe thunderstorms, tropical storms, and of course, hurricanes; and

Whereas, stabilization and re-establishment of barrier islands is an essential infrastructure need for coastal communities in the same manner as re-establishment of electricity, water, sewerage, and roads; therefore, such work on barrier islands should qualify for use of emergency funds under the Stafford Act: Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to amend the Stafford Act to allow the use of emergency funds under the Federal Emergency Management Agency for stabilization and restoration of barrier islands; be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–297. A joint memorial adopted by the Legislature of the State of Washington relative to section 5 of the Marine Mammal Protection Act of 1972 being preserved to continue protecting Puget Sound for current and future citizens of Washington and the United States to enjoy; to the Committee on Commerce, Science, and Transportation.

HOUSE JOINT MEMORIAL 4031

Whereas, Puget Sound provides significant economic and natural resource benefits to the citizens of Washington and the United States; and

Whereas, the state of Washington has adopted an oil spill prevention program with a zero spills strategy to protect the natural beauty of and economic benefits provided by Puget Sound; and

Whereas, the national marine fisheries service has listed the orca whale, Puget Sound chinook salmon, and Hood Canal summer chum under the federal endangered species act, bringing the total number of species listed as threatened, endangered, or candidate species on state and federal lists to forty; and

Whereas, in 1977, Senator Warren Magnuson declared that: ''The waters of Puget Sound, and the attendant resources, are indeed a major national environmental treasure. Puget Sound ought to be strictly protected; its resources ought not to be threatened. Since tanker accidents are directly related to the amount of tanker traffic, there should not be an expansion of traffic over what now presently exists.'';

Whereas, the Magnuson Amendment has protected Puget Sound waters from oil spill risks for twenty-eight years by limiting the amount of oil delivered to Washington refineries by tanker to the quantity used by Washington consumers; and

Whereas, the Washington State Department of Ecology reported in 2004 that approximately six hundred tankers a year

enter Washington waters, and additional tanker traffic would significantly increase the likelihood of oil spills in Puget Sound; and

Whereas, the Magnuson Amendment has effectively limited tankers headed for refineries at Anacortes and Cherry Point near Ferndale by prohibiting federal agencies from issuing permits for the construction or expansion of dock or related facilities unless that expansion was necessary to meet increased Washington state demand;

Now, therefore, Your Memorialists respectfully pray that section 5 of the Marine Mammal Protection Act of 1972 (33 U.S.C. Sec. 476) be preserved to continue protecting Puget Sound for current and future citizens of Washington and the United States to enjoy; be it

Resolved, That copies of this Memorial be immediately transmitted to the Honorable George W. Bush, President of the United States, the Secretary of the United States Department of Commerce, the President of the United States Senate, the Speaker of the House of Representatives, and each member of Congress from the State of Washington.

POM–298. A resolution adopted by the Senate of the Legislature of the State of Louisiana relative to enacting the ''Domestic Energy Production through Offshore Exploration and Equitable Treatment of State Holdings Act of 2006''; to the Committee on Energy and Natural Resources.

SENATE RESOLUTION NO. 19

Whereas, the state of Louisiana currently receives only a small percentage of royalties for oil and gas production in federal waters off the coast of Louisiana; and

Whereas, other states in the United States receive fifty percent of royalties for oil and gas production on federal lands; and

Whereas, this current policy creates an inequity and results in Louisiana not receiving its fair and equitable share of royalty payments; and

Whereas, Louisiana has a greater need than other states to protect its state, its citizens and its infrastructure from coastal erosion and the effects associated with such coastal erosion, such as the impacts from hurricanes and tropical storms; and

Whereas, prior to hurricanes Katrina and Rita, Louisiana accounted for thirty percent of the commercial fisheries production of the lower forty-eight states, and ranked second in the nation for recreational harvest of saltwater fish; and

Whereas, prior to hurricanes Katrina and Rita, Louisiana produced more than eighty percent of the nation's offshore oil and gas supply while providing billions of dollars each year to the Federal treasury; and

Whereas, the United States has consistently received the economic benefits from the coast of Louisiana without Louisiana receiving its fair share of these benefits; and

Whereas, H.R. 4761 will provide the state of Louisiana up to seventy-five percent of oil and gas royalties produced off the coast of Louisiana; and

Whereas, these monies generated by the enactment of H.R. 4761 will provide billions of dollars for Louisiana over the next few decades which can be used for coastal restoration and protection; and

Whereas, leaders throughout Louisiana from Congressman Bobby Jindal, who introduced the bill, to Governor Kathleen Blanco who endorsed it, have come forward to urge its passage: Therefore, be it

Resolved, That the Senate of the Legislature of Louisiana memorializes the Congress of the United States to enact H.R. 4761, the ''Domestic Energy Production through Offshore Exploration and Equitable Treatment of State Holdings Act of 2006''; be it further

Resolved, That a copy of this Resolution shall be transmitted to the secretary of the United States Senate and the clerk of the United States House of Representatives and to each member of the Louisiana delegation to the United States Congress.

POM–299. A resolution adopted by the House of Representatives of the Legislature of the State of Michigan relative to encouraging expansion of existing, or the construction of new petroleum refineries in the United States and to urging the petroleum industry to construct new refineries to meet our increasing energy needs; to the Committee on Energy and Natural Resources.

HOUSE RESOLUTION NO. 67

Whereas, the price of petroleum products has been rising out of control. Currently, the world crude oil price remains near 60 dollars a barrel, practically 30 dollars more than this time last year. Additionally, the national average price of regular gasoline is about 38 cents per gallon more than last year and diesel is almost 54 cents per gallon more than this time last year; and

Whereas, there has not been a new oil refinery built in the United States in nearly 30 years. Yet, in the intervening years, the total energy demand in the United States has grown by about 40 percent. According to the United States Energy Information Administration, the projected petroleum demand between 2003 and 2025 will increase by 30 percent. We need to plan for our future energy needs by incorporating new petroleum refineries into the United States' overall energy policy; and

Whereas, recent major investments in the Marathon Refinery located in the City of Detroit, Michigan's only refinery, will increase the output by about 28 percent, from 74,000 barrels per day to over 102,000 barrels per day. Securing Marathon's investment of $300 million was made possible through the collaborative efforts of Marathon, the city of Detroit, and the state of Michigan. Marathon's commitment to Michigan and the collaboration with the city and state to create a renaissance zone encompassing the refinery illustrates the type of creative solutions that can be used to promote the construction of new refineries; and

Whereas, constructing new refineries would also create new jobs and increase gasoline, fuels, and distillate output—all vital components of strengthening our economy. Michigan is well placed to locate a new refinery due to our proximity with Canada, this country's largest source of imported petroleum. Moreover, Michigan's highly skilled labor force could adapt to employment in the refinery industry; now, therefore, be it

Resolved by the House of Representatives, That we memorialize the Congress of the United States to establish a national energy policy that promotes the expansion of existing or construction of new petroleum refineries in the United States. We also urge the leaders of the petroleum industry to construct new refineries to meet our increasing energy needs; and be it further

Resolved, That it is our intention to work with local governments to identify appropriate locations for new refineries in Michigan communities that have a recognized commitment to job growth and this industry; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States Senate, the Speaker of the United States House of Representatives, the members of the Michigan congressional delegation, the United States Environmental Protection Agency, the United States Department of Energy, the Michigan Petroleum Institute, and the American Petroleum Industries of Michigan.

POM–300. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to memorializing Congress to reauthorize the Abandoned Mine Reclamation Fund; to the Committee on Energy and Natural Resources.

HOUSE RESOLUTION NO. 382

Whereas, substantial coal mining has occurred in Pennsylvania for more than 130 years, and the industry has been a significant employer of our citizens for most of these years; and

Whereas, abandoned mines pose hazards in Pennsylvania of dangerous shafts, mountains of black waste, scarred landscapes, acidic drainages polluting more than 3,000 miles of our streams. and other hazards threatening human health and safety and depressing local economies; and

Whereas, at least 44 of Pennsylvania's 67 counties are affected by abandoned coal mines; and

Whereas, abandoned mines and abandoned mine lands create negative impacts on local economies by destroying recreational opportunities, lowering land values, leaving desolate communities once the mines are exhausted and ruining sites for further residential, forestry, commercial or agricultural uses; and

Whereas, reclamation of abandoned mine sites can add to the economy by creating jobs, increasing community pride, increasing property values, decreasing stress-related costs through streambased recreation, restoring the health of the environment and providing future sites for commercial or industrial endeavors; and

Whereas, Congress established the Abandoned Mine Reclamation Fund under Title IV of the Surface Mining Control and Reclamation Act of 1977 to reclaim areas abandoned before 1977 and the modern environmental standards requiring mine operators to reclaim their sites; and

Whereas, the Surface Mining Control and Reclamation Act of 1977 imposed on coal operators a fee of 35¢ per ton on surface I mined coal and 15¢ per ton on underground mined coal to provide a source of revenue for the Abandoned Mine Reclamation Fund to help finance the reclamation and remediation of lands mined prior to 1977; and

Whereas, the collection of fees on mined coal applied to the Abandoned Mine Reclamation Fund under Title IV of the Surface Mining Control and Reclamation Act of 1977 was set to expire on June 30, 2005, but is currently under extension to October 30, June 30, 2006; and

Whereas, Pennsylvania has relied upon the Abandoned Mine Reclamation Fund as a primary source of money to clean up toxic mine water in our water supplies, restore land, extinguish mine fires and eliminate other dangerous abandoned mine hazards: Now, therefore be it

Resolved (the Senate concurring), That the General Assembly of the Commonwealth of Pennsylvania memorialize the Congress of the United States to reauthorize the collection of fees on mined coal at the current levels to provide continued funding to the Abandoned Mine Reclamation Fund to address abandoned mine hazards, pollution and scarred landscapes in Pennsylvania and other States.

POM–301. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to taking such actions as are necessary to immediately close the Mississippi River Gulf Outlet and to request that the Louisiana congressional delegation file the necessary legislation to accomplish this closure; to the

Committee on Environment and Public Works.

HOUSE CONCURRENT RESOLUTION NO. 38

Whereas, the Mississippi River Gulf Outlet (MRGO), a seventy-six-mile-long, man-made navigational channel which connects the Gulf of Mexico to the Port of New Orleans, was authorized by the United States Congress under the Rivers and Harbors Act of 1956 as a channel with a surface width of six hundred fifty feet, a bottom width of five hundred feet, and a depth of thirty-six feet, and it opened in 1965; and

Whereas, since MRGO was completed, the United States Army Corps of Engineers estimates that the area has lost nearly three thousand two hundred acres of fresh and intermediate marsh, more than ten thousand three hundred acres of brackish marsh, four thousand two hundred acres of saline marsh, and one thousand five hundred acres of cypress swamps and levee forests in addition to major habitat alterations due to saltwater intrusion from the loss of the marshes, which has resulted in dramatic declines in waterfowl and quadruped use of the marshes; and

Whereas, the costs of maintaining MRGO rise each year, with the cost of dredging now over twenty-five million dollars annually, or more than thirteen thousand dollars for each vessel-passage, in addition to the expenditure of millions for shoreline stabilization and marsh protection projects, with an anticipated cost increase of fifty-two percent between 1995 and 2005; and

Whereas, concerns about the environmental impact have increased through the years as evidenced by the fact that in 1998 the ''Coast 2050 Report'' contained closure of MRGO among the consensus recommendations, and the technical committee of the Coastal Wetland Planning, Preservation and Restoration Act Task Force listed closure as one of the highest-ranked strategies for coastal restoration; and

Whereas, in 1998 the St. Bernard Police Jury voted unanimously to request closure of the waterway because of fears that the dramatic loss of coastal wetlands and marshes caused by MRGO exposed the parish and the communities in the parish to much more severe impacts from the hurricanes and tropical storms that regularly occur in the Gulf of Mexico; and

Whereas, those concerns were echoed and amplified by scientists, engineers, and citizens throughout the region as reflected in requests from the Louisiana Legislature to congress in 1999 (SCR No. 266) and again in 2004 (HCR No. 35 and HCR No. 68) to close the waterway, and indeed, those concerns proved true in an extremely dramatic fashion on August 29, 2005, when Hurricane Katrina struck Louisiana's coast with a tidal surge well in excess of twenty feet; and

Whereas, there is a growing consensus that the flooding that occurred in St. Bernard Parish, New Orleans East, and the Lower Ninth Ward of New Orleans was a result of storm surge that flowed up MRGO to the point where it converges with the Intracoastal Waterway and that the confluence created a funnel that directed the storm surge into the New Orleans Industrial Canal, where it overtopped the levees along MRGO and the Industrial Canal and eventually breached the levees and flooded into the neighborhoods that lie close to those three waterways, resulting in more than eleven hundred deaths in the Greater New Orleans area, including one hundred twenty-eight deaths in St. Bernard Parish, destroying over twenty-four thousand homes, and rendering more than sixty-seven thousand residents of St. Bernard Parish and uncounted numbers in New Orleans East and the Lower Ninth Ward of New Orleans homeless, without possessions, and unemployed; and

Whereas, in addition to destroying homes, the flood waters washed away churches and other places of worship, schools, businesses, community centers, recreational facilities, utility and transportation infrastructure, in short the very fabric of society was decimated in these communities; and

Whereas, only three weeks later, on September 24, 2005, storm waters from Hurricane Rita surged up MRGO and caused additional flooding in St. Bernard Parish, New Orleans East, and the Lower Ninth Ward of New Orleans, exacerbating the traumatic losses in that area; and

Whereas, since the two hurricanes caused such widespread damage in St. Bernard Parish and New Orleans, congress has declined to appropriate further funds for dredging MRGO; and

Whereas, some engineers have opined that the current base along MRGO was damaged to the point that it will not support a Category 3 levee in the future; and

Whereas, the United States Army Corps of Engineers has stated that it has no authorization from congress to close the waterway or to fill the waterway to allow for the development of marshes and wetlands; and

Whereas, as the only entity which can authorize the waterway to be closed and which can enable the reestablishment of our essential coastal wetlands, the United States Congress must come to the aid of the citizens of Louisiana, particularly those of St. Bernard Parish and New Orleans by authorizing the immediate closure of MRGO; and

Whereas it is the responsibility of the Louisiana delegation to file the necessary legislation to accomplish the immediate closure of MRGO: Now, therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to immediately close the Mississippi River Gulf Outlet: and be it further

Resolved, That the Legislature of Louisiana does hereby urge and request the Louisiana congressional delegation to file the legislation necessary to accomplish this closure: and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–302. A resolution adopted by the Senate of the Legislature of the State of New Jersey relative to enacting the ''Solid Waste Environmental Regulation Clarification Affecting Railroads Act of 2005''; to the Committee on Environment and Public Works.

SENATE RESOLUTION NO. 14

Whereas, a [conflict in] *provision of* Federal law [and policy] has resulted in the operation of certain solid wastehandling facilities located on railroad property to go unregulated; that certain Federal laws, notably the ''Solid Waste Disposal Act,'' should apply to the operation of these facilities; that [,unfortunately,] a broad-reaching Federal railroad statute [forbids] *has been interpreted by some courts as forbidding* environmental regulatory agencies from overseeing the safe handling of trash at these sites; and that these unintended consequences require the attention of and swift action by the United States Congress in enacting S. 1607, the ''Solid Waste Environmental Regulation Clarification Affecting Railroads Act of 2005''; and

Whereas, the Federal railroad law in question was enacted most recently in the ''Interstate Commerce Commission Termination Act of 1995'' to protect the operation of interstate rail service; that this law grants *literally* ''exclusive'' jurisdiction over rail transportation, and activities incident thereto, to the Federal Surface Transportation Board; that the Board is limited to only a passive role in ensuring that rail facilities are operated with minimal detriment to the public health and safety; and that these sites require active environmental regulation in the same manner that Federal and State environmental regulatory agencies regulate the operation of conventional solid waste handling, processing, transfer and disposal facilities; and

Whereas, the recent proliferation of solid waste rail transfer facilities has affected the ability of State and local governments in New Jersey and elsewhere to engage in environmentally sound long-term solid waste management planning and enforcement; and that, nevertheless, these agencies are still responsible for responding to accidents and incidents occurring at these facilities; and

Whereas, the [State] *New Jersey* Department of Environmental Protection (DEP) fined New York Susquehanna and Western (NYS&W) Railway Corporation $2.5 million for environmental violations associated with the operation of five solid waste transfer sites in North Bergen; that as a result. of seven investigations conducted from November 2004 to July 2005, DEP determined that NYS&W illegally operates five sites which load solid waste from trucks to rail cars; that one of the sites handles bulk shipments of soil and other State regulated waste associated with specific site remediation projects, while the remaining sites are open dumps that handle construction and demolition waste; and that DEP [cites] *cited* NYS&W with violating New Jersey's solid waste and air pollution laws at all five sites by loading solid and hazardous waste materials outdoors, failing to regularly clean areas in which solid waste is handled and failing to contain, collect and dispose of wastewater; and *that the District Court of New Jersey based on the Federal railroad law has temporarily restrained DEP from enforcing its solid waste regulations; and*

Whereas, in addition, DEP cited NYS&W for spilling hazardous waste, failing to contain litter and debris, and accumulating unprocessed waste in the area surrounding the facilities; that NYS&W also failed to control insects and rodents and emitted odor, dust and solid waste particles into the outdoor atmosphere in quantities resulting in air pollution; and that, notwithstanding the foregoing, *it has been argued that* Federal railroad law preempts enforcement actions such as this, even though the Surface Transportation Board has never [clarified whether it even has] *asserted* jurisdiction over the processing and sorting of solid waste at a rail facility; and

Whereas, constructing a transfer station in a former junkyard site in Elwood, a hamlet in Mullica Township, Atlantic County, a proposal by the Southern Railroad of New Jersey, is being resisted for health and safety reasons and challenged by the Pinelands Commission to respect requirements and protections accorded the Pinelands National Reserve under Federal and State statutes; and *the District Court of New Jersey has granted the State of New Jersey a preliminary injunction. ordering that the Pinelands Commission has jurisdiction over the proposed construction; and*

Whereas, the enactment of S. 1607 would ensure that Congress' intent was not to subvert the policies of the ''Solid Waste Disposal Act'' and other Federal and State environmental laws covering the handling of garbage; and that this bill's underlying purpose is to clarify that the true intent of Congress

in passing the solid waste law and the ''Interstate Commerce Commission Termination Act of 1995'' is to ensure that these laws work in tandem to provide for a robust, environmentally responsible rail system: Now, therefore, be it

Resolved by the Senate of the State of New Jersey:

1. This Senate Resolution memorializes Congress to enact S. 1607, the ''Solid Waste Environmental Regulation Clarification Affecting Railroads Act of 2005,'' in order to address the unregulated sorting and processing of waste materials at rail facilities.

2. Duly authenticated copies of this resolution, signed by the President of the Senate and attested by the Secretary thereof, shall be transmitted to the Vice President of the United States, the Speaker of the United States House of Representatives, the majority and minority leaders of the United States Senate and the United States House of Representatives, and each member of Congress elected from this State.

POM–303. A joint memorial adopted by the Legislature of the State of Washington relative to enacting the ''Kidney Care Quality Improvement Act of 2005; to the Committee on Finance.

HOUSE JOINT MEMORIAL 4023

Whereas, four hundred thousand Americans have irreversible kidney failure, a condition called ''End Stage Renal Disease'' (ESRD). ESRD is fatal unless a patient receives either dialysis or kidney transplantation. Since transplantation is limited due to the shortage of donor organs, seventy-five percent of ESRD patients must undergo regular and on-going dialysis treatment for the rest of their lives. In Washington State approximately 16,000 residents have ESRD; and

Whereas, today's ESRD patients are older and sicker due primarily to the aging of the population, and the growing incidence of diabetes and high blood pressure, fueled by the obesity epidemic. ESRD disproportionately impacts African-American and Hispanic individuals; and

Whereas, most patients with ESRD lack access to education programs about their disease that would allow them to make informed choices about their treatment and learn important self-management skills to improve their quality of life; and

Whereas, according to the most recent data available, less than one percent of all ESRD patients use home dialysis because of the barriers patients face in accessing this option. Home dialysis can improve a patient's quality of life by allowing him or her to remain employed and participate in other activities that promote well-being; and

Whereas, there is no coordinated effort between federal and state governments, health care professionals, dialysis providers, educators, patient advocates to develop programs to identify members of high-risk populations and develop culturally appropriate community-based approaches for improving the treatment of chronic kidney disease, which would lead to fewer cases of ESRD; and

Whereas, since 1972, Congress made a commitment to ESRD patients by providing coverage for the lifesaving therapy and dialysis, through the Medicare program. Medicare provides for the care of approximately seventy-five percent of patients receiving dialysis. Improvements are needed to continue to ensure access to high quality treatment for ESRD patients. Better care for patients means a better quality of life, improved rehabilitation, fewer medications, and fewer hospitalizations; and

Whereas, the rate paid by Medicare for ESRD services is the only Medicare prospective payment system without an annual update mechanism to adjust for increases. This means providers must ask Congress for increases rather than relying on the Department of Health and Human Services to make routine, data-driven decisions on payment adequacy. In the past twelve years, there have been only two increases in the ESRD composite rate, totaling 3.6 percent, to cover inflation, new technologies, and other costs, such as nurses' salaries. When adjusted for inflation, the average Medicare payment for dialysis treatment has been reduced from $138 in 1973 to $38 in 2000. The program is no longer sustainable under the current reimbursement structure;

Now, therefore, your Memorialists respectfully request that the United States House of Representatives and the United States Senate enact H.R. 1298 and S. 635, known as the ''Kidney Care Quality Act of 2005.'' The Act will modernize and update treatment of ESRD by adding Medicare coverage for kidney disease patient education services, improve the home dialysis benefit, and provide for an annual update for the Medicare ESRD composite rate. A demonstration project for an outcomes-based ESRD reimbursement system, as well as a study of barriers to accessing the home dialysis benefit, will lead to future improvements in delivery of care. A chronic kidney disease demonstration project will increase public awareness about the disease, with the goal of lowering the number of persons who will need kidney dialysis: Now, therefore, be it

Resolved, That copies of this Memorial be immediately transmitted to the Honorable George W. Bush, President of the United States, the President of the United States Senate, the Speaker of the House of Representatives, and each member of Congress from the State of Washington.

POM–304. A joint memorial adopted by the Legislature of the State of Washington relative to the ''Diabetes Self-Management Training Act''; to the Committee on Finance.

HOUSE JOINT MEMORIAL 4038

Whereas, diabetes is now widely recognized as one of the top public health threats facing our nation today and affects more than 18 million Americans. In 2002, diabetes accounted for 132 billion dollars in direct and indirect health care costs; and

Whereas, diabetes now affects nearly 1.4 million Washington residents: Over 298,000 people in Washington have been diagnosed with diabetes; over 126,000 people have undiagnosed diabetes; and over 963,000 people have prediabetes; and

Whereas, people who have diabetes need skills to manage their diabetes and skills to help them stay active in their lives. This training is central to diabetes prevention and care; and

Whereas, chronic disease self-management programs have a proven success rate, allowing persons with diabetes to better control their diabetes; and

Whereas, persons living with diabetes who are properly trained with self-management skills are better able to prevent the deadly complications of diabetes, which can include heart disease, stroke, blindness, lower extremity amputation, and kidney failure; and

Whereas, certified diabetes educators are highly trained multidisciplinary health care professionals dedicated to delivering quality diabetes self-management training; and

Whereas, evidence has shown that access to a certified diabetes educator improves the management of diabetes, a chronic illness that requries a high level of maintenance; and

Whereas, certified diabetes educators teach people with diabetes how to maintain the daily rigors of diet, exercise, meal planning, medication monitoring, healthy coping skills, and other factors necessary to control the disease; and

Whereas, certified diabetes educators are also on the front line of the efforts to promote prevention of diabetes; and

Whereas, Congress recognized the value of diabetes self-management training when it began covering the benefit in the Balanced Budget Act of 1997. At that time, most certified diabetes educators worked in a hospital setting and were able to bill Medicare for their services through the hospital's provider number. Unfortunately, during these tough economic times, hospitals are closing their diabetes education programs at a rate of two to five per month. This leaves diabetes educators without an avenue to provide or bill for diabetes education—services which are desperately needed to keep up with the growing number of people diagnosed with diabetes each day; and

Whereas, certified diabetes educators have received extensive training in diabetes management. They have met all criteria for initial certification, including a prerequisite qualifying professional credential in a specified health care profession, have professional practice experience in diabetes self-management training that includes one thousand hours of diabetes teaching, have passed a national examination offered by a certifying body recognized as entitled to grant certification to diabetes educators, and are required to renew the certification every five years;

Now, therefore, your Memorialists respectfully request that the United States House of Representatives and the United States Senate enact Senate Bill 626 and House Bill 3612, known as the ''Diabetes Self-Management Training Act.'' The Act will increase access to diabetes care by adding certified diabetes educators to the current list of Medicare providers, thereby making certified diabetes educators billable providers: Now, therefore, be it

Resolved, That copies of this Memorial be immediately transmitted to the Honorable George W. Bush, President of the United States, the President of the United States Senate, the Speaker of the House of Representatives, and each member of Congress from the State of Washington.

POM–305. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to reviewing and considering eliminating provisions of law which reduce social security benefits for those receiving benefits from federal, state, or local government retirement systems; to the Committee on Finance.

HOUSE CONCURRENT RESOLUTION NO. 63

Whereas, the Congress of the United States has enacted both the Government Pension Offset (GPO), reducing the spousal and survivor social security benefit, and the Windfall Elimination Provision (WEP), reducing the earned social security benefit for persons who also receive federal, state, or local retirement; and

Whereas, the intent of congress in enacting the GPO and the WEP provisions was to address concerns that a public employee who had worked primarily in federal, state, and local government employment might receive a public pension in addition to the same social security benefit as a worker who had worked only in employment covered by social security throughout his career; and

Whereas, the purpose of congress in enacting these reduction provisions was to provide a disincentive for public employees to receive two pensions; and

Whereas, the GPO negatively affects a spouse or survivor receiving federal, state, or

local government retirement benefits who would also be entitled to a social security benefit earned by a spouse; and

Whereas, the GPO formula reduces the spousal or survivor social security benefit by two-thirds of the amount of the federal, state, or local government retirement benefit received by the spouse or survivor, in many cases completely eliminating the social security benefit; and

Whereas, the WEP applies to those persons who have earned federal, state, or local government retirement benefits, in addition to working in covered employment and paying into the social security system; and

Whereas, the WEP reduces the earned social security benefit using an averaged indexed monthly earnings formula and may reduce social security benefits for such persons by as much as one-half of the uncovered public retirement benefits earned; and

Whereas, because of these calculation characteristics, the GPO and WEP have a disproportionately negative effect on employees working in lower-wage government jobs, like policemen, firefighters, teachers, and state employees; and

Whereas, these provisions also have a greater adverse effect on women than on men because of the gender differences in salary that continue to plague our nation; and

Whereas, Louisiana is making every effort to improve the quality of life of her citizens and to encourage them to live here lifelong: Now, therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the Congress of the United States to review the GPO and WEP social security benefit reductions and to consider eliminating them; and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation and to the school boards of Beauregard, Calcasieu, Rapides, and Vernon parishes.

POM–306. A resolution adopted by the Senate of the Legislature of the State of Illinois relative to enacting a prescription drug benefit for senior citizens that is run by the Medicare program itself; to the Committee on Finance.

SENATE RESOLUTION NO. 630

Whereas, the Medicare prescription drug benefit enacted in 2003 took effect January 1, 2006, in the form of competing ''Medicare Part D'' plans sold by private insurance companies; and

Whereas, senior citizens are choosing from a wide array of private plans in each geographic area, with a confusing variety of designs and formularies; and

Whereas, the law states that a Medicare plan's formulary must cover just one brandname drug and one generic drug in each therapeutic category—a minimal requirement that will make it difficult for an older person to find all the drugs he/she takes in a single plan; and

Whereas, the drug plans will be allowed to switch the drugs in their formularies on a regular basis, making it likely that many seniors will sign up for a plan that covers a drug they take, only to find out a few months later that the drug is no longer covered by their plan; and

Whereas, the drug plans will bargain with the drug companies for lower prices, but instead of being required to pass the discounts on to seniors, they will be allowed to use the savings for advertising and overhead costs, or to increase their profits; and

Whereas, private drug plans will be unable to bargain effectively, because the Medicare market will be divided among hundreds of plans, diminishing the negotiating power of the huge Medicare population; and

Whereas, a drug benefit that's run by the Medicare program itself, rather than private insurance, could be given the authority to negotiate prices on behalf of all 44 million beneficiaries—resulting in enormous buying power and the ability to get the lowest prices possible; and

Whereas, this was born out by a recent study conducted by Families USA (September 2005), which found that the lowest drug prices negotiated by the private sponsors of the 2004/2005 Medicare discount cards far exceeded the low prices routinely negotiated by the Department of Veterans Affairs on behalf of the nation's veteran population; and

Whereas, seniors would not only benefit by the lower prices of a Medicare-run drug plan, but many would find a Medicare choice much less confusing than having to choose the most appropriate plan from among the dozens being marketed by private insurers: Now, therefore, be it

Resolved, by the Senate of the Ninety-Fourth General Assembly of the State of Illinois, That we call upon the United States Congress to enact a drug benefit for senior citizens that is run by the Medicare program itself; and be it further

Resolved, That a copy of this resolution be sent to the President of the United States, each member of the Illinois Congressional delegation, the Speaker of the United States House of Representatives, and the President of the United States Senate.

POM–307. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Kentucky relative to supporting democracy in Ethiopia through foreign policy efforts; to the Committee on Foreign Relations.

RESOLUTION

A resolution to encourage the President and the United States Congress to support democracy in Ethiopia through foreign policy efforts.

Whereas, the people of Ethiopia have developed and nourished a proud and distinguished culture that has endured for more than three millennia; and

Whereas, Ethiopia and the United States have had a long and productive friendship for many years; and

Whereas, the hope for democratic institutions was created in Ethiopia following the 1991 overthrow of the Communist regime of Mengistu Haile Mariam by a group that became the Ethiopian People's Revolutionary Democratic Front (EPRDF), under the leadership of Prime Minister Meles Zenawi; and

Whereas, the ascendance of the EPRDF led instead to nondemocratic, one-party rule where democratic symbols such as a free press and elections are used but are manipulated by Meles's government for their own ends; and

Whereas, elections were held on May 15, 2005, and the turnout of voters was as high as an estimated ninety percent (90%), with voters waiting in line for up to seventeen (17) hours to cast their votes; and

Whereas, despite a large turnout of electors in which many voted for the main opposition party, the Coalition for Unity and Democracy (CUD), the EPRDF government quickly declared that it had been reelected to power; and

Whereas, facing protests from high schoolers and college students sympathetic with various oppositions parties, government security forces fired on the demonstrators, killing more than eighty (80) people and injuring more than one hundred (100) others; and

Whereas, Tesfaye Adane Tara, an opposition politician elected to parliament in the May elections was shot to death, allegedly by security forces; and

Whereas, human rights groups in Ethiopia alleged that more than three thousand (3,000) people were rounded up and detained following the violence in June of 2005, being held without charges and without constitutional protections of due process; and

Whereas, violence erupted again in early November of 2005; resulting in the death of at least forty-eight (48) people and injuries to hundreds of individuals, including women and children; and

Whereas, leaders of the opposition parties were once again detained and charged with treason, an offense punishable by death; and

Whereas, as many as twenty-five hundred (2,500) opposition supporters and some opposition party election observers were held in remote detention centers; and

Whereas, the Meles government has arrested numerous journalists and closed all independent newspapers in Ethiopia; and

Whereas, reports by Human Rights Watch indicate that the violence is not relegated just to the urban areas, but that checkpoints have been set up throughout the rural areas of the country, in the Oromia and Amhara regions where minority groups are prevalent and international observers are not located; and

Whereas, European Union election observers have condemned the 2005 election results as not meeting the international standard for genuine democratic elections and have reported undemocratic control of the media, a general climate of intimidation and human rights violations against opposition supporters, as well as first-hand accounts of the violence; and

Whereas, many Ethiopians still look to the Western democracies for their greatest hope, encouraging countries that donate foreign aid to intervene and place pressure on the Meles government to follow through with their promised democratic institutions and constitutional protections; and

Whereas, Britain suspended further aid to Ethiopia after the June violence; and

Whereas, members. of the United States Congress have called on the Bush Administration to condition any further economic and military assistance on substantial improvements in these matters; and

Whereas, House Resolution 4423, sponsored by Representative Christopher H. Smith, has been introduced in the United States House of Representatives and calls for the consolidation of security, human rights, democracy, and economic freedom in Ethiopia; Now, therefore, be it

Resolved by the House of Representatives of the General Assembly of the Commonwealth of Kentucky:

Section 1. The House of Representatives urges the United States Congress to continue to encourage the formation of democratic institutions, multiparty participation, free elections, respect for fundamental human rights, and constitutional protections for all citizens in Ethiopia.

Section 2. The House of Representatives encourages the United States Congress to pass House Resolution 4423 as a means for encouraging appropriate action towards freedom and democracy in Ethiopia.

Section 3. The House of Representatives encourages the President and United States Department of State to use every possible means at their command to examine our country's foreign policies toward Ethiopia for ways to encourage democratic institutions, multiparty participation, free elections, respect for fundamental human rights, and constitutional protections for all citizens in Ethiopia.

Section 4. The Clerk of the House of Representatives is hereby directed to transmit a copy of this Resolution to the Honorable George W. Bush, 1600 Pennsylvania Avenue, Washington, D.C. 20500; the Honorable Richard Cheney, Vice President, 1600 Pennsylvania Avenue, Washington, D.C. 20500; the Honorable Condoleeza Rice, 2201 C Street, N.W., Washington, D.C. 20520; His Excellency Kassahun Ayele, Embassy of Ethiopia, 3506 International Drive, N.W., Washington, D.C. 20008; the Honorable Dennis Hastert, Speaker of the House of Representatives, 235 Cannon House Office Building, Washington, D.C. 20515; the Honorable Mitch McConnell, 361–A Russell Senate Office Building, Washington, D.C. 20510; the Honorable Jim Bunning, 316 Hart Senate Office Building, Washington, D.C. 20510; the Honorable Ben Chandler, 1504 Longworth House Office Building, Washington, D.C. 20515; the Honorable Geoff Davis, 1541 Longworth House Office Building, Washington, D.C. 20515; the Honorable Ron Lewis, 2418 Rayburn House Office Building, Washington, D.C. 20515; the Honorable Anne Northup, 2459 Rayburn House Office Buiiding, Washington, D.C. 20515; the Honorable Harold Rogers, 2406 Rayburn House Office Building, Washington, D.C. 20515; the Honorable Ed Whitfield, 301 Cannon House Office Building, Washington, D.C. 20515.

POM–308. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to enacting legislation to provide additional funding for research in order to find a treatment and a cure for Amyotrophic Lateral Sclerosis; to the Committee on Health, Education, Labor, and Pensions.

HOUSE RESOLUTION NO. 616

Whereas, Amyotrophic Lateral Sclerosis (ALS) is better known as Lou Gehrig's disease; and

Whereas, ALS is a fatal neurodegenerative disease characterized by degeneration of cell bodies of the lower motor neurons in the gray matter of the anterior horns of the spinal cord; and

Whereas, The initial symptom of ALS is weakness of the skeletal muscles, especially those of the extremities; and

Whereas, as ALS progresses, the patient experiences difficulty in swallowing, talking and breathing; and

Whereas, ALS eventually causes muscles to atrophy, and the patient becomes a functional guadriplegic; and

Whereas, ALS does not affect a patient's mental capacity, so a patient remains alert and aware of the loss of motor functions and the inevitable outcome of continued deterioration and death; and

Whereas, ALS occurs in adulthood, most commonly between the ages of 40 and 70, with the peak age about 55, and affects men two to three times more often than women; and

Whereas, More than 5,600 new ALS patients are diagnosed annually; and

Whereas, It is estimated that 30,000 Americans may have ALS at any given time; and

Whereas, On average, patients diagnosed with ALS survive two to five years from the time of diagnosis; and

Whereas, Research indicates that military veterans are at a 50% or greater risk of developing ALS than those who have not served in the military; and

Whereas, ALS has no known cause, prevention or cure; and

Whereas, ''Amyotrophic Lateral Sclerosis (ALS) Awareness Month'' will increase public awareness of ALS patients' circumstances, acknowledge the terrible impact this disease has on patients and families and recognize the research for treatment and cure of ALS; therefore be it

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania recognize the month of May 2006 as ''Amyotrophic Lateral Sclerosis (ALS) Awareness Month'' in Pennsylvania; and be it further

Resolved, That the House of Representatives urge the President and Congress of the United States to enact legislation to provide additional funding for ALS research; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, to the Vice President of the United States, to the Speaker of the House of Representatives, to the members of Congress from Pennsylvania and to the United States Secretary of Health and Human Services.

POM–309. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to taking such actions as are necessary to remove the TRIO programs Upward Bound and Talent Search from the list of programs to be eliminated in the 2007 budget and to memorialize congress to continue the funding of such programs; to the Committee on Health, Education, Labor, and Pensions.

HOUSE CONCURRENT RESOLUTION NO. 24

Whereas, the term ''TRIO'' was coined by the late 1960s in reference to a series of federal educational opportunity programs created as part of President Lyndon B. Johnson's ''War on Poverty''; and

Whereas, funded under Title IV of the Higher Education Act of 1965, the TRIO programs have expanded and improved over the decades to provide a wide range of services to help students overcome class-related, social, and cultural barriers to higher education; and

Whereas, the president's 2007 budget proposal requests the nationwide elimination of two TRIO programs, Upward Bound and Talent Search; and

Whereas, Upward Bound, the goal of which is to increase the rates at which participants enroll in and graduate from postsecondary education institutions, provides vital support to participants in their preparation for college entrance, and serves high school students from low-income families, high school students from families in which neither parent holds a bachelor's degree, and low-income, first-generation military veterans who are preparing to enter postsecondary education; and

Whereas, Talent Search, the goal of which is to increase the number of young people from disadvantaged backgrounds who complete high school and enroll in the postsecondary educational institution of their choice, provides academic, career, and financial counseling to its participants and encourages them to graduate from high school and also serves high school dropouts by encouraging them to complete their education; and

Whereas, Upward Bound and Talent Search are two essential programs that provide crucial services to students, such as instruction in core curriculum subjects, academic advising, tutorial services, mentoring programs, assistance in completing college and financial aid applications, and support in preparing for college entrance exams; and

Whereas, it is in the best interest of the Nation's students that Upward Bound and Talent Search, two outstanding TRIO programs, be continued because they have made, and will continue to make, significant contributions toward the improvement of education in the nation and toward ensuring that as many students as possible receive every opportunity afforded by a quality education in the United States of America. Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to remove the TRIO programs Upward Bound and Talent Search from the list of programs to be eliminated in the 2007 budget and does hereby memorialize congress to continue the funding of such programs. Be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–310. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to taking such actions as are necessary to ensure that the Federal Emergency Management Agency and the United States Army Corps of Engineers break up large federal disaster recovery contracts in Louisiana so that small, locally owned businesses can compete for and be awarded such contracts; to the Committee on Homeland Security and Governmental Affairs.

HOUSE CONCURRENT RESOLUTION NO. 4

Whereas, Hurricanes Katrina and Rita struck the state of Louisiana causing severe flooding and damage to the southern part of the state that has threatened the safety and security of the citizens of the affected areas of the state of Louisiana; and

Whereas, the destruction caused by these devastating storms damaged public works, such as levees, bridges, and highways, and spread debris over a wide area of the southern part of the State; and

Whereas, the Federal Emergency Management Agency and the United States Army Corps of Engineers have control over a great percentage of the contracts to repair levees, remove debris, and provide for transportation of trailers and other important activities vital to the restoration and revitalization of the affected areas of Louisiana; and

Whereas, for the most part, these contracts have been awarded to large companies with the result being that small local companies have been shut out of the process; and

Whereas, it is likely that breaking up these large contracts would make it more likely that smaller businesses can be competitive in the bid process; and

Whereas, the awarding of contracts to smaller Louisiana businesses would help to jump start Louisiana post-Katrina economy and help the devastated areas and their people to quicken the pace of recovery. Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to ensure that the Federal Emergency Management Agency and the United States Army Corps of Engineers break up large federal disaster recovery contracts in Louisiana so that small, locally owned businesses can compete for and be awarded such contracts. Be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–311. A resolution adopted by the Senate of the Legislature of the State of Illinois relative to supporting the Secure America and Orderly Immigration Act of 2005; to the Committee on the Judiciary.

SENATE RESOLUTION NO. 578

Whereas, the Secure America and Orderly Immigration Act of 2005 (S. 1033 and H.R. 2330) would require the Secretary of Homeland Security to develop and implement a National Strategy for Border Security, establish a H–5A essential worker visa program for low-skilled workers, and exempt immediate relatives of U.S. citizens from the annual cap on family-sponsored immigrant visas; and

Whereas, the United States House of Representatives passed H.R. 4437 that would criminalize the undocumented, their employers, and asylum-seekers alike, tear apart families, and needlessly devastate our economy; and

Whereas, the United States of America was founded by immigrants who traveled from around the world to seek a better life; and

Whereas, the United States has an undocumented population of 11 million immigrants, including half a million in Illinois; and

Whereas, Illinois immigrants fill key roles in our economy such as paying taxes, including contributions to Social Security that they cannot receive back, raising families, and contributing to our schools, churches, neighborhoods, and community; and

Whereas, our current immigration system contributes to long backlogs, labor abuses, countless deaths on the border, and vigilante violence and is in dire need of reform to meet the challenges of the 21st century; and

Whereas, any comprehensive reform must involve a path to citizenship for these hardworking immigrants, as well as reunification of families and a safe and orderly process for enabling willing immigrant workers to fill essential jobs in our economy and ensure full labor rights; and

Whereas, the immigration initiative severely punishes illegal employment practices while creating a path to earned permanent legal states for individuals who have been working in the United States, paying taxes, obeying the law, and learning English, and protecting workers by ensuring the right to change jobs, join a union, and report abusive employment situations; and

Whereas, modernizing our antiquated and dysfunctional immigration system will uphold our nation's basic values of fairness, equal opportunity, and respect for the law; therefore, be it

Resolved, by the Senate of the Ninety-Fourth General Assembly of the State of Illinois, That we urge the Illinois Congressional Delegation and all of Congress to support ''The Secure America and Orderly Immigration Act of 2005'' (S. 1033 and H.R. 2330), which allows every hardworking, law-abiding individual to achieve the American Dream; and be it further

Resolved, That copies of this resolution be delivered to the President of the United States, the President of the Senate, the Majority and Minority Leaders of the Senate, the Speaker of the House of Representatives, the Majority and Minority Leaders of the House of Representatives, and each member of the Illinois Congressional Delegation.

POM–312. A resolution adopted by the Senate of the Legislature of the State of Illinois relative to a private bill in the United States Congress that was introduced by Congressman BOBBY RUSH in September 2005 on behalf of the La Familia group; to the Committee on the Judiciary.

SENATE RESOLUTION NO. 523

Whereas, United States citizen children throughout Illinois and the nation are being separated from either their father or mother because of our broken immigration laws; this causes great emotional and financial harm to these children and violates the right to family unity; and

Whereas, the thirty-five families, which come from nearly all of the congressional districts in Illinois and are known as La Familia Latina Unida (La Familia), represent families separated, or threatened by the prospect of separation, by the broken immigration laws and regulations that span the State of Illinois; these individuals are mothers or fathers of U.S. citizen children and are married, in most cases, to U.S. citizen spouses; the hardship claimed in each case is the hardship on these U.S. citizens that has occurred due to the separation or imminent separation of their families; and

Whereas, these thirty-five families, including their one hundred U.S. citizen children, have waged a courageous public campaign on their own behalf and on behalf of similarly affected families throughout the nation; the hardship faced by these families is both economic and emotional; and

Whereas, H.R. 3856, a private bill in the United States Congress, was introduced by Congressman BOBBY RUSH in September of this year on behalf of the La Familia group; this bill would confer legal status on the mothers or fathers of these families and allow for their permanent unification; and

Whereas, the immigration cases that are represented encompass a range of human and legal situations that will be highly instructive to the immigration debate in the U.S. Senate; in many of these cases, the individuals have presented themselves fully and completely through the process dictated and have been denied because of the rule that restricts travel to their country of origin in family emergencies, even though they have fully presented themselves in their required applications; and

Whereas, due to the difference in House and Senate rules relating to private bills, the introduction of a companion bill in the U.S. Senate will provide for the more immediate security of these families and allow them to continue their public testimony, a testimony vitally in the public interest in the midst of the upcoming debate over reform of immigration laws; and

Whereas, support for the private bill in the House and Senate does not represent support for any particular immigration reform bill; therefore, be it

Resolved, by the Senate of the Ninety-fourth General Assembly of the State of Illinois, That we strongly recommend passage of H.R. 3856 and the introduction of its companion in the U.S. Senate; and be it further

Resolved, That we encourage the United States Congress to take action on federal immigration reform, which would provide for family unification as part of part of comprehensive immigration reform; and be it further

Resolved, That suitable copies of this resolution be forwarded to the Speaker of the United States House of Representatives, the President pro tempore of the United States Senate, and to each member of the Illinois Congressional delegation.

POM–313. A concurrent resolution adopted by the House of Representatives of the Legislature of the State of Louisiana relative to taking such actions as are necessary to secure our nation's borders, identify and deport immigration violators, preclude automatic citizenship for children born of such violators, and revise the work visa program; to the Committee on the Judiciary.

HOUSE CONCURRENT RESOLUTION NO. 33

Whereas, we support legal immigration to our country and acknowledge the tremendous contributions made by legal immigrants throughout our history to our economy and society; and

Whereas, we must strengthen the Border Patrol to stop illegal crossing and must equip the Border patrol with the tools, technologies, structures, and sufficient force necessary to secure the border; and

Whereas, it is estimated that eleven million citizens of other countries have entered and currently remain in the United States in violation of applicable immigration and naturalization laws; and

Whereas, the ability of such persons to illegally enter and remain in the United States presents a grave risk to the security of the United States; and

Whereas, in many instances the resources of national, state, and local governmental entities are overburdened and depleted or exhausted by attempts to deal with and meet the needs of such persons after they illegally enter the United States; and

Whereas, border security and immigration law enforcement are critical elements in America's national security; and

Whereas, strengthening the capacity of law enforcement to apprehend persons entering our country illegally is essential to protecting the sovereignty of the United States; and

Whereas, immigration enforcement training needs to be provided to state and local law enforcement agencies to strengthen their enforcement of immigration laws; and

Whereas, withholding United States citizenship from children born to illegal aliens will remove another incentive to enter our country illegally; and

Whereas, all employers in the United States should be held responsible for hiring illegal aliens and be subjected to substantial fines for doing so; and

Whereas, working or residing illegally in our country must not establish welfare rights or benefits of any kind; and

Whereas, respect for the rule of law is a bedrock principle of our country, our culture, and our posterity; and

Whereas, elected leaders across the country are constantly and vigorously confronted with demands that appropriate legislative action be taken to address and resolve the problems of illegal immigration. Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to provide appropriate authority and teams to accomplish the following:

(1) Effectively secure the borders of the United States against illegal immigration and all other illegal crossings, using our military if necessary.

(2) Identify all persons who are currently in the United States in violation of immigration and naturalization laws and arrange for their return to their country of origin as expeditiously as reasonably possible.

(3) Preclude automatic citizenship for children born in the United States to persons in the United States in violation of immigration and naturalization laws.

(4) After effectively closing our borders to illegal entry, revise our present work visa program to remove the means by which it is abused, requiring a reliable means of tracking entry and exit and continually verifying the identity and location of each such worker, and providing no amnesty or preference for those persons presently in the United States illegally. Be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America land to each member of the Louisiana congressional delegation.

POM–314. A resolution adopted by the Senate of the State of Michigan relative to providing funding to help states and local communities clean up and address the disastrous

effects of clandestine methamphetamine labs; to the Committee on the Judiciary.

SENATE RESOLUTION NO. 101

Whereas, There is a meth epidemic in the United States, and it is having a devastating effect on our country. Meth abuse is causing social, economic, and environmental problems. Children residing in homes with meth labs live in danger and often suffer from neglect and abuse. Meth production costs citizens and governments millions of dollars for a variety of reasons, including law enforcement costs, drug treatment for offenders, cleanup of production sites, and placement of endangered children; and

Whereas, Meth labs leave behind a toxic mess of chemicals and pose a significant danger to communities. The manufacture of one pound of methamphetamine results in six pounds of waste. These wastes include corrosive liquids, acid vapors, heavy metals, solvents, and other harmful materials that can disfigure skin or cause death. Hazardous materials from meth labs are typically disposed of illegally and may cause severe damage to the environment; and

Whereas, Between 1992 and 2004, the number of clandestine meth lab-related cleanups increased from 394 to over 10,000 nationwide. The cost of cleaning up clandestine labs in FY 2004 was approximately $17.8 million; and

Whereas, States and local governments are bearing the burden of funding the cleanup efforts. Many local communities are finding and seizing meth labs. The lab sites remain dangerous to the public, however, because neither the state or the local community has adequate funding to clean them up; and

Whereas, The Combat Meth Act of 2005, which was recently signed into law as a part of the USA Patriot Improvement and Reauthorization Act of 2005, authorizes cleanup funding, but only for areas designated ''Meth Hot Spots.'' The meth epidemic is a national crisis, however, and scores of states and local governments across the country are in dire need of funding to help clean up clandestine labs; now, therefore, be it

Resolved by the Senate, That we memorialize the United States Congress to provide funding for meth lab cleanup that is available to all states and local governments that are in the midst of the meth epidemic; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States Senate, the Speaker of the United States House of Representatives, and the members of the Michigan congressional delegation.

POM–315. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to increasing the penalties imposed upon a person who vandalizes a national war memorial; to the Committee on the Judiciary.

HOUSE RESOLUTION NO. 628

Whereas, The Civil War is the bloodiest and most tragic war in which this country has ever engaged, and indisputably its worst conflagration occurred July 1 through 3, 1863, in Gettysburg; and

Whereas, there were more than 52,000 human casualties during this three-day event, and nearly every Civil War unit for the North and for the South was engaged; and

Whereas, in the years following the war and continuing through the 1990s with the 1993 dedication of the Friend to Friend Memorial, war memorials have been erected by private donations, publicly dedicated and maintained by the National Park Service as testimony of the sacrifices made by those who fought at Gettysburg; and

Whereas, on February 15, 2006, three Civil War monuments on the Gettysburg Battlefield were vandalized heinously, one representing the 114th PVI Pennsylvania monument and two others representing New York and Massachusetts; and

Whereas, this vandalism demonstrates that present penalties are insufficient to deter such actions; therefore be it

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania memorialize the Congress of the United States to increase the minimum fines and other minimum penalties for vandalizing a national war memorial; and be it further

Resolved, That copies of this resolution be transmitted to the presiding officers of each house of Congress and to each member of Congress from Pennsylvania.

POM–316. A resolution adopted by the Council of the Borough of Roselle Park, State of New Jersey relative to opposing New York/New Jersey/Philadelphia Metropolitan Airspace Redesign proposals of the Federal Aviation Administration; to the Committee on Commerce, Science, and Transportation.

POM–317. A resolution adopted by the Township Committee of the Township of Winfield, State of New Jersey relative to opposing New York/New Jersey/Philadelphia Metropolitan Airspace Redesign proposals of the Federal Aviation Administration; to the Committee on Commerce, Science, and Transportation.

POM–318. A resolution adopted by the Council of the City of Gretna, State of Louisiana relative to enacting the ''Domestic Energy Production through Offshore Exploration and Equitable Treatment of State Holdings Act of 2006''; to the Committee on Energy and Natural Resources.

EXECUTIVE REPORT OF COMMITTEE

The following executive report of a nomination was submitted:

By Mr. DOMENICI for the committee on Energy and Natural Resources.

*Dirk Kempthorne, of Idaho, to be Secretary of the Interior.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. VITTER:

S. 2774. A bill to ensure efficiency and fairness in the awarding of Federal contracts in connection with Hurricane Katrina and Hurricane Rita reconstruction efforts; to the Committee on Homeland Security and Governmental Affairs.

By Mrs. HUTCHISON:

S. 2775. A bill to extend the temporary suspension of duty on electrical radio broadcast receivers not combined with a clock; to the Committee on Finance.

By Mrs. HUTCHISON:

S. 2776. A bill to extend the temporary suspension of duty on electrical radio broadcast receivers combined with a clock; to the Committee on Finance.

By Mrs. HUTCHISON:

S. 2777. A bill to extend the temporary suspension of duty on hand-held radio scanners; to the Committee on Finance.

By Mr. SCHUMER (for himself and Mr. GREGG):

S. 2778. A bill to suspend temporarily the duty on ethanol; to the Committee on Finance.

By Mr. INHOFE (for himself and Mr. VITTER):

S. 2779. A bill to amend titles 38 and 18, United States Code, to prohibit certain demonstrations at cemeteries under the control of the National Cemetery Administration and at Arlington National Cemetery, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. INHOFE (by request):

S. 2780. A bill to authorize the Administrator of the Environmental Protection Agency to advance cooperative conservation efforts, to reduce barriers to the formation and use of partnerships to enable Federal environmental stewardship agencies to meet the conservation goals and obligations of the agencies, to promote remediation of inactive and abandoned mines, and for other purposes; to the Committee on Environment and Public Works.

By Mr. INHOFE (for himself, Mr. CHAFEE, and Ms. MURKOWSKI):

S. 2781. A bill to amend the Federal Water Pollution Control Act to enhance the security of wastewater treatment works; to the Committee on Environment and Public Works.

By Mr. TALENT (for himself, Mr. HARKIN, Mr. BOND, and Mr. LUGAR):

S. 2782. A bill to establish the National Institute of Food and Agriculture, to provide funding for the support of fundamental agricultural research of the highest quality, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEAHY (for himself, Mr. FRIST, Mr. REID, Mr. BIDEN, Mr. DURBIN, Mr. OBAMA, Mr. GRASSLEY, Mr. CORNYN, Mr. BROWNBACK, Mr. GRAHAM, Ms. STABENOW, Mr. MENENDEZ, Mr. ALLEN, Ms. CANTWELL, and Mr. KYL):

S. Res. 472. A resolution commemorating and acknowledging the dedication and sacrifice made by the men and women who have lost their lives while serving as law enforcement officers; considered and agreed to.

By Ms. MURKOWSKI (for herself, Mr. TALENT, and Mrs. LINCOLN):

S. Res. 473. A resolution designating May 14, 2006, as ''National Police Survivors Day''; considered and agreed to.

ADDITIONAL COSPONSORS

S. 333

At the request of Mr. SANTORUM, the name of the Senator from Rhode Island (Mr. REED) was withdrawn as a cosponsor of S. 333, a bill to hold the current regime in Iran accountable for its threatening behavior and to support a transition to democracy in Iran.

S. 772

At the request of Mr. CORNYN, the name of the Senator from Idaho (Mr.

CRAIG) was added as a cosponsor of S. 772, a bill to amend the Internal Revenue Code of 1986 to expand workplace health incentives by equalizing the tax consequences of employee athletic facility use.

S. 2039

At the request of Mr. DURBIN, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. 2039, a bill to provide for loan repayment for prosecutors and public defenders.

S. 2388

At the request of Mr. VOINOVICH, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 2388, a bill to establish a National Commission on the Infrastructure of the United States.

S. 2424

At the request of Mr. ALLEN, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S. 2424, a bill to amend the Internal Revenue Code of 1986 to increase the contribution limits for health savings accounts, and for other purposes.

S. 2491

At the request of Mr. CORNYN, the name of the Senator from Idaho (Mr. CRAIG) was withdrawn as a cosponsor of S. 2491, a bill to award a Congressional gold medal to Byron Nelson in recognition of his significant contributions to the game of golf as a player, a teacher, and a commentator.

At the request of Mr. CORNYN, the names of the Senator from Georgia (Mr. ISAKSON) and the Senator from Iowa (Mr. GRASSLEY) were added as cosponsors of S. 2491, supra.

S. 2503

At the request of Mrs. LINCOLN, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 2503, a bill to amend the Internal Revenue Code of 1986 to provide for an extension of the period of limitation to file claims for refunds on account of disability determinations by the Department of Veterans Affairs.

S. 2679

At the request of Mr. TALENT, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 2679, a bill to establish an Unsolved Crimes Section in the Civil Rights Division of the Department of Justice, and an Unsolved Civil Rights Crime Investigative Office in the Civil Rights Unit of the Federal Bureau of Investigation, and for other purposes.

S. 2694

At the request of Mr. CRAIG, the name of the Senator from Vermont (Mr. JEFFORDS) was added as a cosponsor of S. 2694, a bill to amend title 38, United States Code, to remove certain limitation on attorney representation of claimants for veterans benefits in administrative proceedings before the Department of Veterans Affairs, and for other purposes.

S. 2748

At the request of Mr. BINGAMAN, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 2748, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives to promote energy production and conservation, and for other purposes.

S. RES. 409

At the request of Mr. NELSON of Florida, the name of the Senator from Florida (Mr. MARTINEZ) was added as a cosponsor of S. Res. 409, a resolution supporting democracy, development, and stabilization in Haiti.

S. RES. 469

At the request of Mr. LIEBERMAN, the name of the Senator from Colorado (Mr. SALAZAR) was added as a cosponsor of S. Res. 469, a resolution condemning the April 25, 2006, beating and intimidation of Cuban dissident Martha Beatriz Roque.

S. RES. 470

At the request of Mr. KERRY, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. Res. 470, a resolution promoting a comprehensive political agreement in Iraq.

AMENDMENT NO. 3871

At the request of Mrs. FEINSTEIN, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of amendment No. 3871 intended to be proposed to S. 1955, a bill to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. INHOFE (for himself, Mr. CHAFEE, and Ms. MURKOWSKI):

S. 2781. A bill to amend the Federal Water Pollution Control Act to enhance the security of wastewater treatment works; to the Committee on Environment and Public Works.

Mr. INHOFE. Mr. President, I rise today to introduce the Wastewater Treatment Works Security Act of 2006. I am pleased to be joined in this effort by Senator CHAFEE, the chairman of the Subcommittee on Fisheries, Wildife and Water and Senator MURKOWSKI, an important and influential member of the Committee on Environment and Public Works, EPW. The bill being proposed is similar to legislation, S. 1039, that passed the Committee on Environment and Public Works last Congress on a strong bipartisan vote and a bill that passed the House of Representatives by a vote of 413 to 2. Unfortunately, some of my colleagues in the minority objected to bringing that important, bipartisan legislation to the floor. At an impasse with the close of the 108th Congress, I asked the Government Accountability Office to survey the wastewater community in order to determine what steps publicly owned treatment works, POTWs, had taken to assess their security and if need be, what steps they had taken to enhance security at their facilities.

In March 2006 we received GAO's report and the results confirm that the approach advocated by the House of Representatives and by the EPW Committee is the right approach. The Federal Government must work cooperatively with our counterparts at the state and local level to ensure our nation's infrastructure is secure. GAO found that without a federal requirement to do so, the overwhelming majority of the largest POTWs have conducted or are in the process of conducting vulnerability assessments. They did not need a heavy handed federal mandate to do the right thing. Of those who have not and do not plan to do a vulnerability assessment, a majority believed they had taken sufficient other security measures or believed that by updating their Emergency Response Plan the utility had a good understanding of its vulnerabilities.

While this is tremendous progress, it is important that all systems know what their vulnerabilities are and take steps to mitigate them. The legislation my colleagues Senator CHAFEE and Senator MURKOWSKI and I introduce today builds upon the good work already taking place by working in collaboration with the publicly owned treatment works. For the few systems remaining who have not done an assessment, our bill provides them an incentive to do so by authorizing funding. Further, once these systems have completed their assessments and certified to EPA that they have done so, they can join their colleagues in seeking grants to address some of the security problems identified in the assessments.

During Hurricane Katrina, we saw how important emergency response plans are and how valuable mutual aid agreements can be. Our bill allows funding for the development, expansion or upgrading of an emergency response plan as well as for the voluntary creation of a mutual aid agreement or participation in such an agreement.

The GAO also found that the majority facilities had actually made significant security improvements prior to the tragedy of September 11. Of the 206 who responded, 149 had vehicle gates; 174 had security fences; 160 had redundant power sources; 133 had redundant pumping devices or collection bypass systems. Following September 11, 138 facilities now have safeguards for onsite delivery of materials and 112 have additional site lighting. It is important for all of my colleagues to note how much progress these entities have taken to secure their facilities and protect their communities.

The use of chlorine has been a topic of discussion for years. Chlorine is by far the most effective disinfectant available and it is the least expensive. During these times of aging systems, growing Federal regulations and limited resources, cost is an important

consideration. In its January 2005 report on security at wastewater utilities, the GAO estimated it would cost a utility $12.5 million to switch from chlorine to sodium hypochlorite. There are other considerations that must be considered as well, such as downstream effects of a chlorine alternative. For example, the switch from chlorine to chloramines in Washington, DC's drinking water system was found to cause lead to leach out of service pipes and into the faucets of homes and businesses. Thus, decisions about chlorine must be fully evaluated and must be site specific. Many POTWs are already undergoing these evaluations. After careful review of cost, technical feasibility and safety considerations, and without the presence of a Federal mandate on technology, 116 of the 206 largest POTWs do not use gaseous chlorine. According to the GAO report, another 20 plan to switch to a technology other than chlorine. To sum, nearly two-thirds of the nation's largest POTWs are not using chlorine. Those who continue to use chlorine have taken steps to ensure the chlorine is secure.

While the GAO report found significant steps were being taken at the nation's largest wastewater utilities, the Office also found an area very much in need of assistance. Each POTW has a collection system that consists of the pipes to carry wastewater from homes and businesses to the treatment works. These pipes are often large enough for an individual to stand in and they provide an underground roadway beneath most major cities. In its January 2005 report, 42 of the 50 experts on GAO's panel identified the collection system as the most vulnerable asset of a POTW. However, in discussions with engineers and utility managers, there remain many questions and obstacles on how to effectively secure a collection system. Therefore, our bill authorizes a research program to identify how a collection system could be used in a terrorist attack, how to identify potential chemicals or explosives that could be placed in a collection system and how best to mitigate against these risks. Finally, our legislation asks EPA to examine the various drinking water technologies to determine how affordable and effective each is.

As GAO found, POTWs are taking the critical steps necessary to secure their facilities and develop appropriate response mechanisms in the event of an attack or natural disaster. We at the Federal level must continue to work with them, not against them by imposing one-size-fits-all, heavyhanded unfunded Federal regulations. I hope my colleagues will join me in supporting this legislation and that we can finally enact wastewater security legislation.

By Mr. TALENT (for himself, Mr. HARKIN, Mr. BOND, and Mr. LUGAR):

S. 2782. A bill to establish the National Institute of Food and Agriculture, to provide funding for the support of fundamental agricultural research of the highest quality, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. HARKIN. Mr. President, today, Senator TALENT and I, along with a group of our colleagues, are introducing the National Institute of Food and Agriculture Act of 2006. In the 2002 farm bill, a research, education and economics task force within the Department of Agriculture, USDA, was established to evaluate agricultural research. A key recommendation of this task force was to create a National Institute for Food and Agriculture, NIFA, within USDA in order to support fundamental agricultural research to ensure that American agriculture remains competitive now and in the future. This bill does exactly that. The NIFA would be a grant-making agency that funds food and agricultural research through a competitive, peer-reviewed process. These funds would be in addition to, not as a substitute for, current research programs at USDA's Agricultural Research Service, ARS, and Cooperative State Research, Education, and Extension Service, CSREES.

American agriculture must ensure that our Nation continues to produce safe and nutritious food for an increasing population. Other challenges in the areas of food and agriculture are problems we are facing right now: renewable energy, rural development, overweight and obesity, and environmental challenges. Investment in fundamental research remains our best hope to finding solutions to problems confronting American farmers and consumers of food and agriculture products now and in the future. Our Nation's investment in research has produced remarkable tangible results in the medical field, but food and agricultural research lags far behind. USDA's task force noted that the amount of funding designated for competitively awarded, peer-reviewed agricultural research grants is outpaced 100 to 1 by the National Institutes of Health. Our entire Nation is reaping the benefits of past agricultural research, but more can be done, and research will become much more important in the future as we face increased globalization and competition from foreign markets. Increasing our investment in food and agriculture research is a necessity for the future of America's food and agriculture industry and consumers alike. And that is why I support the National Institute of Food and Agriculture Act of 2006. I encourage my colleagues to do so too.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 472—COMMEMORATING AND ACKNOWLEDGING THE DEDICATION AND SACRIFICE MADE BY THE MEN AND WOMEN WHO HAVE LOST THEIR LIVES WHILE SERVING AS LAW ENFORCEMENT OFFICERS

Mr. LEAHY (for himself, Mr. FRIST, Mr. REID, Mr. BIDEN, Mr. DURBIN, Mr. OBAMA, Mr. GRASSLEY, Mr. CORNYN, Mr. BROWNBACK, Mr. GRAHAM, Ms. STABENOW, Mr. MENENDEZ, Mr. ALLEN, Ms. CANTWELL, and Mr. KYL) submitted the following resolution; which was considered and agreed to:

S. RES. 472

Whereas the well-being of all citizens of the United States is preserved and enhanced as a direct result of the vigilance and dedication of law enforcement personnel;

Whereas more than 900,000 men and women, at great risk to their personal safety, presently serve their fellow citizens as guardians of peace;

Whereas peace officers are on the front lines in preserving the right of the children of the United States to receive an education in a crime-free environment, a right that is all too often threatened by the insidious fear caused by violence in schools;

Whereas 156 peace officers across the United States were killed in the line of duty during 2005, which is below the decade-long annual average of 167 deaths;

Whereas a number of factors contributed to this reduction in deaths, including—

(1) better equipment and increased use of bullet-resistant vests;

(2) improved training;

(3) longer prison terms for violent offenders; and

(4) advanced emergency medical care;

Whereas every other day, 1 out of every 16 peace officers is assaulted, 1 out of every 56 peace officers is injured, and 1 out of every 5,500 peace officers is killed in the line of duty somewhere in the United States; and

Whereas on May 15, 2006, more than 20,000 peace officers are expected to gather in Washington, D.C., to join with the families of their recently fallen comrades to honor those comrades and all others who went before them: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes May 15, 2006, as ''Peace Officers Memorial Day'', in honor of the Federal, State, and local officers that have been killed or disabled in the line of duty; and

(2) calls on the people of the United States to observe that day with appropriate ceremonies and respect.

SENATE RESOLUTION 473—DESIGNATING MAY 14, 2006, AS ''NATIONAL POLICE SURVIVORS DAY''

Ms. MURKOWSKI (for herself, Mr. TALENT, and Mrs. LINCOLN) submitted the following resolution; which was considered and agreed to:

S. RES. 473

Whereas, in the United States, 1 law enforcement officer is killed every 53 hours, and between 140 and 160 law enforcement officers lose their lives in the line of duty each year;

Whereas, on May 14, 1983, on the eve of the 2nd annual National Peace Officers' Memorial Service, 10 widows of fallen law enforcement officers came together at dinner to discuss the lack of support for law enforcement survivors;

Whereas, exactly 1 year later, that discussion led to the formation of Concerns of Police Survivors, Inc. at the first annual National Police Survivors Seminar, which drew 110 law enforcement survivors from throughout the United States;

Whereas Concerns of Police Survivors, Inc. has grown to serve over 15,000 surviving families of fallen law enforcement officers by providing healing, love, and the opportunity for a renewed life;

Whereas Concerns of Police Survivors, Inc. and its 48 chapters throughout the United States—

(1) provide a program of peer support and counseling to law enforcement survivors for 365 days a year;

(2) helps survivors obtain the death benefits to which they are entitled; and

(3) sponsors scholarships for children and surviving spouses to pursue post-secondary education;

Whereas Concerns of Police Survivors, Inc. sponsors a year-round series of seminars, meetings and youth activities, including the National Police Survivors' Seminar during National Police Week, retreats for parents, spouses, siblings, and programs and summer activities for young and adolescent children;

Whereas Concerns of Police Survivors, Inc. helps law enforcement agencies cope with the loss of an officer by promoting the adoption of standardized policies and procedures for line-of-duty deaths; and

Whereas Concerns of Police Survivors, Inc. inspires the public to recognize the sacrifices made by law enforcement families by encouraging all citizens of the United States to tie a blue ribbon to their car antenna during National Police Week: Now, therefore, be it

Resolved, That the Senate—

(1) designates May 14, 2006, as ''National Police Survivors Day''; and

(2) calls on the people of the United States to observe National Police Survivors' Day with appropriate ceremonies to pay respect to—

(A) the survivors of the fallen heroes of law enforcement; and

(B) the fallen law enforcement officers who, through their courageous deeds, have made the ultimate sacrifice in service to their community.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3874. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table.

SA 3875. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3876. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3877. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3878. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3879. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3880. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3881. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3882. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3883. Mr. VITTER (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3884. Mr. VITTER submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3885. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3886. Mr. FRIST proposed an amendment to the bill S. 1955, supra.

SA 3887. Mr. FRIST proposed an amendment to amendment SA 3886 proposed by Mr. FRIST to the bill S. 1955, supra.

SA 3888. Mr. FRIST proposed an amendment to the bill S. 1955, supra.

SA 3889. Mr. FRIST proposed an amendment to the bill S. 1955, supra.

SA 3890. Mr. FRIST proposed an amendment to amendment SA 3889 proposed by Mr. FRIST to the bill S. 1955, supra.

SA 3891. Ms. COLLINS (for herself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3892. Ms. COLLINS (for herself and Mr. BINGAMAN) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3893. Ms. COLLINS (for herself and Mr. FEINGOLD) submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3894. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3895. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3896. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3897. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3898. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3899. Mr. DURBIN (for himself, Mrs. LINCOLN, Mr. REID, Mr. BAUCUS, Mr. KENNEDY, Mrs. CLINTON, Mr. KERRY, Mr. BINGAMAN, Ms. CANTWELL, Mr. PRYOR, Mr. HARKIN, Mr. OBAMA, Mr. LAUTENBERG, Mr. SCHUMER, Mr. KOHL, Mr. LIEBERMAN, Mr. DODD, Mr. DAYTON, Mr. JOHNSON, Mr. MENENDEZ, Mrs. BOXER, Mr. NELSON, of Florida, Ms. MIKULSKI, Ms. STABENOW, Mr. CARPER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3900. Mr. CARPER (for himself and Mrs. FEINSTEIN) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3901. Mr. AKAKA (for himself and Mr. OBAMA) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3902. Mr. PRYOR submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3903. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3904. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3905. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3906. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3907. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3908. Mr. BAUCUS (for himself and Mr. COLEMAN) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3909. Mr. FEINGOLD (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3910. Mr. FEINGOLD (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3911. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3912. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3913. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3914. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3915. Mr. NELSON, of Florida (for himself and Ms. SNOWE) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3916. Mr. REID (for himself, Mrs. CLINTON, Mrs. MURRAY, and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3917. Mr. BAUCUS (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3918. Mr. DODD (for himself and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3919. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3920. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1955, supra; which was ordered to lie on the table.

SA 3921. Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill S. 1955, supra; which was ordered to lie on the table.

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

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

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

TEXT OF AMENDMENTS

SA 3874. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

SA 3875. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

SA 3876. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

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

SA 3877. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

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

SA 3878. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

SA 3879. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

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

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

''SEC. 29___. PRESERVING STATE AUTHORITY OVER HEALTH INSURANCE.

''(a) FEDERAL RATING RULES.—

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

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

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

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

''(b) FEDERAL BENEFIT CHOICE STANDARDS.—

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

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

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

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

''(c) FEDERAL HARMONIZATION STANDARDS.—

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

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

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

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

SA 3880. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

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

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

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

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

shall not apply and shall not be enforced.

SA 3881. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON PARTICIPATION.

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

SA 3882. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

National Association of Insurance Commissioners''.

SA 3883. Mr. VITTER (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. GAO STUDY CONCERNING BENEFITS MANDATES.

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

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

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

(1) chiropractic coverage;

(2) mammography services;

(3) minimum hospital stays;

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

(5) bone density screenings;

(6) cervical cancer screenings;

(7) maternity care;

(8) well-baby care;

(9) immunizations;

(10) autism treatments and services;

(11) obesity coverage; and

(12) diabetes coverage.

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

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

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

(A) a list of all benefits covered;

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

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

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

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

SA 3884. Mr. VITTER submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

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

(2) tamper-indicating technologies; and

(3) blister security packaging when possible.

(b) USE OF TECHNOLOGIES.—

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

(A) implementing inventory control;

(B) tracking and tracing prescription drugs;

(C) verifying shipment or receipt of prescription drugs;

(D) authenticating finished prescription drugs; and

(E) electronically authenticating the pedigree of prescription drugs.

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

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

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

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

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

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

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

(d) STANDARDS FOR PACKAGING.—

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

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

(B) at the item level.

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

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

(f) TRANSITIONAL PROVISIONS; EFFECTIVE DATES.—

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

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

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

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

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

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

(ii) December 31, 2007; and

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

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

(g) DEFINITIONS.—In this Act:

(1) The term ''pedigree''—

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

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

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

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

SA 3885. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health

plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH RECORDS

SEC. ___01. SHORT TITLE.

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

SEC. ___02. PURPOSES.

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

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

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

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

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

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

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

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

SEC. ___03. DEFINITIONS.

In this title:

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

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

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

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

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

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

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

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

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

SEC. ___04. INDEPENDENT HEALTH RECORD BANKS.

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

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

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

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

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

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

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

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

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

(b) ESTABLISHMENT.—

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

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

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

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

(c) MEMBERSHIP.—

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

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

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

(1) INDIVIDUAL CONSUMERS.—

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

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

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

(e) FINANCING OF ACTIVITIES.—

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

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

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

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

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

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

SEC. ___05. HEALTHCARE CLEARINGHOUSE ACTIVITIES.

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

(b) ACCREDITATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) AVAILABILITY OF DATA FOR EMERGENCY HEALTHCARE.—

(1) FINDINGS.—Congress finds that—

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

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

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

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

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

(C) payment data;

(D) arrival and first assessment data;

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

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

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

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

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

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

(b) PROVISION OF INFORMATION AND INFORMATIONAL PROVISION.—

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

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

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

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

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

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

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

SEC. ___08. REGULATORY OVERSIGHT.

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

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

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

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

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

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

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

(b) INTERAGENCY COUNCIL FOR SECURITY AUDITING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. ___09. PENALTIES FOR FRAUD AND ABUSE.

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

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

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

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

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

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

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

''(2) $50.

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

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

''(e) REPORTS.—

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

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

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

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

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

''(B) shall be furnished to employees—

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

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

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

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

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

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

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

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

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

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

SA 3886. Mr. FRIST proposed an amendment to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; as follows:

At the end of the modified amendment at the following;

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

SA 3887. Mr. FRIST proposed an amendment to amendment SA 3886 proposed by Mr. FRIST to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; as follows:

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

SA 3888. Mr. FRIST proposed an amendment to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; as follows:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Marketplace Modernization and Affordability Act of 2006''.

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

(c) PURPOSES.—It is the purpose of this Act to—

(1) make more affordable health insurance options available to small businesses, working families, and all Americans;

(2) assure effective State regulatory protection of the interests of health insurance consumers; and

(3) create a more efficient and affordable health insurance marketplace through collaborative development of uniform regulatory standards.

TITLE I—SMALL BUSINESS HEALTH PLANS

SEC. 101. RULES GOVERNING SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''SEC. 801. SMALL BUSINESS HEALTH PLANS.

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

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

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its

members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

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

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

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

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

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

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

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

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

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

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

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

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

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

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

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

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

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

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

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

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

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

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

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

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

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

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

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

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

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

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged,

subject to subparagraph (B) and the terms of this title.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''(c) DOMICILE AND NON-DOMICILE STATES.—

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

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2006), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2006)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

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

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 806. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

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

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 807. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

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

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

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

''SEC. 808. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

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

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)-1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

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

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

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

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

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

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

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2006) (concerning health plan rating and benefits) are met.''.

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

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

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

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Certification of small business health plans.
''803. Requirements relating to sponsors and boards of trustees.
''804. Participation and coverage requirements.
''805. Other requirements relating to plan documents, contribution rates, and benefit options.
''806. Requirements for application and related requirements.
''807. Notice requirements for voluntary termination.
''808. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

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

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

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

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

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

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

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 201. MARKET RELIEF.

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

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

''(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

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

''(11) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

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

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

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

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

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

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

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

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

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply

rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2006.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

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

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules

are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

"PART II—AFFORDABLE PLANS

"SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the Benefit Choice Standards in their entirety and as the exclusive laws of the State that relate to benefit, service, and provider mandates in the group and individual insurance markets.

''(2) BENEFIT CHOICE STANDARDS.—The term 'Benefit Choice Standards' means the Standards issued under section 2922.

''(3) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Benefit Choice Standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the Benefit Choice Standards, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Benefit Choice Standards and that adherence to such Standards is included as a term of such contract.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the group or individual health insurance markets, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(7) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) BENEFIT CHOICE OPTIONS.—

''(1) DEVELOPMENT.—Not later than 6 months after the date of enactment of this title, the Secretary shall issue, by interim final rule, Benefit Choice Standards that implement the standards provided for in this part.

''(2) BASIC OPTIONS.—The Benefit Choice Standards shall provide that a health insurance issuer in a State, may offer a coverage plan or plan in the small group market, individual market, large group market, or through a small business health plan, that does not comply with one or more mandates regarding covered benefits, services, or category of provider as may be in effect in such State with respect to such market or markets (either prior to or following the date of enactment of this title), if such issuer also offers in such market or markets an enhanced option as provided for in paragraph (3).

''(3) ENHANCED OPTION.—A health insurance issuer issuing a basic option as provided for in paragraph (2) shall also offer to purchasers (including, with respect to a small business health plan, the participating employers of such plan) an enhanced option, which shall at a minimum include such covered benefits, services, and categories of providers as are covered by a State employee coverage plan in one of the 5 most populous States as are in effect in the calendar year in which such enhanced option is offered.

''(4) PUBLICATION OF BENEFITS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary shall publish in the Federal Register such covered benefits, services, and categories of providers covered in that calendar year by the State employee coverage plans in the 5 most populous States.

''(b) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

"SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

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

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

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

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

"SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

"SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create

any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

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

''Subtitle B—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2932(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2932(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2932(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

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

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

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

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

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

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the covered benefit, service, or category of provider mandate standards provided for in section 2922.

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

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

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

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

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall be effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

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

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle shall supersede any and all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NON-APPLICATION WHERE CONSISTENT WITH MARKET CONDUCT EXAMINATION HARMONIZED STANDARD.—Subsection (a)(1) shall not supersede any State law of a nonadopting State that relates to the harmonized standards issued under section 2932(b)(1)(B) to the extent that the State agency responsible for regulating insurance (or other applicable State agency) exercises its authority under State law consistent with the harmonized standards issued under section 2932(b)(1)(B).

''(5) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(6) PREEMPTION LIMITED TO HARMONIZED STANDARDS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State requirements for form and rate filing, market conduct reviews, prompt payment of claims, or internal reviews that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months and one day after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

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

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any

conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

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

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

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

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

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

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

SA 3889. Mr. FRIST proposed an amendment to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; as follows:

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

SA 3890. Mr. FRIST proposed an amendment to amendment SA 3889 proposed by Mr. FRIST to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; as follows:

At the end of the amendment add the following:

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

SA 3891. Ms. COLLINS (for herself and Ms. MURKOWSKI) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

SA 3892. Ms. COLLINS (for herself and Mr. BINGAMAN) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

SA 3893. Ms. COLLINS (for herself and Mr. FEINGOLD) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

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

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

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

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

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

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

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

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

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

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

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

''(A) WAITING PERIODS.—For''; and

(2) by adding at the end the following:

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

SA 3894. Ms. LANDRIEU submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

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

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

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

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

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

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

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

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

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

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

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

SA 3895. Ms. LANDRIEU submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

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

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

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

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

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

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

SA 3896. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

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

SEC. 2. REPEAL.

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

SEC. 3. NATIONAL BIODEFENSE INJURY COMPENSATION PROGRAM.

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

''(q) BIODEFENSE INJURY COMPENSATION PROGRAM.—

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

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

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

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

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

''(4) INJURY TABLE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(6) SPECIAL MASTERS.—

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

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

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

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

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

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

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

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

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

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

(3) in paragraph (2)—

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

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

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

''(3) EXCLUSIVITY; OFFSET.—

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

''(i) this subsection;

''(ii) subsection (q); or

''(iii) part C.

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

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

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

(5) in paragraph (6)—

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

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

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

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

(D) by adding at the end the following:

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

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

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

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

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

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

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

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

(6) in paragraph (7)—

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

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

''(i) a substance that is—

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

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

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

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

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

''(II) is—

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

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

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

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

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

(B) in subparagraph (B)—

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

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

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

SA 3897. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

SEC. 2. MEDICARE FOR ALL.

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

''TITLE XXII—MEDICARE FOR ALL

''SEC. 2201. DESCRIPTION OF PROGRAM.

''The program under this title—

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

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

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

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

''(a) ELIGIBILITY.—

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

''(2) ELIGIBLE INDIVIDUAL.—

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

''(i) is—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(b) AUTOMATIC ENROLLMENT.—

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

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

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

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

''(c) COVERAGE.—

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

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

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

''(d) RELATION TO OTHER PROGRAMS.—

''(1) CONSTRUCTION.—

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

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

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

''SEC. 2203. BENEFITS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(b) COST-SHARING.—

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

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

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

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

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

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

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

''(d) PAYMENT SCHEDULE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(c) INCORPORATION OF PROVISIONS.—

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

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

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

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

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

''SEC. 2206. ADMINISTRATION.

''Except as otherwise provided in this title—

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

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

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

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

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

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

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

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

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

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

SEC. 3. FINANCING THROUGH EMPLOYMENT TAX.

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

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

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

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

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

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

(d) RAILROAD RETIREMENT TAX.—

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

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

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

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

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

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

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

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

(f) CONFORMING AMENDMENTS.—

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

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

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

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

SA 3898. Mr. KENNEDY submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE __—HEALTHY FAMILIES

SEC. __01. SHORT TITLE.

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

SEC. __02. FINDINGS.

Congress makes the following findings:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. __03. PURPOSES.

The purposes of this title are—

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

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

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

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

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

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

SEC. __04. DEFINITIONS.

In this title:

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

(A) under 18 years of age; or

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

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

(A) who is—

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

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

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

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

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

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

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

(3) EMPLOYER.—

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

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

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

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

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

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

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

(B) COVERED EMPLOYER.—

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

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

(II) includes—

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

(bb) any successor in interest of an employer;

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) PARENT.—The term ''parent'' means a biological, foster, or adoptive parent of an employee, a stepparent of an employee, or a legal guardian or other person who stood in loco parentis to an employee when the employee was a child.

(7) PRO RATA.—The term ''pro rata'', with respect to benefits offered to part-time employees, means the proportion of each of the benefits offered to full-time employees that are offered to part-time employees that, for each benefit, is equal to the ratio of part-time hours worked to full-time hours worked.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(9) SICK LEAVE.—The term ''sick leave'' means an increment of compensated leave provided by an employer to an employee as a benefit of employment for use by the employee during an absence from employment for any of the reasons described in paragraphs (1) through (3) of section __05(d).

(10) SPOUSE.—The term ''spouse'', with respect to an employee, has the meaning given such term by the marriage laws of the State in which the employee resides.

SEC. __05. PROVISION OF PAID SICK LEAVE.

(a) IN GENERAL.—An employer shall provide for each employee employed by the employer not less than—

(1) 7 days of sick leave with pay annually for employees working 30 or more hours per week; or

(2) a pro rata number of days or hours of sick leave with pay annually for employees working less than—

(A) 30 hours per week on a year-round basis; or

(B) 1,500 hours throughout the year involved.

(b) ACCRUAL.—

(1) PERIOD OF ACCRUAL.—Sick leave provided for under this section shall accrue as determined appropriate by the employer, but not on less than a quarterly basis.

(2) ACCUMULATION.—Accrued sick leave provided for under this section shall carry over from year to year, but this title shall not be construed to require an employer to permit an employee to accumulate more than 7 days of the sick leave.

(3) USE.—The sick leave may be used as accrued. The employer, at the discretion of the employer, may loan the sick leave to the employee in advance of accrual by such employee.

(c) CALCULATION.—

(1) LESS THAN A FULL WORKDAY.—Unless the employer and employee agree to designate otherwise, for periods of sick leave that are less than a normal workday, that leave shall be counted—

(A) on an hourly basis; or

(B) in the smallest increment that the employer's payroll system uses to account for absences or use of leave.

(2) VARIABLE SCHEDULE.—If the schedule of an employee varies from week to week, a weekly average of the hours worked over the 12-week period prior to the beginning of a sick leave period shall be used to calculate the employee's normal workweek for the purpose of determining the amount of sick leave to which the employee is entitled.

(d) USES.—Sick leave accrued under this section may be used by an employee for any of the following:

(1) An absence resulting from a physical or mental illness, injury, or medical condition of the employee.

(2) An absence resulting from obtaining professional medical diagnosis or care, or preventive medical care, for the employee subject to the requirement of subsection (e).

(3) An absence for the purpose of caring for a child, a parent, a spouse, or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship, who—

(A) has any of the conditions or needs for diagnosis or care described in paragraph (1) or (2); and

(B) in the case of someone who is not a child, is otherwise in need of care.

(e) SCHEDULING.—An employee shall make a reasonable effort to schedule leave under paragraphs (2) and (3) of subsection (d) in a manner that does not unduly disrupt the operations of the employer.

(f) PROCEDURES.—

(1) IN GENERAL.—Paid sick leave shall be provided upon the oral or written request of an employee. Such request shall—

(A) include a reason for the absence involved and the expected duration of the leave;

(B) in a case in which the need for leave is foreseeable at least 7 days in advance of such leave, be provided at least 7 days in advance of such leave; and

(C) otherwise, be provided as soon as practicable after the employee is aware of the need for such leave.

(2) CERTIFICATION.—

(A) PROVISION.—

(i) IN GENERAL.—Subject to subparagraph (C), an employer may require that a request for leave be supported by a certification issued by the health care professional of the eligible employee or of an individual described in subsection (d)(3), as appropriate, if the leave period covers more than 3 consecutive workdays.

(ii) TIMELINESS.—The employee shall provide a copy of such certification to the employer in a timely manner, not later than 30 days after the first day of the leave. The employer shall not delay the commencement of

the leave on the basis that the employer has not yet received the certification.

(B) SUFFICIENT CERTIFICATION.—

(i) IN GENERAL.—A certification provided under subparagraph (A) shall be sufficient if it states—

(I) the date on which the leave will be needed;

(II) the probable duration of the leave;

(III) the appropriate medical facts within the knowledge of the health care provider regarding the condition involved, subject to clause (ii); and

(IV)(aa) for purposes of leave under subsection (d)(1), a statement that leave from work is medically necessary;

(bb) for purposes of leave under subsection (d)(2), the dates on which testing for a medical diagnosis or care is expected to be given and the duration of such testing or care; and

(cc) for purposes of leave under subsection (d)(3), in the case of leave to care for someone who is not a child, a statement that care is needed for an individual described in such subsection, and an estimate of the amount of time that such care is needed for such individual.

(ii) LIMITATION.—In issuing a certification under subparagraph (A), a health care provider shall make reasonable efforts to limit the medical facts described in clause (i)(III) that are disclosed in the certification to the minimum necessary to establish a need for the employee to utilize paid sick leave.

(C) REGULATIONS.—Regulations prescribed under section __13 shall specify the manner in which an employee who does not have health insurance shall provide a certification for purposes of this paragraph.

(D) CONFIDENTIALITY AND NONDISCLOSURE.—

(i) PROTECTED HEALTH INFORMATION.—Nothing in this title shall be construed to require a health care provider to disclose information in violation of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) or the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d–2 note).

(ii) HEALTH INFORMATION RECORDS.—If an employer possesses health information about an employee or an employee's child, parent, spouse or other individual described in subsection (d)(3), such information shall—

(I) be maintained on a separate form and in a separate file from other personnel information;

(II) be treated as a confidential medical record; and

(III) not be disclosed except to the affected employee or with the permission of the affected employee.

(g) CURRENT LEAVE POLICIES.—

(1) EQUIVALENCY REQUIREMENT.—An employer with a leave policy providing paid leave options shall not be required to modify such policy, if such policy offers an employee the option, at the employee's discretion, to take paid sick leave that is at least equivalent to the sick leave described in paragraphs (1) and (2) of subsection (a) and subsection (d), or if the policy offers paid leave (in amounts equivalent to the amounts described in such paragraphs) for purposes that include the reasons described in subsection (d).

(2) NO ELIMINATION OR REDUCTION OF LEAVE.—An employer may not eliminate or reduce leave in existence on the date of enactment of this Act, regardless of the type of such leave, in order to comply with the provisions of this title.

SEC. __06. POSTING REQUIREMENT.

(a) IN GENERAL.—Each employer shall post and keep posted a notice, to be prepared or approved in accordance with procedures specified in regulations prescribed under section __13, setting forth excerpts from, or summaries of, the pertinent provisions of this title including—

(1) information describing leave available to employees under this title;

(2) information pertaining to the filing of an action under this title;

(3) the details of the notice requirement for foreseeable leave under section __05(f)(1)(B); and

(4) information that describes—

(A) the protections that an employee has in exercising rights under this title; and

(B) how the employee can contact the Secretary (or other appropriate authority as described in section __08) if any of the rights are violated.

(b) LOCATION.—The notice described under subsection (a) shall be posted—

(1) in conspicuous places on the premises of the employer, where notices to employees (including applicants) are customarily posted; or

(2) in employee handbooks.

(c) VIOLATION; PENALTY.—Any employer who willfully violates the posting requirements of this section shall be subject to a civil fine in an amount not to exceed $100 for each separate offense.

SEC. __07. PROHIBITED ACTS.

(a) INTERFERENCE WITH RIGHTS.—

(1) EXERCISE OF RIGHTS.—It shall be unlawful for any employer to interfere with, restrain, or deny the exercise of, or the attempt to exercise, any right provided under this title.

(2) DISCRIMINATION.—It shall be unlawful for any employer to discharge or in any other manner discriminate against (including retaliating against) any individual for opposing any practice made unlawful by this title, including—

(A) discharging or discriminating against (including retaliating against) any individual for exercising, or attempting to exercise, any right provided under this title;

(B) using the taking of sick leave under this title as a negative factor in an employment action, such as hiring, promotion, or a disciplinary action; or

(C) counting the sick leave under a no-fault attendance policy.

(b) INTERFERENCE WITH PROCEEDINGS OR INQUIRIES.—It shall be unlawful for any person to discharge or in any other manner discriminate against (including retaliating against) any individual because such individual—

(1) has filed an action, or has instituted or caused to be instituted any proceeding, under or related to this title;

(2) has given, or is about to give, any information in connection with any inquiry or proceeding relating to any right provided under this title; or

(3) has testified, or is about to testify, in any inquiry or proceeding relating to any right provided under this title.

(c) CONSTRUCTION.—Nothing in this section shall be construed to state or imply that the scope of the activities prohibited by section 105 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2615) is less than the scope of the activities prohibited by this section.

SEC. __08. ENFORCEMENT AUTHORITY.

(a) IN GENERAL.—

(1) DEFINITION.—In this subsection:

(A) the term ''employee'' means an employee described in clause (i) or (ii) of section __04(2)(A); and

(B) the term ''employer'' means an employer described in subclause (I) or (II) of section __04(3)(A)(i).

(2) INVESTIGATIVE AUTHORITY.—

(A) IN GENERAL.—To ensure compliance with the provisions of this title, or any regulation or order issued under this title, the Secretary shall have, subject to subparagraph (C), the investigative authority provided under section 11(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(a)), with respect to employees and employers.

(B) OBLIGATION TO KEEP AND PRESERVE RECORDS.—An employer shall make, keep, and preserve records pertaining to compliance with this title in accordance with section 11(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(c)) and in accordance with regulations prescribed by the Secretary.

(C) REQUIRED SUBMISSIONS GENERALLY LIMITED TO AN ANNUAL BASIS.—The Secretary shall not require, under the authority of this paragraph, an employer to submit to the Secretary any books or records more than once during any 12-month period, unless the Secretary has reasonable cause to believe there may exist a violation of this title or any regulation or order issued pursuant to this title, or is investigating a charge pursuant to paragraph (4).

(D) SUBPOENA AUTHORITY.—For the purposes of any investigation provided for in this paragraph, the Secretary shall have the subpoena authority provided for under section 9 of the Fair Labor Standards Act of 1938 (29 U.S.C. 209).

(3) CIVIL ACTION BY EMPLOYEES.—

(A) RIGHT OF ACTION.—An action to recover the damages or equitable relief prescribed in subparagraph (B) may be maintained against any employer in any Federal or State court of competent jurisdiction by one or more employees or their representative for and on behalf of—

(i) the employees; or

(ii) the employees and other employees similarly situated.

(B) LIABILITY.—Any employer who violates section __07 (including a violation relating to rights provided under section __05) shall be liable to any employee affected—

(i) for damages equal to—

(I) the amount of—

(aa) any wages, salary, employment benefits, or other compensation denied or lost to such employee by reason of the violation; or

(bb) in a case in which wages, salary, employment benefits, or other compensation have not been denied or lost to the employee, any actual monetary losses sustained by the employee as a direct result of the violation up to a sum equal to 7 days of wages or salary for the employee;

(II) the interest on the amount described in subclause (I) calculated at the prevailing rate; and

(III) an additional amount as liquidated damages; and

(ii) for such equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(C) FEES AND COSTS.—The court in an action under this paragraph shall, in addition to any judgment awarded to the plaintiff, allow a reasonable attorney's fee, reasonable expert witness fees, and other costs of the action to be paid by the defendant.

(4) ACTION BY THE SECRETARY.—

(A) ADMINISTRATIVE ACTION.—The Secretary shall receive, investigate, and attempt to resolve complaints of violations of section __07 (including a violation relating to rights provided under section __05) in the same manner that the Secretary receives, investigates, and attempts to resolve complaints of violations of sections 6 and 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206 and 207).

(B) CIVIL ACTION.—The Secretary may bring an action in any court of competent jurisdiction to recover the damages described in paragraph (3)(B)(i).

(C) SUMS RECOVERED.—Any sums recovered by the Secretary pursuant to subparagraph (B) shall be held in a special deposit account

and shall be paid, on order of the Secretary, directly to each employee affected. Any such sums not paid to an employee because of inability to do so within a period of 3 years shall be deposited into the Treasury of the United States as miscellaneous receipts.

(5) LIMITATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an action may be brought under paragraph (3), (4), or (6) not later than 2 years after the date of the last event constituting the alleged violation for which the action is brought.

(B) WILLFUL VIOLATION.—In the case of an action brought for a willful violation of section __07 (including a willful violation relating to rights provided under section __05), such action may be brought within 3 years of the date of the last event constituting the alleged violation for which such action is brought.

(C) COMMENCEMENT.—In determining when an action is commenced under paragraph (3), (4), or (6) for the purposes of this paragraph, it shall be considered to be commenced on the date when the complaint is filed.

(6) ACTION FOR INJUNCTION BY SECRETARY.—The district courts of the United States shall have jurisdiction, for cause shown, in an action brought by the Secretary—

(A) to restrain violations of section __07 (including a violation relating to rights provided under section __05), including the restraint of any withholding of payment of wages, salary, employment benefits, or other compensation, plus interest, found by the court to be due to employees eligible under this title; or

(B) to award such other equitable relief as may be appropriate, including employment, reinstatement, and promotion.

(7) SOLICITOR OF LABOR.—The Solicitor of Labor may appear for and represent the Secretary on any litigation brought under paragraph (4) or (6).

(8) GOVERNMENT ACCOUNTABILITY OFFICE AND LIBRARY OF CONGRESS.—Notwithstanding any other provision of this subsection, in the case of the Government Accountability Office and the Library of Congress, the authority of the Secretary of Labor under this subsection shall be exercised respectively by the Comptroller General of the United States and the Librarian of Congress.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—The powers, remedies, and procedures provided in the Congressional Accountability Act of 1995 (2 U.S.C. 1301 et seq.) to the Board (as defined in section 101 of that Act (2 U.S.C. 1301)), or any person, alleging a violation of section 202(a)(1) of that Act (2 U.S.C. 1312(a)(1)) shall be the powers, remedies, and procedures this title provides to that Board, or any person, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(iii).

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—The powers, remedies, and procedures provided in chapter 5 of title 3, United States Code, to the President, the Merit Systems Protection Board, or any person, alleging a violation of section 412(a)(1) of that title, shall be the powers, remedies, and procedures this title provides to the President, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(iv).

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—The powers, remedies, and procedures provided in title 5, United States Code, to an employing agency, provided in chapter 12 of that title to the Merit Systems Protection Board, or provided in that title to any person, alleging a violation of chapter 63 of that title, shall be the powers, remedies, and procedures this title provides to that agency, that Board, or any person, respectively, alleging an unlawful employment practice in violation of this title against an employee described in section __04(2)(A)(v).

SEC. __09. GAO STUDY.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to determine the following:

(1) The number of days employees used paid sick leave including—

(A) the number of employees who used paid sick leave annually;

(B) both the number of consecutive days, and total days, employees used paid sick leave for their illnesses, or illnesses of—

(i) a child;

(ii) a spouse;

(iii) a parent; or

(iv) any other individual; and

(C) the number of employees who used paid sick leave for leave periods covering more than 3 consecutive workdays.

(2) Whether employees used paid sick leave to care for illnesses or conditions caused by domestic violence against the employees or their family members.

(3) The cost to employers of implementing paid sick leave policies.

(4) The benefits to employers of implementing the policies, including improvements in retention and absentee rates and productivity.

(5) The cost to employees of providing certification issued by a health care provider to obtain paid sick leave.

(6) The benefits of paid sick leave to employees and their family members.

(7) Whether the provision of paid sick leave has affected the ability of employees to care for their family members.

(8) Whether and in what way the provision of paid sick leave affected the ability of employees to provide for their health needs.

(9) Whether the provision of paid sick leave affected the ability of employees to sustain an adequate income while meeting health needs of the employees and their family members.

(10) Whether employers who administered paid sick leave policies prior to the date of enactment of this Act were affected by the provisions of this title.

(11) Whether other types of leave were affected by this title including whether this title affected—

(A) paid vacation leave;

(B) paid family or medical leave; or

(C) personal leave.

(12) Whether paid sick leave affected retention and turnover.

(13) Whether paid sick leave increased the use of less costly preventive medical care and lowered the use of emergency room care.

(14) Whether paid sick leave reduced the number of children sent to school when the children were sick.

(15) Whether paid sick leave reduced the costs of presenteeism for employers.

(b) AGGREGATING DATA.—The data collected under paragraphs (1), (2), and (7) of subsection (a) shall be aggregated by gender, race, disability, earnings level, age, marital status, and family type, including parental status.

(c) REPORTS.—

(1) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the appropriate committees of Congress concerning the results of the study conducted pursuant to subsection (a) and the data aggregated under subsection (b).

(2) FOLLOWUP REPORT.—Not later that 5 years after the date of enactment of this Act the Comptroller General of the United States shall prepare and submit a followup report to the appropriate committees of Congress concerning the results of the study conducted pursuant to subsection (a) and the data aggregated under subsection (b).

SEC. __10. EFFECT ON OTHER LAWS.

(a) FEDERAL AND STATE ANTIDISCRIMINATION LAWS.—Nothing in this title shall be construed to modify or affect any Federal or State law prohibiting discrimination on the basis of race, religion, color, national origin, sex, age, or disability.

(b) STATE AND LOCAL LAWS.—Nothing in this title shall be construed to supersede any provision of any State or local law that provides greater paid sick leave or other leave rights than the rights established under this title.

SEC. __11. EFFECT ON EXISTING EMPLOYMENT BENEFITS.

(a) MORE PROTECTIVE.—Nothing in this title shall be construed to diminish the obligation of an employer to comply with any contract, collective bargaining agreement, or any employment benefit program or plan that provides greater paid sick leave rights to employees than the rights established under this title.

(b) LESS PROTECTIVE.—The rights established for employees under this title shall not be diminished by any contract, collective bargaining agreement, or any employment benefit program or plan.

SEC. __12. ENCOURAGEMENT OF MORE GENEROUS LEAVE POLICIES.

Nothing in this title shall be construed to discourage employers from adopting or retaining leave policies more generous than policies that comply with the requirements of this title.

SEC. __13. REGULATIONS.

(a) IN GENERAL.—

(1) AUTHORITY.—Except as provided in paragraph (2), not later than 120 days after the date of enactment of this Act, the Secretary shall prescribe such regulations as are necessary to carry out this title with respect to employees described in clause (i) or (ii) of section __04(2)(A).

(2) GOVERNMENT ACCOUNTABILITY OFFICE; LIBRARY OF CONGRESS.—The Comptroller General of the United States and the Librarian of Congress shall prescribe the regulations with respect to employees of the Government Accountability Office and the Library of Congress, respectively.

(b) EMPLOYEES COVERED BY CONGRESSIONAL ACCOUNTABILITY ACT OF 1995.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Board of Directors of the Office of Compliance shall prescribe (in accordance with section 304 of the Congressional Accountability Act of 1995 (2 U.S.C. 1384)) such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(iii).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the Board may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(c) EMPLOYEES COVERED BY CHAPTER 5 OF TITLE 3, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the President (or the designee of the President) shall prescribe such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(iv).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the President (or designee) may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

(d) EMPLOYEES COVERED BY CHAPTER 63 OF TITLE 5, UNITED STATES CODE.—

(1) AUTHORITY.—Not later than 120 days after the date of enactment of this Act, the Director of the Office of Personnel Management shall prescribe such regulations as are necessary to carry out this title with respect to employees described in section __04(2)(A)(v).

(2) AGENCY REGULATIONS.—The regulations prescribed under paragraph (1) shall be the same as substantive regulations promulgated by the Secretary to carry out this title except insofar as the Director may determine, for good cause shown and stated together with the regulations prescribed under paragraph (1), that a modification of such regulations would be more effective for the implementation of the rights and protections involved under this section.

SEC. __14. EFFECTIVE DATES.

(a) IN GENERAL.—This title shall take effect 1 year after the date of issuance of regulations under section __13(a)(1).

(b) COLLECTIVE BARGAINING AGREEMENTS.—In the case of a collective bargaining agreement in effect on the effective date prescribed by subsection (a), this title shall take effect on the earlier of—

(1) the date of the termination of such agreement; or

(2) the date that occurs 18 months after the date of issuance of regulations under section __13(a)(1).

SA 3899. Mr. DURBIN (for himself, Mrs. LINCOLN, Mr. REID, Mr. BAUCUS, Mr. KENNEDY, Mrs. CLINTON, Mr. KERRY, Mr. BINGAMAN, Ms. CANTWELL, Mr. PRYOR, Mr. HARKIN, Mr. OBAMA, Mr. LAUTENBERG, Mr. SCHUMER, Mr. KOHL, Mr. LIEBERMAN, Mr. DODD, Mr. DAYTON, Mr. JOHNSON, Mr. MENENDEZ, Mrs. BOXER, Mr. NELSON of Florda, Ms. MIKULSKI, Ms. STABENOW, Mr. CARPER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Employers Health Benefits Program Act of 2006''.

SEC. 2. DEFINITIONS.

(a) IN GENERAL.—In this Act, the terms ''member of family'', ''health benefits plan'', ''carrier'', ''employee organizations'', and ''dependent'' have the meanings given such terms in section 8901 of title 5, United States Code.

(b) OTHER TERMS.—In this Act:

(1) EMPLOYEE.—The term ''employee'' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(6)). Such term shall not include an employee of the Federal Government.

(2) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers who employed an average of at least 1 but not more than 100 employees on business days during the year preceding the date of application. Such term shall not include the Federal Government.

(3) HEALTH STATUS-RELATED FACTOR.—The term ''health status-related factor'' has the meaning given such term in section 2791(d)(9) of the Public Health Service Act (42 U.S.C. 300gg–91(d)(9)).

(4) OFFICE.—The term ''Office'' means the Office of Personnel Management.

(5) PARTICIPATING EMPLOYER.—The term ''participating employer'' means an employer that—

(A) elects to provide health insurance coverage under this Act to its employees; and

(B) is not offering other comprehensive health insurance coverage to such employees.

(c) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of subsection (b)(2):

(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence for the full year prior to the date on which the employer applies to participate, the determination of whether such employer meets the requirements of subsection (b)(2) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the employer's first full year.

(3) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(d) WAIVER AND CONTINUATION OF PARTICIPATION.—

(1) WAIVER.—The Office may waive the limitations relating to the size of an employer which may participate in the health insurance program established under this Act on a case by case basis if the Office determines that such employer makes a compelling case for such a waiver. In making determinations under this paragraph, the Office may consider the effects of the employment of temporary and seasonal workers and other factors.

(2) CONTINUATION OF PARTICIPATION.—An employer participating in the program under this Act that experiences an increase in the number of employees so that such employer has in excess of 100 employees, may not be excluded from participation solely as a result of such increase in employees.

(e) TREATMENT OF HEALTH BENEFITS PLAN AS GROUP HEALTH PLAN.—A health benefits plan offered under this Act shall be treated as a group health plan for purposes of applying the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) except to the extent that a provision of this Act expressly provides otherwise.

SEC. 3. HEALTH INSURANCE COVERAGE FOR NON-FEDERAL EMPLOYEES.

(a) ADMINISTRATION.—The Office shall administer a health insurance program for non-Federal employees and employers in accordance with this Act.

(b) REGULATIONS.—Except as provided under this Act, the Office shall prescribe regulations to apply the provisions of chapter 89 of title 5, United States Code, to the greatest extent practicable to participating carriers, employers, and employees covered under this Act.

(c) LIMITATIONS.—In no event shall the enactment of this Act result in—

(1) any increase in the level of individual or Federal Government contributions required under chapter 89 of title 5, United States Code, including copayments or deductibles;

(2) any decrease in the types of benefits offered under such chapter 89; or

(3) any other change that would adversely affect the coverage afforded under such chapter 89 to employees and annuitants and members of family under that chapter.

(d) ENROLLMENT.—The Office shall develop methods to facilitate enrollment under this Act, including the use of the Internet.

(e) CONTRACTS FOR ADMINISTRATION.—The Office may enter into contracts for the performance of appropriate administrative functions under this Act.

(f) SEPARATE RISK POOL.—In the administration of this Act, the Office shall ensure that covered employees under this Act are in a risk pool that is separate from the risk pool maintained for covered individuals under chapter 89 of title 5, United States Code.

(g) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to require a carrier that is participating in the program under chapter 89 of title 5, United States Code, to provide health benefits plan coverage under this Act.

SEC. 4. CONTRACT REQUIREMENT.

(a) IN GENERAL.—The Office may enter into contracts with qualified carriers offering health benefits plans of the type described in section 8903 or 8903a of title 5, United States Code, without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to provide health insurance coverage to employees of participating employers under this Act. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Office shall ensure that health benefits coverage is provided for individuals only, individuals with one or more children, married individuals without children, and married individuals with one or more children.

(b) ELIGIBILITY.—A carrier shall be eligible to enter into a contract under subsection (a) if such carrier—

(1) is licensed to offer health benefits plan coverage in each State in which the plan is offered; and

(2) meets such other requirements as determined appropriate by the Office.

(c) STATEMENT OF BENEFITS.—

(1) IN GENERAL.—Each contract under this Act shall contain a detailed statement of benefits offered and shall include information concerning such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(2) ENSURING A RANGE OF PLANS.—The Office shall ensure that a range of health benefits plans are available to participating employers under this Act.

(3) PARTICIPATING PLANS.—The Office shall not prohibit the offering of any health benefits plan to a participating employer if such plan is eligible to participate in the Federal Employees Health Benefits Program.

(4) NATIONWIDE PLAN.—With respect to all nationwide plans, the Office shall develop a benefit package that shall be offered in the case of a contract for a health benefit plan that is to be offered on a nationwide basis that meets all State benefit mandates.

(d) STANDARDS.—The minimum standards prescribed for health benefits plans under section 8902(e) of title 5, United States Code, and for carriers offering plans, shall apply to plans and carriers under this Act. Approval of a plan may be withdrawn by the Office only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

(e) CONVERSION.—

(1) IN GENERAL.—A contract may not be made or a plan approved under this section if the carrier under such contract or plan does not offer to each enrollee whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which the individual may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An enrollee who exercises this option shall pay the full periodic charges of the nongroup contract.

(2) NONCANCELLABLE.—The benefits and coverage made available under paragraph (1) may not be canceled by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(f) REQUIREMENT OF PAYMENT FOR OR PROVISION OF HEALTH SERVICE.—Each contract entered into under this Act shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of title 5, United States Code, is entitled thereto under the terms of the contract.

SEC. 5. ELIGIBILITY.

An individual shall be eligible to enroll in a plan under this Act if such individual—

(1) is an employee of an employer described in section 2(b)(2), or is a self employed individual as defined in section 401(c)(1)(B) of the Internal Revenue Code of 1986; and

(2) is not otherwise enrolled or eligible for enrollment in a plan under chapter 89 of title 5, United States Code.

SEC. 6. ALTERNATIVE CONDITIONS TO FEDERAL EMPLOYEE PLANS.

(a) TREATMENT OF EMPLOYEE.—For purposes of enrollment in a health benefits plan under this Act, an individual who had coverage under a health insurance plan and is not a qualified beneficiary as defined under section 4980B(g)(1) of the Internal Revenue Code of 1986 shall be treated in a similar manner as an individual who begins employment as an employee under chapter 89 of title 5, United States Code.

(b) PREEXISTING CONDITION EXCLUSIONS.—

(1) IN GENERAL.—Each contract under this Act may include a preexisting condition exclusion as defined under section 9801(b)(1) of the Internal Revenue Code of 1986.

(2) EXCLUSION PERIOD.—A preexisting condition exclusion under this subsection shall provide for coverage of a preexisting condition to begin not later than 6 months after the date on which the coverage of the individual under a health benefits plan commences, reduced by the aggregate 1 day for each day that the individual was covered under a health insurance plan immediately preceding the date the individual submitted an application for coverage under this Act. This provision shall be applied notwithstanding the applicable provision for the reduction of the exclusion period provided for in section 701(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(3)).

(c) RATES AND PREMIUMS.—

(1) IN GENERAL.—Rates charged and premiums paid for a health benefits plan under this Act—

(A) shall be determined in accordance with this subsection;

(B) may be annually adjusted subject to paragraph (3);

(C) shall be negotiated in the same manner as rates and premiums are negotiated under such chapter 89; and

(D) shall be adjusted to cover the administrative costs of the Office under this Act.

(2) DETERMINATIONS.—In determining rates and premiums under this Act, the following provisions shall apply:

(A) IN GENERAL.—A carrier that enters into a contract under this Act shall determine that amount of premiums to assess for coverage under a health benefits plan based on an community rate that may be annually adjusted—

(i) for the geographic area involved if the adjustment is based on geographical divisions that are not smaller than a metropolitan statistical area and the carrier provides evidence of geographic variation in cost of services;

(ii) based on whether such coverage is for an individual, two adults, one adult and one or more children, or a family; and

(iii) based on the age of covered individuals (subject to subparagraph (C)).

(B) LIMITATION.—Premium rates charged for coverage under this Act shall not vary based on health-status related factors, gender, class of business, or claims experience

(C) AGE ADJUSTMENTS.—

(i) IN GENERAL.—With respect to subparagraph (A)(iii), in making adjustments based on age, the Office shall establish no more than 5 age brackets to be used by the carrier in establishing rates. The rates for any age bracket may not vary by more than 50 percent above or below the community rate on the basis of attained age. Age-related premiums may not vary within age brackets.

(ii) AGE 65 AND OLDER.—With respect to subparagraph (A)(iii), a carrier may develop separate rates for covered individuals who are 65 years of age or older for whom medicare is the primary payor for health benefits coverage which is not covered under medicare.

''(3) READJUSTMENTS.—Any readjustment in rates charged or premiums paid for a health benefits plan under this Act shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the practice of the Office for the Federal Employees Health Benefits Program.

(d) TERMINATION AND REENROLLMENT.—If an individual who is enrolled in a health benefits plan under this Act terminates the enrollment, the individual shall not be eligible for reenrollment until the first open enrollment period following the expiration of 6 months after the date of such termination.

(e) CONTINUED APPLICABILITY OF STATE LAW.—

(1) HEALTH INSURANCE OR PLANS.—

(A) PLANS.—With respect to a contract entered into under this Act under which a carrier will offer health benefits plan coverage, State mandated benefit laws in effect in the State in which the plan is offered shall continue to apply.

(B) RATING RULES.—The rating requirements under subparagraphs (A) and (B) of subsection (c)(2) shall supercede State rating rules for qualified plans under this Act, except with respect to States that provide a rating variance with respect to age that is less than the Federal limit or that provide for some form of community rating.

(2) LIMITATION.—Nothing in this subsection shall be construed to preempt—

(A) any State or local law or regulation except those laws and regulations described in subparagraph (B) of paragraph (1);

(B) any State grievance, claims, and appeals procedure law, except to the extent that such law is preempted under section 514 of the Employee Retirement Income Security Act of 1974; and

(C) State network adequacy laws.

(f) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to limit the application of the service-charge system used by the Office for determining profits for participating carriers under chapter 89 of title 5, United States Code.

SEC. 7. ENCOURAGING PARTICIPATION BY CARRIERS THROUGH ADJUSTMENTS FOR RISK.

(a) APPLICATION OF RISK CORRIDORS.—

(1) IN GENERAL.—This section shall only apply to carriers with respect to health benefits plans offered under this Act during any of calendar years 2007 through 2009.

(2) NOTIFICATION OF COSTS UNDER THE PLAN.—In the case of a carrier that offers a health benefits plan under this Act in any of calendar years 2007 through 2009, the carrier shall notify the Office, before such date in the succeeding year as the Office specifies, of the total amount of costs incurred in providing benefits under the health benefits plan for the year involved and the portion of such costs that is attributable to administrative expenses.

(3) ALLOWABLE COSTS DEFINED.—For purposes of this section, the term ''allowable costs'' means, with respect to a health benefits plan offered by a carrier under this Act, for a year, the total amount of costs described in paragraph (2) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such paragraph.

(b) ADJUSTMENT OF PAYMENT.—

(1) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN 3 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for a calendar year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year involved, there shall be no payment adjustment under this section for the plan and year.

(2) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE 103 PERCENT OF TARGET AMOUNT.—

(A) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier of an amount equal to 75 percent of the difference between such allowable costs and 103 percent of such target amount.

(B) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are greater than 108 percent of the target amount for the plan and year, the Office shall reimburse the carrier for such excess costs through payment to the carrier in an amount equal to the sum of—

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between such allowable costs and 108 percent of such target amount.

(3) REDUCTION IN PAYMENT IF ALLOWABLE COSTS BELOW 97 PERCENT OF TARGET AMOUNT.—

(A) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the carrier shall be required to pay into the contingency reserve fund maintained under section 8909(b)(2) of title 5, United States Code, an amount equal to 75 percent of the difference between 97 percent

of the target amount and such allowable costs.

(B) COSTS BELOW 92 PERCENT OF TARGET AMOUNT.—If the allowable costs for the carrier with respect to the health benefits plan involved for the year are less than 92 percent of the target amount for the plan and year, the carrier shall be required to pay into the stabilization fund under section 8909(b)(2) of title 5, United States Code, an amount equal to the sum of—

(i) 3.75 percent of such target amount; and

(ii) 90 percent of the difference between 92 percent of such target amount and such allowable costs.

(4) TARGET AMOUNT DESCRIBED.—

(A) IN GENERAL.—For purposes of this subsection, the term ''target amount'' means, with respect to a health benefits plan offered by a carrier under this Act in any of calendar years 2007 through 2011, an amount equal to—

(i) the total of the monthly premiums estimated by the carrier and approved by the Office to be paid for enrollees in the plan under this Act for the calendar year involved; reduced by

(ii) the amount of administrative expenses that the carrier estimates, and the Office approves, will be incurred by the carrier with respect to the plan for such calendar year.

(B) SUBMISSION OF TARGET AMOUNT.—Not later than December 31, 2006, and each December 31 thereafter through calendar year 2010, a carrier shall submit to the Office a description of the target amount for such carrier with respect to health benefits plans provided by the carrier under this Act.

(c) DISCLOSURE OF INFORMATION.—

(1) IN GENERAL.—Each contract under this Act shall provide—

(A) that a carrier offering a health benefits plan under this Act shall provide the Office with such information as the Office determines is necessary to carry out this subsection including the notification of costs under subsection (a)(2) and the target amount under subsection (b)(4)(B); and

(B) that the Office has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Office under such subsections.

(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Office only for the purposes of, and to the extent necessary in, carrying out this section.

SEC. 8. ENCOURAGING PARTICIPATION BY CARRIERS THROUGH REINSURANCE.

(a) ESTABLISHMENT.—The Office shall establish a reinsurance fund to provide payments to carriers that experience one or more catastrophic claims during a year for health benefits provided to individuals enrolled in a health benefits plan under this Act.

(b) ELIGIBILITY FOR PAYMENTS.—To be eligible for a payment from the reinsurance fund for a plan year, a carrier under this Act shall submit to the Office an application that contains—

(1) a certification by the carrier that the carrier paid for at least one episode of care during the year for covered health benefits for an individual in an amount that is in excess of $50,000; and

(2) such other information determined appropriate by the Office.

(c) PAYMENT.—

(1) IN GENERAL.—The amount of a payment from the reinsurance fund to a carrier under this section for a catastrophic episode of care shall be determined by the Office but shall not exceed an amount equal to 80 percent of the applicable catastrophic claim amount.

(2) APPLICABLE CATASTROPHIC CLAIM AMOUNT.—For purposes of paragraph (1), the applicable catastrophic episode of care amount shall be equal to the difference between—

(A) the amount of the catastrophic claim; and

(B) $50,000.

(3) LIMITATION.—In determining the amount of a payment under paragraph (1), if the amount of the catastrophic claim exceeds the amount that would be paid for the healthcare items or services involved under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Office shall use the amount that would be paid under such title XVIII for purposes of paragraph (2)(A).

(d) DEFINITION.—In this section, the term ''catastrophic claim'' means a claim submitted to a carrier, by or on behalf of an enrollee in a health benefits plan under this Act, that is in excess of $50,000.

(e) TERMINATION OF FUND.—The reinsurance fund established under subsection (a) shall terminate on the date that is 2 years after the date on which the first contract period becomes effective under this Act.

SEC. 9. CONTINGENCY RESERVE FUND.

Beginning on October 1, 2010, the Office may use amounts appropriated under section 14(a) that remain unobligated to establish a contingency reserve fund to provide assistance to carriers offering health benefits plans under this Act that experience unanticipated financial hardships (as determined by the Office).

SEC. 10. EMPLOYER PARTICIPATION.

(a) REGULATIONS.—The Office shall prescribe regulations providing for employer participation under this Act, including the offering of health benefits plans under this Act to employees.

(b) ENROLLMENT AND OFFERING OF OTHER COVERAGE.—

(1) ENROLLMENT.—A participating employer shall ensure that each eligible employee has an opportunity to enroll in a plan under this Act.

(2) PROHIBITION ON OFFERING OTHER COMPREHENSIVE HEALTH BENEFIT COVERAGE.—A participating employer may not offer a health insurance plan providing comprehensive health benefit coverage to employees other than a health benefits plan that—

(A) meets the requirements described in section 4(a); and

(B) is offered only through the enrollment process established by the Office under section 3.

(3) OFFER OF SUPPLEMENTAL COVERAGE OPTIONS.—

(A) IN GENERAL.—A participating employer may offer supplementary coverage options to employees.

(B) DEFINITION.—In subparagraph (A), the term ''supplementary coverage'' means benefits described as ''excepted benefits'' under section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91(c)).

(c) RULE OF CONSTRUCTION.—Except as provided in section 15, nothing in this Act shall be construed to require that an employer make premium contributions on behalf of employees.

SEC. 11. ADMINISTRATION THROUGH REGIONAL ADMINISTRATIVE ENTITIES.

(a) IN GENERAL.—In order to provide for the administration of the benefits under this Act with maximum efficiency and convenience for participating employers and health care providers and other individuals and entities providing services to such employers, the Office is authorized to enter into contracts with eligible entities to perform, on a regional basis, one or more of the following:

(1) Collect and maintain all information relating to individuals, families, and employers participating in the program under this Act in the region served.

(2) Receive, disburse, and account for payments of premiums to participating employers by individuals in the region served, and for payments by participating employers to carriers.

(3) Serve as a channel of communication between carriers, participating employers, and individuals relating to the administration of this Act.

(4) Otherwise carry out such activities for the administration of this Act, in such manner, as may be provided for in the contract entered into under this section.

(5) The processing of grievances and appeals.

(b) APPLICATION.—To be eligible to receive a contract under subsection (a), an entity shall prepare and submit to the Office an application at such time, in such manner, and containing such information as the Office may require.

(c) PROCESS.—

(1) COMPETITIVE BIDDING.—All contracts under this section shall be awarded through a competitive bidding process on a bi-annual basis.

(2) REQUIREMENT.—No contract shall be entered into with any entity under this section unless the Office finds that such entity will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Office finds pertinent.

(3) PUBLICATION OF STANDARDS AND CRITERIA.—The Office shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. In establishing such standards and criteria, the Office shall provide for a system to measure an entity's performance of responsibilities.

(4) TERM.—Each contract under this section shall be for a term of at least 1 year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term, except that the Office may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the entity involved as the Office may provide in regulations) if the Office finds that the entity has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the program established by this Act.

(d) TERMS OF CONTRACT.—A contract entered into under this section shall include—

(1) a description of the duties of the contracting entity;

(2) an assurance that the entity will furnish to the Office such timely information and reports as the Office determines appropriate;

(3) an assurance that the entity will maintain such records and afford such access thereto as the Office finds necessary to assure the correctness and verification of the information and reports under paragraph (2) and otherwise to carry out the purposes of this Act;

(4) an assurance that the entity shall comply with such confidentiality and privacy protection guidelines and procedures as the Office may require; and

(5) such other terms and conditions not inconsistent with this section as the Office may find necessary or appropriate.

SEC. 12. COORDINATION WITH SOCIAL SECURITY BENEFITS.

Benefits under this Act shall, with respect to an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, be offered (for use in coordination with those medicare benefits) to the same extent and in the same manner as if coverage were under chapter 89 of title 5, United States Code.

SEC. 13. PUBLIC EDUCATION CAMPAIGN.

(a) IN GENERAL.—In carrying out this Act, the Office shall develop and implement an educational campaign to provide information to employers and the general public concerning the health insurance program developed under this Act.

(b) ANNUAL PROGRESS REPORTS.—Not later than 1 year and 2 years after the implementation of the campaign under subsection (a), the Office shall submit to the appropriate committees of Congress a report that describes the activities of the Office under subsection (a), including a determination by the office of the percentage of employers with knowledge of the health benefits programs provided for under this Act.

(c) PUBLIC EDUCATION CAMPAIGN.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2007 and 2008.

SEC. 14. APPROPRIATIONS.

There are authorized to be appropriated to the Office, such sums as may be necessary in each fiscal year for the development and administration of the program under this Act.

SEC. 15. REFUNDABLE CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and inserting after section 35 the following new section:

"SEC. 36. SMALL BUSINESS EMPLOYEE HEALTH INSURANCE EXPENSES.

''(a) DETERMINATION OF AMOUNT.—In the case of a qualified small employer, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the sum of—

''(1) the expense amount described in subsection (b), and

''(2) the expense amount described in subsection (c), paid by the taxpayer during the taxable year.

''(b) SUBSECTION (b) EXPENSE AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The expense amount described in this subsection is the applicable percentage of the amount of qualified employee health insurance expenses of each qualified employee.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

''(A) IN GENERAL.—The applicable percentage is equal to—

''(i) 25 percent in the case of self-only coverage,

''(ii) 35 percent in the case of family coverage (as defined in section 220(c)(5)), and

''(iii) 30 percent in the case of coverage for two adults or one adult and one or more children.

''(B) BONUS FOR PAYMENT OF GREATER PERCENTAGE OF PREMIUMS.—The applicable percentage otherwise specified in subparagraph (A) shall be increased by 5 percentage points for each additional 10 percent of the qualified employee health insurance expenses of each qualified employee exceeding 60 percent which are paid by the qualified small employer.

''(c) SUBSECTION (c) EXPENSE AMOUNT.—For purposes of this section—

''(1) IN GENERAL.—The expense amount described in this subsection is, with respect to the first credit year of a qualified small employer which is an eligible employer, 10 percent of the qualified employee health insurance expenses of each qualified employee.

''(2) FIRST CREDIT YEAR.—For purposes of paragraph (1), the term 'first credit year' means the taxable year which includes the date that the health insurance coverage to which the qualified employee health insurance expenses relate becomes effective.

''(d) LIMITATION BASED ON WAGES.— With respect to a qualified employee whose wages at an annual rate during the taxable year exceed $25,000, the percentage which would (but for this section) be taken into account as the percentage for purposes of subsection (b)(2) or (c)(1) for the taxable year shall be reduced by an amount equal to the product of such percentage and the percentage that such qualified employee's wages in excess of $25,000 bears to $5,000.

''(e) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED SMALL EMPLOYER.—The term 'qualified small employer' means any employer (as defined in section 2(b)(2) of the Small Employers Health Benefits Program Act of 2006) which—

''(A) is a participating employer (as defined in section 2(b)(5) of such Act),

''(B) pays or incurs at least 60 percent of the qualified employee health insurance expenses of each qualified employee for self-only coverage, and

''(C) pays or incurs at least 50 percent of the qualified employee health insurance expenses of each qualified employee for all other categories of coverage.

''(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

''(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer for health insurance coverage under such Act to the extent such amount is attributable to coverage provided to any employee while such employee is a qualified employee.

''(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account under subparagraph (A).

''(3) QUALIFIED EMPLOYEE.—

''(A) DEFINITION.—

''(i) IN GENERAL.—The term 'qualified employee' means, with respect to any period, an employee (as defined in section 2(b)(1) of such Act) of an employer if the total amount of wages paid or incurred by such employer to such employee at an annual rate during the taxable year exceeds $5,000 but does not exceed $30,000.

''(ii) ANNUAL ADJUSTMENT.—For each taxable year after 2007, the dollar amounts specified for the preceding taxable year (after the application of this subparagraph) shall be increased by the same percentage as the average percentage increase in premiums under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code for the calendar year in which such taxable year begins over the preceding calendar year.

''(B) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(f) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

''(g) CREDITS FOR NONPROFIT ORGANIZATIONS.—Any credit which would be allowable under subsection (a) with respect to a qualified small business if such qualified small business were not exempt from tax under this chapter shall be treated as a credit allowable under this subpart to such qualified small business.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 36 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

''Sec. 36. Small business employee health insurance expenses.

''Sec. 37. Overpayments of tax.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2006.

SEC. 16. EFFECTIVE DATE.

Except as provided in section 10(e), this Act shall take effect on the date of enactment of this Act and shall apply to contracts that take effect with respect to calendar year 2007 and each calendar year thereafter.

SA 3900. Mr. CARPER (for himself and Mrs. FEINSTEIN) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. CANCER SCREENING.

(a) FINDINGS.—Congress makes the following findings:

(1) About 1,400,000 new cases of cancer will be diagnosed in the United States in 2006.

(2) Medical costs, lost wages, and lost productivity due to cancer cost the United States and estimated $210,000,000,000 in 2005.

(3) In 2006, cancer will take the lives of 565,000 Americans, or about 1,500 people per day.

(4) About half of all new cancer cases can be prevented or detected earlier through screening.

(5) The 5 year survival rate for cancers of the breast, colon, rectum, cervix, prostate, oral cavity, and skin is currently about 86 percent, in part due to earlier diagnosis through screening. If these cancers were diagnosed at the earliest stage through regular cancer screenings, that survival rate could increase to 95 percent.

(b) LIMITATIONS.—Notwithstanding any other provision of this Act (or an amendment made by this Act), nothing in this Act (or amendment) shall be construed to permit a small business health plan to be offered in a State, or to permit the offering of any other health insurance coverage in such State, if the plan or coverage fails to comply with laws of the State that require coverage for cancer screening, including screening for breast, cervical, colorectal, prostate, lung, uterine, skin, colon, stomach, and other cancers.

SA 3901. Mr. AKAKA (for himself and Mr. OBAMA) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small

business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. REPEAL OF REQUIREMENT FOR DOCUMENTATION EVIDENCING CITIZENSHIP OR NATIONALITY AS A CONDITION FOR RECEIPT OF MEDICAL ASSISTANCE UNDER THE MEDICAID PROGRAM.

(a) REPEAL.—Subsections (i)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as added by section 6036 of the Deficit Reduction Act of 2005, are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)—

(i) in paragraph (20), by adding ''or'' after the semicolon at the end; and

(ii) in paragraph (21), by striking ''; or'' and inserting a period;

(B) by redesignating subsection (y), as added by section 6043(b) of the Deficit Reduction Act of 2005, as subsection (x); and

(C) by redesignating subsection (z), as added by section 6081(a) of the Deficit Reduction Act of 2005, as subsection (y).

(2) Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 is repealed.

(c) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005.

SA 3902. Mr. PRYOR submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike title III.

SA 3903. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the end of the amendment, add the following:

TITLE ___—MISCELLANEOUS PROVISIONS

SEC. ___. GAO EVALUATION.

(a) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, the Government Accountability Office shall conduct a study, and submit to the appropriate committees of Congress a report, concerning the impact of this Act (and the amendments made by this Act) on the costs and quality of health care coverage.

(b) REPEAL.—If the study and report under subsection (a) finds that the implementation of this Act (and amendments) does not result in a decrease in health care coverage costs or in an increase in access to such coverage, the provisions of this Act (and such amendments) shall be repealed effective on the date on which such report is submitted.

SA 3904. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON PREEMPTION.

Unless otherwise specifically provided for in this Act (or an amendment made by this Act), nothing in this Act (or amendment) shall be construed to preempt any State or local law related to health insurance.

SA 3905. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. BENEFIT REVIEW PANEL ON HEALTH INSURANCE.

(a) BENEFIT REVIEW PANEL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with the National Association of Insurance Commissioners, shall establish the Benefit Review Panel on Health Insurance (referred to in this section as the ''Panel'') to develop recommendations that a Federal floor of benefit mandates be established from the current array of inconsistent State health insurance laws and in accordance with the laws adopted in a plurality of the States.

(2) COMPOSITION.—The Panel shall be composed of the following individuals appointed by the Secretary:

(A) Two State insurance commissioners, of which—

(i) 1 shall be a Democrat and 1 shall be a Republican; and

(ii) 1 shall be designated as the chairperson and 1 shall be designated as the vice-chairperson.

(B) Two representatives of State government, of which—

(i) 1 shall be a governor of a State and 1 shall be a State legislator; and

(ii) 1 shall be a Democrat and 1 shall be a Republican.

(C) Two representatives of employers, of which 1 shall represent small employers and 1 shall represent large employers.

(D) Two representatives of health insurers, of which 1 shall represent insurers that offer coverage in all markets (including individual, small, and large markets), and 1 shall represent insurers that offer coverage in the small market.

(E) Two representatives of consumer organizations.

(F) Two representatives of insurance agents and brokers.

(G) Two representatives of healthcare providers.

(H) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

(I) One administrator of a qualified high risk pool.

(3) TERMS.—The members of the Panel shall serve for the duration of the Panel. The Secretary shall fill vacancies in the Panel as needed and in a manner consistent with the composition described in paragraph (2).

(b) DEVELOPMENT OF A FEDERAL STANDARD BENEFIT PACKAGE.—In accordance with the process described in subsection (c), the Panel shall identify and recommend a Federal standard benefit package of benefit mandates from among the current array of inconsistent State insurance laws.

(c) PROCESS FOR DEVELOPING A STANDARD FEDERAL BENEFIT PACKAGE.—

(1) IN GENERAL.—In developing the standard benefit package recommendations described in subsection (b), the Panel shall—

(A) review all State laws that regulate insurance benefits; and

(B) develop recommendations to harmonize inconsistent State insurance laws with the laws adopted in a plurality of the States.

(2) CONSULTATION.—The Panel shall consult with the National Association of Insurance Commissioners in identifying the benefit mandates of the States.

(d) RECOMMENDATIONS AND ADOPTION BY SECRETARY.—

(1) RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Panel shall recommend to the Secretary the adoption of the harmonized standards identified under subsection (c).

(2) REGULATIONS.—Not later than 120 days after receipt of the Panel's recommendations under paragraph (1), the Secretary shall issue final regulations adopting such recommendations as the Federal standard benefit package. If the Secretary finds the recommended standards for an element of the standard benefit package to be arbitrary and inconsistent with the plurality requirements of this section, the Secretary may issue a unique standard only for such element, through a process similar to the process set forth in subsection (c) and through the issuance of proposed and final regulations.

(3) EFFECTIVE DATE.—The regulations issued by the Secretary under paragraph (2) shall be effective on the date that is 2 years after the date on which such regulations were issued.

(e) TERMINATION.—The Panel shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

(f) UPDATED STANDARD BENEFIT PACKAGE.—

(1) IN GENERAL.—Not later than 2 years after the termination of the Panel under subsection (e), and every 2 years thereafter, the Secretary shall update the standard benefit package adopted under subsection (d)(2). Such updated standard benefit package shall be adopted in accordance with paragraph (2).

(2) UPDATED STANDARD BENEFIT PACKAGE.—

(A) IN GENERAL.—In order to update the standard benefit package in accordance with paragraph (1), the Secretary shall review all State laws that regulate insurance mandates and identify whether a plurality of States have adopted substantially similar requirements that differ from the standard benefit package adopted by the Secretary under subsection (d). In such case, the Secretary shall consider State laws that have been enacted with effective dates that are contingent upon adoption as a harmonized standard in the standard benefit package by the Secretary. Substantially similar requirements by different States shall be considered to be an updated harmonized standard.

(B) REPORT.—The Secretary shall request the National Association of Insurance Commissioners to issue a report to the Secretary every 2 years to assist the Secretary in identifying the updated benefit mandates of the States under this paragraph. Nothing in this subparagraph shall be construed to prohibit

the Secretary from issuing updated standards in the absence of such a report.

(C) REGULATIONS.—The Secretary shall issue regulations adopting the updated standard benefit package under this paragraph within 90 days of identifying the standards in need of updating. Such regulations shall be effective beginning on the date that is 2 years after the date on which such regulations are issued.

(g) PUBLICATION.—

(1) LISTING.—The Secretary shall maintain an up-to-date listing of all harmonized standards in the standard benefit package adopted under this section on the Internet website of the Department of Health and Human Services.

(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish, on the Internet website of the Department of Health and Human Services, sample contract language that incorporates the standard benefit package adopted under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of benefits that shall be included in such sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 2 years after the issuance by the Secretary of final regulations adopting the Federal standard benefit package under this section, the States may adopt such standard benefit package (and become an adopting State) and, in which case, shall enforce the harmonized standard benefit package pursuant to State law.

SA 3906. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. STATE OPT OUT.

(a) IN GENERAL.—The provisions of this Act (and the amendments made by this Act) shall not apply with respect to a State if—

(1) the governor of such State certifies to the State legislature that the application of such provisions would have a detrimental effect on the residents of the State; and

(2) the State enacts legislation that provides that such provisions shall not apply in the State.

(b) PARTIAL OPT OUT.—A State may apply subsection with respect to all of the provisions of this Act (or amendments) or to select provisions.

SA 3907. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS

(a) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) increasing the premiums paid by women of child bearing age for health insurance coverage;

(2) nullifying, superseding, or limiting the application of any State law that requires a health insurance issuer to provide coverage for maternity care or related per- and postnatal care for women and their infants;

(3) limiting the ability of the State to enforce any law described in paragraph (2);

shall not apply and shall not be enforced.

(b) LIMITATION ON USE OF GENDER IN SETTING RATES.—Notwithstanding any other provision of this Act (or an amendment made by this Act), a health insurance issuer that offers a small business health plan may not use gender as a characteristic in setting health insurance premium rates with respect to such plan.

SA 3908. Mr. BAUCUS (for himself and Mr. COLEMAN) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. CLARIFICATION OF AVAILABILITY OF TARGETED CASE MANAGEMENT SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)) is amended—

(1) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by striking ''subsection'' and inserting ''title'';

(B) in subparagraph (A)—

(i) in clause (i)—

(I) by inserting ''targeted'' before ''case''; and

(II) by inserting ''that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas and'' after ''means services''; and

(ii) in clause (iii), in the matter preceding subclause (I), by striking ''Such term'' and all that follows through ''the following'' and inserting ''Except as provided in subparagraph (B), such term does not include the following activities with respect to the delivery of foster care services''; and

(C) by amending subparagraph (B) to read as follows:

''(B) Such term includes the activities described in subclauses (II) and (VIII) of subparagraph (A)(iii) in the case of an individual who is eligible for medical assistance under the State plan but who is not eligible for services or payments to be made on their behalf under part E of title IV.'';

(2) in subparagraphs (A) and (B) of paragraph (3), by inserting ''targeted'' before ''case management activity'' each place it appears;

(3) in paragraph (4), by striking ''only'' and all that follows through the period and inserting ''is available under this title for targeted case management services as furnished under the plan unless there are other third parties liable to pay for such services.''; and

(4) by adding at the end the following new paragraph:

''(6) Nothing in this subsection shall be construed as limiting the responsibility of the program established under this title to—

''(A) pay for any item or service for which no other payor is legally liable;

''(B) treat other payors or providers as legally liable who have no enforceable responsibility to pay for any item or service; or

''(C) treat the availability of public funding for any item or service as creating a legal liability.''.

(b) CONFORMING AMENDMENT.—The heading for section 6052 of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 93) is amended to read as follows: ''**clarification of availability of targeted case management services**''

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of, and the amendments to section 1915(g) of the Social Security Act made by, section 6052 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 93).

SA 3909. Mr. FEINGOLD (for himself and Mr. GRAHAM) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH REFORM

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Reform Health Care Now Act''.

SEC. ___02. SENATE CONSIDERATION OF HEALTH CARE REFORM LEGISLATION.

(a) INTRODUCTION.—

(1) IN GENERAL.—Not later than 30 calendar days after the commencement of the session of Congress that follows the date of enactment of this Act, the chair of the Senate Committee on Health, Education, Labor, and Pensions, the Chair of the Senate Committee on Finance, the Majority Leader of the Senate, and the Minority Leader of the Senate shall each introduce a bill to provide a significant increase in access to health care coverage for the people of the United States.

(2) MINORITY PARTY.—These bills may be introduced by request and only 1 qualified bill may be introduced by each individual referred to in paragraph (1) within a Congress. If either committee chair fails to introduce the bill within the 30-day period, the ranking minority party member of the respective committee may instead introduce a bill that will qualify for the expedited procedure provided in this section.

(3) QUALIFIED BILL.—

(A) IN GENERAL.—In order to qualify as a qualified bill—

(i) the title of the bill shall be ''To reform the health care system of the United States and to provide insurance coverage for Americans.'';

(ii) the bill shall reach the goal of providing health care coverage to 95 percent of Americans within 10 years; and

(iii) the bill shall be deficit neutral.

(B) DETERMINATION.—Whether or not a bill meets the criteria in subparagraph (A) shall be determined by the Chair of the Senate Budget Committee, relying on estimates of the Congressional Budget Office, subject to the final approval of the Senate.

(b) REFERRAL.—

(1) COMMITTEE BILLS.—Upon introduction, the bill authored by the Chair of the Senate Committee on Finance shall be referred to that Committee and the bill introduced by the Chair of the Senate Committee on Health, Education, Labor, and Pensions shall be referred to that committee. If either committee has not reported the bill referred to it (or another qualified bill) by the end of a 60 calendar-day period beginning on the date of referral, the committee is, as of that date, automatically discharged from further consideration of the bill, and the bill is placed directly on the chamber's legislative calendar. In calculating the 60-day period, adjournments for more than 3 days are not counted.

(2) LEADER BILLS.—The bills introduced by the Senate Majority Leader and the Senate Minority Leader shall, on introduction, be placed directly on the Senate Calendar of Business.

(c) MOTION TO PROCEED.—

(1) IN GENERAL.—On or after the third day following the committee report or discharge or upon a bill being placed on the calendar under subsection (b)(2), it shall be in order for any Member, after consultation with the Majority Leader, to move to proceed to the consideration of any qualified bill. Notice shall first be given before proceeding. This motion to proceed to the consideration of a bill can be offered by a Member only on the day after the calendar day on which the Member announces the Member's intention to offer it.

(2) CONSIDERATION.—The motion to proceed to a given qualified bill can be made even if a motion to the same effect has previously been rejected. No more than 3 such motions may be made, however, in any 1 congressional session.

(3) PRIVILEGED AND NONDEBATABLE.—The motion to proceed is privileged, and all points of order against the motion to proceed to consideration and its consideration are waived. The motion is not debatable, is not amendable, and is not subject to a motion to postpone.

(4) NO OTHER BUSINESS OR RECONSIDERATION.—The motion is not subject to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or disagreed to is not in order.

(d) CONSIDERATION OF QUALIFIED BILL.—

(1) IN GENERAL.—If the motion to proceed is adopted, the chamber shall immediately proceed to the consideration of a qualified bill without intervening motion, order, or other business, and the bill remains the unfinished business of the Senate until disposed of. A motion to limit debate is in order and is not debatable.

(2) ONLY BUSINESS.—The qualified bill is not subject to a motion to postpone or a motion to proceed to the consideration of other business before the bill is disposed of.

(3) RELEVANT AMENDMENTS.—Only relevant amendments may be offered to the bill.

SEC. ___03. HOUSE CONSIDERATION OF HEALTH CARE REFORM LEGISLATION.

(a) INTRODUCTION.—

(1) IN GENERAL.—Not later than 30 calendar days after the commencement of the session of Congress that follows the date of enactment of this Act, the chair of the House Committee on Energy and Commerce, the chair of the House Committee on Ways and Means, the Majority Leader of the House, and the Minority Leader of the House shall each introduce a bill to provide a significant increase in access to health care coverage for the people of the United States.

(2) MINORITY PARTY.—These bills may be introduced by request and only 1 qualified bill may be introduced by each individual referred to in paragraph (1) within a Congress. If either committee chair fails to introduce the bill within the 30-day period, the ranking minority party member of the respective committee may, within the following 30 days, instead introduce a bill that will qualify for the expedited procedure provided in this section.

(3) QUALIFIED BILL.—

(A) IN GENERAL.—To qualify for the expedited procedure under this section as a qualified bill, the bill shall—

(i) reach the goal of providing healthcare coverage to 95 percent of Americans within 10 years; and

(ii) be deficit neutral.

(B) DETERMINATION.—Whether or not a bill meets the criteria in subparagraph (A) shall be determined by the Speaker's ruling on a point of order based on a Congressional Budget Office estimate of the bill.

(b) REFERRAL.—

(1) COMMITTEE BILLS.—Upon introduction, the bill authored by the Chair of the House Committee on Energy and Commerce shall be referred to that committee and the bill introduced by the Chair of the House Committee on Ways and Means shall be referred to that committee. If either committee has not reported the bill referred to it (or another qualified bill) by the end of 60 days of consideration beginning on the date of referral, the committee shall be automatically discharged from further consideration of the bill, and the bill shall be placed directly on the Calendar of the Whole House on the State of the Union. In calculating the 60-day period, adjournments for more than 3 days are not counted.

(2) LEADER BILLS.—The bills introduced by the House Majority Leader and House Minority Leader will, on introduction, be placed directly on the Calendar of the Whole House on the State of the Union.

(c) MOTION TO PROCEED.—

(1) IN GENERAL.—On or after the third day following the committee report or discharge or upon a bill being placed on the calendar under subsection (b)(2), it shall be in order for any Member, after consultation with the Majority Leader, to move to proceed to the consideration of any qualified bill. Notice must first be given before proceeding. This motion to proceed to the consideration of a bill can be offered by a Member only on the day after the calendar day on which the Member announces the Member's intention to offer it.

(2) CONSIDERATION.—The motion to proceed to a given qualified bill can be made even if a motion to the same effect has previously been rejected. No more than 3 such motions may be made, however, in any 1 congressional session.

(3) PRIVILEGED AND NONDEBATABLE.—The motion to proceed is privileged, and all points of order against the motion to proceed to consideration and its consideration are waived. The motion is not debatable, is not amendable, and is not subject to a motion to postpone.

(4) NO OTHER BUSINESS OR RECONSIDERATION.—The motion is not subject to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or disagreed to is not in order.

(d) CONSIDERATION OF A QUALIFIED BILL.—

(1) IN GENERAL.—If the motion to proceed is adopted, the chamber will immediately proceed to the consideration of a qualified bill without intervening motion, order, or other business, and the bill remains the unfinished business of the House until disposed of.

(2) COMMITTEE OF THE WHOLE.—The bill will be considered in the Committee of the Whole under the 5-minute rule, and the bill shall be considered as read and open for amendment at any time.

(3) LIMIT DEBATE.—A motion to further limit debate is in order and is not debatable.

(4) RELEVANT AMENDMENTS.—Only relevant amendments may be offered to the bill.

SA 3910. Mr. FEINGOLD (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH CARE PURCHASING COOPERATIVES

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Promoting Health Care Purchasing Cooperatives Act''.

SEC. ___02. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress makes the following findings:

(1) Health care spending in the United States has reached 15 percent of the Gross Domestic Product of the United States, yet 45,000,000 people, or 15.6 percent of the population, remains uninsured.

(2) After nearly a decade of manageable increases in commercial insurance premiums, many employers are now faced with consecutive years of double digit premium increases.

(3) Purchasing cooperatives owned by participating businesses are a proven method of achieving the bargaining power necessary to manage the cost and quality of employer-sponsored health plans and other employee benefits.

(4) The Employer Health Care Alliance Cooperative has provided its members with health care purchasing power through provider contracting, data collection, activities to enhance quality improvements in the health care community, and activities to promote employee health care consumerism.

(5) According to the National Business Coalition on Health, there are nearly 80 employer-led coalitions across the United States that collectively purchase health care, proactively challenge high costs and the inefficient delivery of health care, and share information on quality. These coalitions represent more than 10,000 employers.

(b) PURPOSE.—It is the purpose of this title to build off of successful local employer-led health insurance initiatives by improving the value of their employees' health care.

SEC. ___03. GRANTS TO SELF INSURED BUSINESSES TO FORM HEALTH CARE COOPERATIVES.

(a) AUTHORIZATION.—The Secretary of Health and Human Services (in this title referred to as the ''Secretary''), acting through the Director of the Agency for Healthcare Research and Quality, is authorized to award grants to eligible groups that meet the criteria described in subsection (d), for the development of health care purchasing cooperatives. Such grants may be used to provide support for the professional staff of such cooperatives, and to obtain contracted services for planning, development, and implementation activities for establishing such health care purchasing cooperatives.

(b) ELIGIBLE GROUP DEFINED.—

(1) IN GENERAL.—In this section, the term ''eligible group'' means a consortium of 2 or more self-insured employers, including agricultural producers, each of which are responsible for their own health insurance risk pool with respect to their employees.

(2) NO TRANSFER OF RISK.—Individual employers who are members of an eligible group may not transfer insurance risk to such group.

(c) APPLICATION.—An eligible group desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) CRITERIA.—

(1) FEASIBILITY STUDY GRANTS.—

(A) IN GENERAL.—An eligible group may submit an application under subsection (c) for a grant to conduct a feasibility study concerning the establishment of a health insurance purchasing cooperative. The Secretary shall approve applications submitted under the preceding sentence if the study will consider the criteria described in paragraph (2).

(B) REPORT.—After completion of a feasibility study under a grant under this section, an eligible group shall submit to the Secretary a report describing the results of such study.

(2) GRANT CRITERIA.—The criteria described in this paragraph include the following with respect to the eligible group:

(A) The ability of the group to effectively pool the health care purchasing power of employers.

(B) The ability of the group to provide data to employers to enable such employers to make data-based decisions regarding their health plans.

(C) The ability of the group to drive quality improvement in the health care community.

(D) The ability of the group to promote health care consumerism through employee education, self-care, and comparative provider performance information.

(E) The ability of the group to meet any other criteria determined appropriate by the Secretary.

(e) COOPERATIVE GRANTS.—After the submission of a report by an eligible group under subsection (d)(1)(B), the Secretary shall determine whether to award the group a grant for the establishment of a cooperative under subsection (a). In making a determination under the preceding sentence, the Secretary shall consider the criteria described in subsection (d)(2) with respect to the group.

(f) COOPERATIVES.—

(1) IN GENERAL.—An eligible group awarded a grant under subsection (a) shall establish or expand a health insurance purchasing cooperative that shall—

(A) be a nonprofit organization;

(B) be wholly owned, and democratically governed by its member-employers;

(C) exist solely to serve the membership base;

(D) be governed by a board of directors that is democratically elected by the cooperative membership using a 1-member, 1-vote standard; and

(E) accept any new member in accordance with specific criteria, including a limitation on the number of members, determined by the Secretary.

(2) AUTHORIZED COOPERATIVE ACTIVITIES.—A cooperative established under paragraph (1) shall—

(A) assist the members of the cooperative in pooling their health care insurance purchasing power;

(B) provide data to improve the ability of the members of the cooperative to make data-based decisions regarding their health plans;

(C) conduct activities to enhance quality improvement in the health care community;

(D) work to promote health care consumerism through employee education, self-care, and comparative provider performance information; and

(E) conduct any other activities determined appropriate by the Secretary.

(g) REVIEW.—

(1) IN GENERAL.—Not later than 1 year after the date on which grants are awarded under this section, and every 2 years thereafter, the Secretary shall study programs funded by grants under this section and provide to the appropriate committees of Congress a report on the progress of such programs in improving the access of employees to quality, affordable health insurance.

(2) SLIDING SCALE FUNDING.—The Secretary shall use the information included in the report under paragraph (1) to establish a schedule for scaling back payments under this section with the goal of ensuring that programs funded with grants under this section are self sufficient within 10 years.

SEC. ___04. GRANTS TO SMALL BUSINESSES TO FORM HEALTH CARE COOPERATIVES.

The Secretary shall carry out a grant program that is identical to the grant program provided in section ___03, except that an eligible group for a grant under this section shall be a consortium of 2 or more employers, including agricultural producers, each of which—

(1) have 99 employees or less; and

(2) are purchasers of health insurance (are not self-insured) for their employees.

SEC. ___05. AUTHORIZATION OF APPROPRIATIONS.

From the administrative funds provided to the Secretary, the Secretary may use not more than a total of $60,000,000 for fiscal years 2006 through 2015 to carry out this title.

SA 3911. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. APPLICATION TO SMALL EMPLOYERS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this Act (and amendments) shall only apply to small employers (as defined in section 808(a)(10) of the Employee Retirement Income Security Act of 1974 (as added by section 101(a)) and including self-employed individuals) and health insurance coverage issued through small employers or to the employees of small employers (or self-employed individuals). Nothing in this Act (or an amendment made by this Act) shall be construed to preempt or supersede State laws relating to health insurance offered in the large group or individual markets or to limit the application of section 805(a)(3)(B) of the Employee Retirement Income Security Act of 1974 (as added by section 101(a)).

SA 3912. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny coverage for a preventive service that is recommended by the United States Preventive Services Task Force through a rating of ''A'' of ''B''; or

(2) limiting the ability of a State to enforce State laws that require the coverage described in paragraph (1);

shall not apply and shall not be enforced.

SA 3913. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny coverage for screening for obesity in adults and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults; or

(2) limiting the ability of a State to enforce State laws that require the coverage described in paragraph (1);

shall not apply and shall not be enforced.

SA 3914. Mr. HARKIN submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROMOTING CESSATION OF TOBACCO USE BY PREGNANT WOMEN UNDER THE MEDICAID PROGRAM.

(a) DROPPING EXCEPTION FROM MEDICAID PRESCRIPTION DRUG COVERAGE FOR TOBACCO CESSATION MEDICATIONS.—Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) by redesignating subparagraphs (F) through (J) as subparagraphs (E) through (I), respectively; and

(3) in subparagraph (F) (as redesignated by paragraph (2)), by inserting before the period at the end the following: ''except, in the case of a pregnant woman, agents approved by the Food and Drug Administration for purposes of promoting, and when used to promote, tobacco cessation''.

(b) REQUIRING COVERAGE OF TOBACCO CESSATION COUNSELING SERVICES FOR PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d(a)(4)) is amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling for cessation of tobacco use (as defined in subsection (y)) for pregnant women''; and

(2) by adding at the end the following:

''(y)(1) For purposes of this title, the term 'counseling for cessation of tobacco use' means therapy and counseling for cessation of tobacco use for pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) therapy and counseling services recommended in 'Treating Tobacco Use and Dependence: A Clinical Practice Guideline', published by the Public Health Service in June 2000, or any subsequent modification of such Guideline; and

''(B) such other therapy and counseling services that the Secretary recognizes to be effective.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) REMOVAL OF COST SHARING FOR TOBACCO CESSATION COUNSELING SERVICES FOR PREGNANT WOMEN.—

(1) GENERAL COST SHARING PROTECTIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting '', and counseling for cessation of tobacco use (as defined in section 1905(y))'' after ''complicate the pregnancy''.

(2) ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting ''or to counseling for cessation of tobacco use (as defined in section 1905(y))'' after ''''complicate the pregnancy''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to services furnished on or after that date.

SA 3915. Mr. NELSON of Florida (for himself and Ms. SNOWE) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTION FOR MEDICARE BENEFICIARIES WHO ENROLL IN THE PRESCRIPTION DRUG BENEFIT DURING 2006.

(a) IN GENERAL.—Section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–21(e)(3)(B)) is amended—

(1) in clause (iii), by striking ''May 15, 2006'' and inserting ''December 31, 2006''; and

(2) by adding at the end the following new sentence:

''An individual making an election during the period beginning on November 15, 2006, and ending on December 15, 2006, shall specify whether the election is to be effective with respect to 2006 or with respect to 2007 (or both).''.

(b) ONE-TIME CHANGE OF PLAN ENROLLMENT FOR MEDICARE PRESCRIPTION DRUG BENEFIT DURING ALL OF 2006.—

(1) IN GENERAL.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(B)—

(i) in the heading, by striking ''**for first 6 months**'';

(ii) in clause (i), by striking ''the first 6 months of 2006,'' and all that follows through ''is a Medicare+Choice eligible individual,'' and inserting ''2006,''; and

(iii) in clause (ii), by inserting ''(other than during 2006)'' after ''paragraph (3)''; and

(B) in paragraph (4), by striking ''2006'' and inserting ''2007'' each place it appears.

(2) CONFORMING AMENDMENT.—Section 1860D–1(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended by striking ''subparagraphs (B) and (C) of paragraph (2)'' and inserting ''paragraph (2)(C)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2071).

SA 3916. Mr. REID (for himself, Mrs. CLINTON, Mrs. MURRAY, and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of—

(1) permitting a health insurance issuer to deny, exclude, or restrict coverage for prescription contraceptive drugs or devices approved by the Food and Drug Administration, or generic equivalents approved as substitutable by the Food and Drug Administration, and outpatient contraceptive services; or

(2) limiting the ability of a State to enforce State laws that prohibit denials, exclusions, or restrictions of coverage described in paragraph (1);

shall not apply and shall not be enforced.

SA 3917. Mr. BAUCUS (for himself and Mr. REID) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. ADDITIONAL FUNDING FOR ENROLLMENT ASSISTANCE.

(a) IN GENERAL.—There are appropriated, to be transferred from the Federal Supplementary Medical Insurance Trust Fund, not to exceed $25,000,000 for the Centers for Medicare & Medicaid Services, for the purpose of ensuring that individuals have adequate access to impartial advice on and assistance enrolling in the prescription drug program under part D of title XVIII of the Social Security Act.

(b) USE OF FUNDS.—Amounts provided under subsection (a) shall be used for the following purposes:

(1) GRANTS FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—To provide additional grants to States for State health insurance counseling programs (receiving assistance under section 4360 of the Omnibus Reconciliation Act of 1990) to broaden their capacity to—

(A) provide personal and impartial assistance to individuals seeking to enroll in a prescription drug plan or an MA–PD plan under such prescription drug program;

(B) educate and assist individuals in applying for a low-income subsidy under section 1860D–14 of such Act (42 U.S.C. 1395w–114); and

(C) assist individuals in accessing benefits under such a prescription drug plan or such an MA–PD plan once they are enrolled in a plan.

(2) GRANTS FOR INNOVATIVE PROGRAMS.—To provide grants to eligible States to support innovative programs that provide any of the services described in subparagraphs (A), (B), and (C) of paragraph (1).

(3) PROMOTION.—To widely promote and disseminate information about the existence of, and services provided by, State health insurance counseling programs.

(c) ADMINISTRATION.—

(1) SHIPS.—The amount of a grant under subsection (b)(1) from the total amount made available for such grants shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–101(a)(3))) residing in a rural area (as determined by the Administrator of the Centers for Medicare & Medicaid Services) relative to the total number of such individuals in each State, as estimated by the Administrator.

(2) INNOVATIVE PROGRAMS.—A State is eligible for a grant under subsection (b)(2) if the percentage of part D eligible individuals (as so defined) with creditable prescription drug coverage (as defined in section 1860D–13(b)(4) of the Social Security Act (42 U.S.C. 1395w–113(b)(4))) in the State is below the national average.

(d) AVAILABILITY.—Amounts provided under subsection (a) shall remain available—

(1) for obligation until December 31, 2008; and

(2) for expenditure until December 31, 2010.

SA 3918. Mr. DODD (for himself and Mr. MENENDEZ) submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this

Act), any provision of this Act (or amendment) that has the effect of preempting any State law that requires health plans and health insurance issuers to cover services for beneficiaries or enrollees participating in clinical trials shall not apply and shall not be enforced.

SA 3919. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of preempting any State law that requires health plans and health insurance issuers to provide coverage for services for newborns and children, including pediatric and well-child care, and immunizations shall not apply and shall not be enforced.

SA 3920. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON APPLICATION OF CERTAIN PROVISIONS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), any provision of this Act (or amendment) that has the effect of permitting health insurance issuers to vary premiums based on health status shall not apply and shall not be enforced.

SA 3921. Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

Strike all after the enacting clause insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Internet Pharmacy Consumer Protection Act'' or the ''Ryan Haight Act''.

SEC. 2. INTERNET SALES OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter 5 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503A the following section:

''SEC. 503B. INTERNET SALES OF PRESCRIPTION DRUGS.

''(a) REQUIREMENTS REGARDING INFORMATION ON INTERNET SITE.—

''(1) IN GENERAL.—A person may not dispense a prescription drug pursuant to a sale of the drug by such person if—

''(A) the purchaser of the drug submitted the purchase order for the drug, or conducted any other part of the sales transaction for the drug, through an Internet site;

''(B) the person dispenses the drug to the purchaser by mailing or shipping the drug to the purchaser; and

''(C) such site, or any other Internet site used by such person for purposes of sales of a prescription drug, fails to meet each of the requirements specified in paragraph (2), other than a site or pages on a site that—

''(i) are not intended to be accessed by purchasers or prospective purchasers; or

''(ii) provide an Internet information location tool within the meaning of section 231(e)(5) of the Communications Act of 1934 (47 U.S.C. 231(e)(5)).

''(2) REQUIREMENTS.—With respect to an Internet site, the requirements referred to in subparagraph (C) of paragraph (1) for a person to whom such paragraph applies are as follows:

''(A) Each page of the site shall include either the following information or a link to a page that provides the following information:

''(i) The name of such person.

''(ii) Each State in which the person is authorized by law to dispense prescription drugs.

''(iii) The address and telephone number of each place of business of the person with respect to sales of prescription drugs through the Internet, other than a place of business that does not mail or ship prescription drugs to purchasers.

''(iv) The name of each individual who serves as a pharmacist for prescription drugs that are mailed or shipped pursuant to the site, and each State in which the individual is authorized by law to dispense prescription drugs.

''(v) If the person provides for medical consultations through the site for purposes of providing prescriptions, the name of each individual who provides such consultations; each State in which the individual is licensed or otherwise authorized by law to provide such consultations or practice medicine; and the type or types of health professions for which the individual holds such licenses or other authorizations.

''(B) A link to which paragraph (1) applies shall be displayed in a clear and prominent place and manner, and shall include in the caption for the link the words 'licensing and contact information'.

''(b) INTERNET SALES WITHOUT APPROPRIATE MEDICAL RELATIONSHIPS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a person may not dispense a prescription drug, or sell such a drug, if—

''(A) for purposes of such dispensing or sale, the purchaser communicated with the person through the Internet;

''(B) the patient for whom the drug was dispensed or purchased did not, when such communications began, have a prescription for the drug that is valid in the United States;

''(C) pursuant to such communications, the person provided for the involvement of a practitioner, or an individual represented by the person as a practitioner, and the practitioner or such individual issued a prescription for the drug that was purchased;

''(D) the person knew, or had reason to know, that the practitioner or the individual referred to in subparagraph (C) did not, when issuing the prescription, have a qualifying medical relationship with the patient; and

''(E) the person received payment for the dispensing or sale of the drug.

For purposes of subparagraph (E), payment is received if money or other valuable consideration is received.

''(2) EXCEPTIONS.—Paragraph (1) does not apply to—

''(A) the dispensing or selling of a prescription drug pursuant to telemedicine practices sponsored by—

''(i) a hospital that has in effect a provider agreement under title XVIII of the Social Security Act (relating to the Medicare program); or

''(ii) a group practice that has not fewer than 100 physicians who have in effect provider agreements under such title; or

''(B) the dispensing or selling of a prescription drug pursuant to practices that promote the public health, as determined by the Secretary by regulation.

''(3) QUALIFYING MEDICAL RELATIONSHIP.—

''(A) IN GENERAL.—With respect to issuing a prescription for a drug for a patient, a practitioner has a qualifying medical relationship with the patient for purposes of this section if—

''(i) at least one in-person medical evaluation of the patient has been conducted by the practitioner; or

''(ii) the practitioner conducts a medical evaluation of the patient as a covering practitioner.

''(B) IN-PERSON MEDICAL EVALUATION.—A medical evaluation by a practitioner is an in-person medical evaluation for purposes of this section if the practitioner is in the physical presence of the patient as part of conducting the evaluation, without regard to whether portions of the evaluation are conducted by other health professionals.

''(C) COVERING PRACTITIONER.—With respect to a patient, a practitioner is a covering practitioner for purposes of this section if the practitioner conducts a medical evaluation of the patient at the request of a practitioner who has conducted at least one in-person medical evaluation of the patient and is temporarily unavailable to conduct the evaluation of the patient. A practitioner is a covering practitioner without regard to whether the practitioner has conducted any in-person medical evaluation of the patient involved.

''(4) RULES OF CONSTRUCTION.—

''(A) INDIVIDUALS REPRESENTED AS PRACTITIONERS.—A person who is not a practitioner (as defined in subsection (d)(1)) lacks legal capacity under this section to have a qualifying medical relationship with any patient.

''(B) STANDARD PRACTICE OF PHARMACY.—Paragraph (1) may not be construed as prohibiting any conduct that is a standard practice in the practice of pharmacy.

''(C) APPLICABILITY OF REQUIREMENTS.—Paragraph (3) may not be construed as having any applicability beyond this section, and does not affect any State law, or interpretation of State law, concerning the practice of medicine.

''(c) ACTIONS BY STATES.—

''(1) IN GENERAL.—Whenever an attorney general of any State has reason to believe that the interests of the residents of that State have been or are being threatened or adversely affected because any person has engaged or is engaging in a pattern or practice that violates section 301(l), the State may bring a civil action on behalf of its residents in an appropriate district court of the United States to enjoin such practice, to enforce compliance with such section (including a nationwide injunction), to obtain damages, restitution, or other compensation on behalf of residents of such State, to obtain reasonable attorneys fees and costs if the State prevails in the civil action, or to obtain such further and other relief as the court may deem appropriate.

''(2) NOTICE.—The State shall serve prior written notice of any civil action under paragraph (1) or (5)(B) upon the Secretary and provide the Secretary with a copy of its complaint, except that if it is not feasible for the State to provide such prior notice, the State shall serve such notice immediately upon instituting such action. Upon receiving a notice respecting a civil action, the Secretary shall have the right—

''(A) to intervene in such action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(3) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this chapter shall prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of such State to conduct investigations or to administer oaths or affirmations or to compel the attendance of witnesses or the production of documentary and other evidence.

''(4) VENUE; SERVICE OF PROCESS.—Any civil action brought under paragraph (1) in a district court of the United States may be brought in the district in which the defendant is found, is an inhabitant, or transacts business or wherever venue is proper under section 1391 of title 28, United States Code. Process in such an action may be served in any district in which the defendant is an inhabitant or in which the defendant may be found.

''(5) ACTIONS BY OTHER STATE OFFICIALS.—

''(A) Nothing contained in this section shall prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any civil or criminal statute of such State.

''(B) In addition to actions brought by an attorney general of a State under paragraph (1), such an action may be brought by officers of such State who are authorized by the State to bring actions in such State on behalf of its residents.

''(d) GENERAL DEFINITIONS.—For purposes of this section:

''(1) The term 'practitioner' means a practitioner referred to in section 503(b)(1) with respect to issuing a written or oral prescription.

''(2) The term 'prescription drug' means a drug that is subject to section 503(b)(1).

''(3) The term 'qualifying medical relationship', with respect to a practitioner and a patient, has the meaning indicated for such term in subsection (b).

''(e) INTERNET-RELATED DEFINITIONS.—

''(1) IN GENERAL.—For purposes of this section:

''(A) The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected world-wide network of networks that employ the transmission control protocol/internet protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio.

''(B) The term 'link', with respect to the Internet, means one or more letters, words, numbers, symbols, or graphic items that appear on a page of an Internet site for the purpose of serving, when activated, as a method for executing an electronic command—

''(i) to move from viewing one portion of a page on such site to another portion of the page;

''(ii) to move from viewing one page on such site to another page on such site; or

''(iii) to move from viewing a page on one Internet site to a page on another Internet site.

''(C) The term 'page', with respect to the Internet, means a document or other file accessed at an Internet site.

''(D)(i) The terms 'site' and 'address', with respect to the Internet, mean a specific location on the Internet that is determined by Internet Protocol numbers. Such term includes the domain name, if any.

''(ii) The term 'domain name' means a method of representing an Internet address without direct reference to the Internet Protocol numbers for the address, including methods that use designations such as '.com', '.edu', '.gov', '.net', or '.org'.

''(iii) The term 'Internet Protocol numbers' includes any successor protocol for determining a specific location on the Internet.

''(2) AUTHORITY OF SECRETARY.—The Secretary may by regulation modify any definition under paragraph (1) to take into account changes in technology.

''(f) INTERACTIVE COMPUTER SERVICE; ADVERTISING.—No provider of an interactive computer service, as defined in section 230(f)(2) of the Communications Act of 1934 (47 U.S.C. 230(f)(2)), or of advertising services shall be liable under this section for dispensing or selling prescription drugs in violation of this section on account of another person's selling or dispensing such drugs, provided that the provider of the interactive computer service or of advertising services does not own or exercise corporate control over such person.''.

(b) INCLUSION AS PROHIBITED ACT.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after paragraph (k) the following:

''(l) The dispensing or selling of a prescription drug in violation of section 503B.''.

(c) INTERNET SALES OF PRESCRIPTION DRUGS; CONSIDERATION BY SECRETARY OF PRACTICES AND PROCEDURES FOR CERTIFICATION OF LEGITIMATE BUSINESSES.—In carrying out section 503B of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a) of this section), the Secretary of Health and Human Services shall take into consideration the practices and procedures of public or private entities that certify that businesses selling prescription drugs through Internet sites are legitimate businesses, including practices and procedures regarding disclosure formats and verification programs.

(d) REPORTS REGARDING INTERNET-RELATED VIOLATIONS OF STATE AND FEDERAL LAWS ON DISPENSING OF DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, pursuant to the submission of an application meeting the criteria of the Secretary, make an award of a grant or contract to the National Clearinghouse on Internet Prescribing (operated by the Federation of State Medical Boards) for the purpose of—

(A) identifying Internet sites that appear to be in violation of State or Federal laws concerning the dispensing of drugs;

(B) reporting such sites to State medical licensing boards and State pharmacy licensing boards, and to the Attorney General and the Secretary, for further investigation; and

(C) submitting, for each fiscal year for which the award under this subsection is made, a report to the Secretary describing investigations undertaken with respect to violations described in subparagraph (A).

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there is authorized to be appropriated $100,000 for each of the fiscal years 2006 through 2008.

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect upon the expiration of the 60-day period beginning on the date of the enactment of this Act, without regard to whether a final rule to implement such amendments has been promulgated by the Secretary of Health and Human Services under section 701(a) of the Federal Food, Drug, and Cosmetic Act. The preceding sentence may not be construed as affecting the authority of such Secretary to promulgate such a final rule.

SA 3922. Mr. SALAZAR submitted an amendment intended to be proposed by him to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

TITLE ____—NATIONAL COMMISSION ON HEALTH CARE ACT

SEC. ___1. SHORT TITLE.

This title may be cited as the ''National Commission on Health Care Act''.

SEC. ___2. FINDINGS.

Congress makes the following findings:

(1) Americans spent $1.9 trillion on health care in 2005, up from $1.4 trillion in 2001.

(2) While 174 million Americans were covered by employer-sponsored health insurance in 2004, rising health care costs to both employers and employees jeopardize the ability of employers and employees to maintain needed coverage.

(3) One in every 6 people in the United States, or approximately 46 million people lacked health insurance in 2004, and the number of uninsured individuals is expected to grow.

(4) The medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) provided health insurance to 41.7 million elderly and disabled Americans in 2004, while the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) provided health care for 55 million low-income children and their parents, pregnant women, and low-income elderly individuals in 2004. Federal and State government expenditures for both programs were approximately $606 billion in 2004.

SEC. ___3. PURPOSE.

The purpose of this title is to establish a National Commission on Health Care to—

(1) examine and report on—

(A) the factors leading to the rising costs of health care for individuals and businesses participating in employer-based health insurance and the rising health care expenditures for public health care programs;

(B) the barriers that prevent individuals from securing adequate health care coverage; and

(C) the issues faced by people covered by public health care programs;

(2) ascertain, evaluate, and report on the evidence developed by all relevant Federal, State, and local governmental agencies regarding the facts and circumstances surrounding rising health care costs and the barriers to adequate insurance coverage;

(3) build upon the investigations of past and current entities by reviewing the findings, conclusions, and recommendations of—

(A) executive branch, congressional, or independent commission investigations into the issues of health care services or health care costs; and

(B) State and local entities that have developed innovative solutions to deal with the health care needs in their respective communities; and

(4) investigate and report to the President and the Congress on its findings, conclusions, and recommendations for policy solutions to the health care problems, including current private and public services and the lack of health care insurance for more than 45,800,0000 Americans.

SEC. ___4. ESTABLISHMENT.

There is established in the legislative branch the National Commission on Health Care (referred to in this title as the ''Commission'').

SEC. ___5. COMPOSITION OF COMMISSION.

(a) MEMBERS.—The Commission shall be composed of 10 members, of whom—

(1) 1 member shall be appointed by the President, who shall serve as the chairperson of the Commission;

(2) 1 member shall be appointed jointly by the Majority Leader of the Senate and the Speaker of the House of Representatives, after consultation with the Minority Leader of the Senate and the Minority Leader of the House of Representatives, who shall serve as vice chairperson of the Commission;

(3) 2 members shall be appointed by the senior member of the Republican leadership of the Senate;

(4) 2 members shall be appointed by the senior member of the Democratic leadership of the Senate;

(5) 2 members shall be appointed by the senior member of the Republican leadership of the House of Representatives; and

(6) 2 members shall be appointed by the senior member of the Democratic leadership of the House of Representatives.

(b) QUALIFICATIONS; INITIAL MEETING.—

(1) POLITICAL PARTY AFFILIATION.—Not more than 5 members of the Commission shall be from the same political party.

(2) NONGOVERNMENTAL APPOINTEES.—An individual appointed to the Commission may not be an officer or employee of the Federal Government or any State or local government.

(3) OTHER QUALIFICATIONS.—It is the sense of Congress that individuals appointed to the Commission should be prominent United States citizens, with national recognition and significant depth of experience in such professions or memberships as governmental service, health care services, health care administration, business, public administration, and research institutions or programs with health care emphasis.

(4) DEADLINE FOR APPOINTMENT.—All members of the Commission shall be appointed not later than May 15, 2006, or 60 days after the date of enactment of this title, whichever is later.

(5) INITIAL MEETING.—The Commission shall meet and begin the operations of the Commission as soon as practicable after all members of the Commission are appointed.

(c) QUORUM; VACANCIES.—After its initial meeting, the Commission shall meet upon the call of the chairperson or a majority of its members. Six members of the Commission shall constitute a quorum. Any vacancy in the Commission shall not affect its powers, and shall be filled in the same manner in which the original appointment was made.

SEC. ___6. FUNCTIONS OF COMMISSION.

(a) IN GENERAL.—The functions of the Commission are to—

(1) conduct a study that—

(A) investigates relevant facts and experiences relating to the problems within the sphere of health care, including any relevant legislation, Executive order, regulation, plan, policy, practice, or procedure; and

(B) investigates relevant facts and circumstances relating to—

(i) the rising costs of health care;

(ii) the impact of the rising costs of health care on American businesses;

(iii) the provision of health care by State and local health care agencies;

(iv) the effects of increases in insurance premiums on health care coverage for businesses and individuals;

(v) the private health insurance industry;

(vi) the public health programs;

(vii) innovations and reforms necessary to increase the provision of affordable, quality health care to all Americans;

(viii) the role of congressional oversight and resource allocation; and

(ix) other areas of the public and private sectors determined relevant by the Commission for its inquiry;

(2) identify, review, and evaluate the lessons learned from past legislative structuring of health care, coordination, management policies, and procedures of the Federal Government, and, when appropriate, State and local governments and nongovernmental entities, relative to administering, representing and implementing and receiving health care; and

(3) submit to the President and Congress such reports as are required by this title containing such findings, conclusions, and recommendations as the Commission shall determine, including proposing organization, coordination, planning, management arrangements, procedures, rules, and regulations.

SEC. ___7. POWERS OF COMMISSION.

(a) HEARINGS AND EVIDENCE.—The Commission or, on the authority of the Commission, any subcommittee or member thereof, may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission determines appropriate for the purposes of carrying out this title.

(b) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided for in appropriation Acts, enter into contracts to enable the Commission to discharge its duties under this title.

(c) INFORMATION FROM FEDERAL AGENCIES.—

(1) IN GENERAL.—The Commission is authorized to secure directly from any executive department, bureau, agency, board, commission, office, independent establishment, or instrumentality of the Government, information, suggestions, estimates, and statistics for the purposes of this title. Each department, bureau, agency, board, commission, office, independent establishment, or instrumentality shall, to the extent authorized by law, furnish such information, suggestions, estimates, and statistics directly to the Commission, upon request made by the chairperson, the chairperson of any subcommittee created by a majority of the Commission, or any member designated by a majority of the Commission.

(2) RECEIPT, HANDLING STORAGE, AND DISSEMINATION.—Information shall only be received, handled, stored, and disseminated by members of the Commission and its staff consistent with all applicable statutes, regulations, and Executive orders.

(d) ASSISTANCE FROM FEDERAL AGENCIES.—

(1) GENERAL SERVICES ADMINISTRATION.—The Administrator of General Services shall provide to the Commission on a reimbursable basis administrative support and other services for the performance of the Commission's functions.

(2) OTHER DEPARTMENTS AND AGENCIES.—In addition to the assistance prescribed in paragraph (1), departments and agencies of the United States may provide to the Commission such services, funds, facilities, staff, and other support services as they may determine advisable and as may be authorized by law.

(e) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(f) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

SEC. ___8. STAFF OF COMMISSION.

(a) IN GENERAL.—

(1) APPOINTMENT AND COMPENSATION.—The chairperson of the Commission, in consultation with vice chairperson, in accordance with rules agreed upon by the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this subsection may exceed the equivalent of that payable for a position at level V of the Executive Schedule under section 5316 of title 5, United States Code.

(2) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The staff director and any personnel of the Commission who are employees shall be employees under section 2105 of title 5, United States Code, for purposes of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of that title.

(B) MEMBERS OF COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(b) DETAILEES.—Any Federal Government employee may be detailed to the Commission without reimbursement from the Commission, and such detailee shall retain the rights, status, and privileges of the detailee's regular employment without interruption.

(c) CONSULTANT SERVICES.—The Commission is authorized to procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, but at rates not to exceed the daily rate paid a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

SEC. ___9. COMPENSATION AND TRAVEL EXPENSES.

(a) COMPENSATION.—Each member of the Commission may be compensated at a rate not to exceed the daily equivalent of the annual rate of basic pay in effect for a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which that member is engaged in the actual performance of the duties of the Commission.

(b) TRAVEL EXPENSES.—While away from their homes or regular places of business in the performance of services for the Commission, members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5, United States Code.

SEC. ___10. REPORTS OF COMMISSION; TERMINATION.

(a) INTERIM REPORTS.—The Commission may submit to the President and Congress interim reports containing such findings, conclusions, and recommendations for corrective measures as have been agreed to by a majority of Commission members.

(b) FINAL REPORT.—Not later than 12 months after the date of the enactment of this title, the Commission shall submit to the President and Congress a final report containing such findings, conclusions, and recommendations for corrective measures as have been agreed to by a majority of Commission members.

(c) TERMINATION.—

(1) IN GENERAL.—The Commission, and all the authorities of this title, shall terminate 60 days after the date on which the final report is submitted under subsection (b).

(2) ADMINISTRATIVE ACTIVITIES BEFORE TERMINATION.—The Commission may use the 60 day period referred to in paragraph (1) for the purpose of concluding its activities, including providing testimony to committees of Congress concerning its reports and disseminating the final report.

SEC. __11. FUNDING.

(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this title $6,000,000.

(b) DURATION OF AVAILABILITY.—Amounts made available to the Commission under subsection (a) shall remain available until the termination of the Commission.

SA 3923. Ms. STABENOW (for herself and Mr. LEVIN) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce the costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___—THREE-SHARE PROGRAM

SEC. ___01. THREE-SHARE PROGRAMS.

Title XXIX of the Public Health Service Act, as added by section 201, is amended by adding at the end the following:

"Subtitle C—Providing for the Uninsured

"SEC. 2941. THREE-SHARE PROGRAMS.

''(a) PILOT PROGRAMS.—The Secretary, acting through the Administrator, shall award grants under this section for the startup and operation of 25 eligible three-share pilot programs for a 5-year period.

''(b) GRANTS FOR THREE-SHARE PROGRAMS.—

''(1) ESTABLISHMENT.—The Administrator may award grants to eligible entities—

''(A) to establish three-share programs;

''(B) to provide for contributions to the premiums assessed for coverage under a three-share program as provided for in subsection (c)(2)(B)(iii); and

''(C) to establish risk pools.

''(2) THREE-SHARE PROGRAM PLAN.—Each entity desiring a grant under this subsection shall develop a plan for the establishment and operation of a three-share program that meets the requirements of paragraphs (2) and (3) of subsection (c).

''(3) APPLICATION.—Each entity desiring a grant under this subsection shall submit an application to the Administrator at such time, in such manner and containing such information as the Administrator may require, including—

''(A) the three-share program plan described in paragraph (2); and

''(B) an assurance that the eligible entity will—

''(i) determine a benefit package;

''(ii) recruit businesses and employees for the three-share program;

''(iii) build and manage a network of health providers or contract with an existing network or licensed insurance provider;

''(iv) manage all administrative needs; and

''(v) establish relationships among community, business, and provider interests.

''(4) PRIORITY.—In awarding grants under this section the Administrator shall give priority to an applicant—

''(A) that is an existing three-share program;

''(B) that is an eligible three-share program that has demonstrated community support; or

''(C) that is located in a State with insurance laws and regulations that permit three-share program expansion.

''(c) GRANT ELIGIBILITY.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator, shall promulgate regulations providing for the eligibility of three-share programs for participation in the pilot program under this section.

''(2) THREE-SHARE PROGRAM REQUIREMENTS.—

''(A) IN GENERAL.—To be determined to be an eligible three-share program for purposes of participation in the pilot program under this section a three-share program shall—

''(i) be either a non-profit or local governmental entity;

''(ii) define the region in which such program will provide services;

''(iii) have the capacity to carry out administrative functions of managing health plans, including monthly billings, verification/enrollment of eligible employers and employees, maintenance of membership rosters, development of member materials (such as handbooks and identification cards), customer service, and claims processing; and

''(iv) have demonstrated community involvement.

''(B) PAYMENT.—To be eligible under paragraph (1), a three-share program shall pay the costs of services provided under subparagraph (A)(ii) by charging a monthly premium for each covered individual to be divided as follows:

''(i) Not more than 30 percent of such premium shall be paid by a qualified employee desiring coverage under the three-share program.

''(ii) Not more than 30 percent of such premium shall be paid by the qualified employer of such a qualified employee.

''(iii) At least 40 percent of such premium shall be paid from amounts provided under a grant under this section.

''(iv) Any remaining amount shall be paid by the three-share program from other public, private, or charitable sources.

''(C) PROGRAM FLEXIBILITY.—A three-share program may set an income eligibility guideline for enrollment purposes.

''(3) COVERAGE.—

''(A) IN GENERAL.—To be an eligible three-share program under this section, the three-share program shall provide at least the following benefits:

''(i) Physicians services.

''(ii) In-patient hospital services.

''(iii) Out-patient services.

''(iv) Emergency room visits.

''(v) Emergency ambulance services.

''(vi) Diagnostic lab fees and x-rays.

''(vii) Prescription drug benefits.

''(B) LIMITATION.—Nothing in subparagraph (A) shall be construed to require that a three-share program provide coverage for services performed outside the region described in paragraph (2)(A)(i).

''(C) PREEXISTING CONDITIONS.—A program described in subparagraph (A) shall not be an eligible three-share program under paragraph (1) if any individual can be excluded from coverage under such program because of a preexisting health condition.

''(d) GRANTS FOR EXISTING THREE-SHARE PROGRAMS TO MEET CERTIFICATION REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator may award grants to three-share programs that are operating on the date of enactment of this section.

''(2) APPLICATION.—Each eligible entity desiring a grant under this subsection shall submit an application to the Administrator at such time, in such manner, and containing such information as the Administrator may require.

''(e) APPLICATION OF STATE LAWS.—Nothing in this section shall be construed to preempt State law.

''(f) DISTRESSED BUSINESS FORMULA.—

''(1) IN GENERAL.—Not later than 60 days after the date of enactment of this section, the Administrator of the Health Resources and Services Administration shall develop a formula to determine which businesses qualify as distressed businesses for purposes of this section.

''(2) EFFECT ON INSURANCE MARKET.—Granting eligibility to a distressed business using the formula under paragraph (1) shall not interfere with the insurance market. Any business found to have reduced benefits to qualify as a distressed business under the formula under paragraph (1) shall not be eligible to be a three-share program for purposes of this section.

''(g) DEFINITIONS.—In this section:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(2) COVERED INDIVIDUAL.—The term 'covered individual' means—

''(A) a qualified employee; or

''(B) a child under the age of 23 or a spouse of such qualified employee who—

''(i) lacks access to health care coverage through their employment or employer;

''(ii) lacks access to health coverage through a family member;

''(iii) is not eligible for coverage under the medicare program under title XVIII or the medicaid program under title XIX; and

''(iv) does not qualify for benefits under the State Children's Health Insurance Program under title XXI.

''(3) DISTRESSED BUSINESS.—The term 'distressed business' means a business that—

''(A) in light of economic hardship and rising health care premiums may be forced to discontinue or scale back its health care coverage; and

''(B) qualifies as a distressed business according to the formula under subsection (g).

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity that meets the requirements of subsection (a)(2)(A).

''(5) QUALIFIED EMPLOYEE.—The term 'qualified employee' means any individual employed by a qualified employer who meets certain criteria including—

''(A) lacking access to health coverage through a family member or common law partner;

''(B) not being eligible for coverage under the medicare program under title XVIII or the medicaid program under title XIX; and

''(C) agreeing that the share of fees described in subsection (a)(2)(B)(i) shall be paid in the form of payroll deductions from the wages of such individual.

''(6) QUALIFIED EMPLOYER.—The term 'qualified employer' means an employer as defined in section 3(d) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(d)) who—

''(A) is a small business concern as defined in section 3(a) of the Small Business Act (15 U.S.C. 632);

''(B) is located in the region described in subsection (a)(2)(A)(i); and

''(C) has not contributed to the health care benefits of its employees for at least 12 months consecutively or currently provides insurance but is classified as a distressed business.

''(h) EVALUATION.—Not later than 90 days after the end of the 5-year period during which grants are available under this section, the Government Accountability Office

shall submit to the Secretary and the appropriate committees of Congress a report concerning—

''(1) the effectiveness of the programs established under this section;

''(2) the number of individuals covered under such programs;

''(3) any resulting best practices; and

''(4) the level of community involvement.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2006 through 2011.''.

SA 3924. Ms. SNOWE (for herself, Mr. BYRD, Mr. TALENT, and Mr. DOMENICI) submitted an amendment intended to be proposed by her to the bill S. 1955, to amend title I of the Employee Retirement Security Act of 1974 and the Public Health Service Act to expand health care access and reduce costs through the creation of small business health plans and through modernization of the health insurance marketplace; which was ordered to lie on the table; as follows:

In part II of subtitle A of title XXIX of the Public Health Service Act, as added by section 201 of the amendment, strike all through section 2922 and insert the following:

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 2922(b)

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the List of Required Benefits and Terms of Application in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other applicable State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the List of Required Benefits and Terms of Application, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(4) LIST OF REQUIRED BENEFITS.—The term 'List of Required Benefits' means the List issued under section 2922(a).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term 'State Provider Freedom of Choice Law' means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law.

''(8) TERMS OF APPLICATION.—The term 'Terms of Application' means terms provided under section 2922(a).

''SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through small business health plans, the List of Required Benefits applicable to the small group market shall apply.

''(b) TERMS OF APPLICATION.—

''(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such State mandate shall, subject to paragraph (3) (concerning uniform application), apply to a coverage plan or plan in, as applicable, the small group or large group market or through a small business health plan in such State.

''(2) STATES WITHOUT MANDATES.—With respect to a State that does not have a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such mandate shall not apply, as applicable, to a coverage plan or plan in the small group or large group market or through a small business health plan in such State.

''(3) UNIFORM APPLICATION OF LAWS.—

''(A) IN GENERAL.—With respect to a State described in paragraph (1), in applying a covered benefit, service, or category of provider mandate that is on the List of Required Benefits under subsection (a) the State shall permit a coverage plan or plan offered in the small group or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the remaining Federal Employees Health Benefits Program plans, as determined by the Secretary, in consultation with the Director of the Office of Personnel Management.

''(B) EXCEPTION REGARDING STATE PROVIDER FREEDOM OF CHOICE LAWS.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 2921(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

''(c) PUBLICATION OF BENEFIT APPLICATIONS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

''(d) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''(e) UPDATING OF LIST OF REQUIRED BENEFITS.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition and Forestry be authorized to conduct a full committee hearing during the session of the Senate on Wednesday, May 10, 2006 at 10 a.m. in SH–216, Hart Senate Office Building. The purpose of this hearing will be to review the implementation of the Sugar Provisions of the Farm Security and Rural Investment Act of 2002.

The PRESIDING OFFICER. Without objection it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on May 10, 2006, at 5:45 p.m., in closed session for a discussion on the situation in Afghanistan.

The PRESIDING OFFICER. Without objection it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, May 10 at 11:30 a.m. The purpose of this meeting is to consider the nomination of Dirk Kempthorne to be Secretary of the Interior.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Wednesday, May 10, 2006, at 10 a.m., in 215 Dirksen Senate Office Building, to hear testimony on ''Fostering Permanence: Progress Achieved and Challenges Ahead for America's Child Welfare System''.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Foreign Relations authorized to meet during the session of the Senate on Wednesday, May 10, 2006, at 9:30 a.m. to hold a hearing on nominations.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Wednesday, May 10, 2006, at 9:30 a.m. in Room 485 of the Russell Senate Office Building to conduct an oversight hearing on Economic Development in Indian Country.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on May 10, 2006 at 2:30 p.m. to hold a closed Business Meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the Senate Committee on the Judiciary be authorized to meet to conduct a hearing on ''Modern Enforcement of the Voting Rights Act'' on Wednesday, May 10, 2006, at 9:30 a.m. in Room 226 of the Dirksen Senate Office Building.

WITNESS LIST

Panel I: The Honorable Wan J. Kim, Assistant Attorney General for the Civil Rights Division, United States Department of Justice, Washington, DC.

Panel II: Robert B. McDuff, The Law Offices of Robert McDuff, Jackson, MS; Gregory Coleman, Weil Gotshall & Manges, Austin, TX; Natalie Landreth, Attorney, Native American Rights Fund (NARF), Anchorage, AK; Frank B. Strickland, Partner, Strickland Brockington Lewis, Atlanta, GA; Juan Cartagena, General Counsel, Community Service Society of New York, NY.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON PUBLIC LANDS AND FORESTS

Mr. ALEXANDER, Mr. President, I ask unanimous consent that the Subcommittee of Public Lands and Forests of the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, May 10 at 2:30 p.m.

The purpose of the hearing is to receive testimony of the following bills: S. 906, to promote Wildland Firefighter Safety; S. 2003, to make permanent the authorization for Watershed Restoration and Enhancement Agreements; H.R. 585, to require Federal land managers to support, and to communicate, coordinate, and cooperate with, designated gateway communities, to improve the ability of gateway communities to participate in Federal land management planning conducted by the Forest Service and agencies of the Department of the Interior, and to respond to the impacts of the public use of the Federal lands administered by these agencies, and for other purposes; and H.R. 3981, to authorize the Secretary of Agriculture to carry out certain land exchanges involving small parcels of National Forest System land in the Tahoe National Forest in the State of California, and for other purposes.

The PRESIDING OFFICER. Without objection, it so ordered.

PRIVILEGES OF THE FLOOR

Mr. BURNS. Mr. President, I ask unanimous consent that privileges of the floor be granted to Mike Campbell, a fellow in my office, during the debate on S. 1955.

The PRESIDING OFFICER. Without objection, it is so ordered.

VITIATION OF ORDER WITH RESPECT TO S. 1042, S. 1043, S. 1044, AND S. 1045

Mr. FRIST. Mr. President, I ask unanimous consent that the order of November 15, 2005, with respect to S. 1042, S. 1043, S. 1044, and S. 1045 be vitiated.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMEMORATING THE DEDICATION AND SACRIFICE OF LAW ENFORCEMENT OFFICERS

Mr. FRIST. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 472 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 472) commemorating and acknowledging the dedication and sacrifice made by the men and women who have lost their lives while serving as law enforcement officers.

There being no objection, the Senate proceeded to consider the resolution.

Mr. LEAHY. Mr. President, I join in introducing a bipartisan resolution to designate May 15, 2006, as National Peace Officers Memorial Day.

This is the tenth year running that I have been involved in the introduction of this resolution to keep alive in the memory of all Americans the sacrifice and commitment of those law enforcement officers who lost their lives serving their communities. For 8 years I introduced this resolution with my old friend and our former colleague Senator Campbell, a former deputy sheriff who was a true leader on this issue. Now I have teamed with Senator SPECTER, another former prosecutor, in this worthy cause. We have all witnessed firsthand the risks faced by law enforcement officers every day while they serve and protect our communities.

I also want to thank each of our Nation's law enforcement officers for their commitment to the safety and protection of their fellow citizens. They are the real-life heroes; too many of whom too often make the ultimate sacrifice. It is important to support and respect our state and local police officers and all of our first responders.

Currently, more than 850,000 men and women who guard our communities do so at great risk. Each year, one in 16 officers is assaulted, one in 56 officers is injured, and one in 5,500 officers is killed in the line of duty in the United States every other day. After the hijacked planes hit the World Trade Center in New York City on September 11, 2001, 72 peace officers died while trying to ensure that their fellow citizens in those buildings got to safety. That act of terrorism resulted in the highest number of peace officers ever killed in a single incident in the history of our country, and is a tragic reminder of how important it is for the Congress to provide all of the resources necessary to protect officers in the line of duty.

In 2005, 156 law enforcement officers died while serving in the line of duty, well below the decade-long average of 169 deaths annually, and a major drop from 2001 when a total of 237 officers were killed. A number of factors contributed to this reduction including better equipment and the increased use of bullet-resistant vests, improved

training and advanced emergency medical care. And, in total, more than 17,500 men and women have made the ultimate sacrifice.

In the 108th Congress, we shepherded into law a number of measures to make a difference in the lives of all police officers and the communities they serve. We improved the Justice Department's Public Safety Officers Benefits program by making law the Hometown Heroes Survivors Benefits Act, P.L. No. 108–182: which allows survivors of public safety officers who suffer fatal heart attacks or strokes while participating in nonroutine stressful or strenuous physical activities to qualify for Federal survivor benefits.

We also enacted the Campbell-Leahy Bulletproof Vest Partnership Grant Act, P.L. No. 108–372, which extends through FY 2007 the authorization of appropriations for the Bulletproof Vest Partnership Grant Program. This program helps State, tribal and local jurisdictions purchase armor vests for use by law enforcement officers.

Incredibly, President Bush has proposed significant cuts to the bulletproof vest program in his fiscal year 2007 budget proposal, but I will work with other Senators to make sure the program is fully funded. Bulletproof vests have saved the lives of thousands of officers and are a fundamental line of defense that no officer should be without. I know I am not alone in calling for the Senate to fully fund the bulletproof vest program and I truly hope Senators will agree that it is critical that we provide the funding authorized for this program. Hundreds of thousands of police officers are counting on us.

The Law Enforcement Officers Safety Act, which Senator CAMPBELL and I championed in the Senate, was signed into law, P.L. No: 108–277. This measure established national measures of uniformity and consistency to permit trained and certified on-duty, off-duty or retired law enforcement officers to carry concealed firearms in most situations so that they may respond immediately to crimes across State and other jurisdictional lines, as well as to protect themselves and their families from vindictive criminals.

National Peace Officers Memorial Day will provide the people of the United States with the opportunity to honor the extraordinary service and sacrifice given year after year by our police forces. More than 20,000 peace officers are expected to gather in Washington to join with the families of their fallen comrades. I hope all Senators will join me in honoring their service by passing this important bipartisan legislation.

Mr. KYL. Mr. President, I rise today in support of the resolution introduced by Senator LEAHY and others to recognize May 15, 2006, as ''Peace Officers Memorial Day. Peace Officers work tirelessly to protect our society from criminals who would prey on the weak and innocent. They are the front line in a battle for justice and the rule of law. They often are unheralded heroes, whose simple act of going to work puts them in harm's way for our sake.

Tens of thousands of police officers were assaulted last year, and that number is likely to be similar this year. It is important that we take a moment to recognize the crucial service they provide.

Last year, 156 police officers were killed in the line of duty. Justice for the families of slain officers often comes slowly. I have introduced legislation that would speed up the process for the most hardened of criminals, those who murder police men and women. The Law Enforcement Officers' Protection Act would guarantee tough punishment for criminals who murder or assault police officers. Part of the legislation is named after Dr. John B. Jamison, a Coconino County, AZ Reserve Sheriffs Deputy who was slain while responding to a fellow deputy's call for assistance. The killer fired 30 rounds from an assault rifle into Deputy Jamison's car, killing him before he could reach for his gun or even unbuckle his seatbelt. He is survived by two children. State courts completed their review of the killer's conviction and sentence in 1985. Federal courts then delayed the case for an additional 15 years. One judge on the U.S. Court of Appeals for the Ninth Circuit even tried to postpone the killer's final execution date on the alleged basis that that killer was wrongfully denied Sate funds to investigate a rare neurological condition that his lawyer had learned of while watching television. Deputy Jamison's killer ultimately was executed in 2000—18 years after the crime occurred, and 15 years after Federal habeas corpus proceedings began.

So as we recognize the sacrifice that peace officers make to protect us every day—to protect the streets on which we drive to work, protect the neighborhoods where our children play, protect the stores where we shop, protect the very halls of government where I stand today—I urge my colleagues to help protect the peace officers and bring justice to the families of those who have given the ultimate sacrifice for the benefit of the rest of us.

Mr. FRIST. I ask unanimous consent that the resolution and preamble be agreed to en bloc, the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 472) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 472

Whereas the well-being of all citizens of the United States is preserved and enhanced as a direct result of the vigilance and dedication of law enforcement personnel;

Whereas more than 900,000 men and women, at great risk to their personal safety, presently serve their fellow citizens as guardians of peace;

Whereas peace officers are on the front lines in preserving the right of the children of the United States to receive an education in a crime-free environment, a right that is all too often threatened by the insidious fear caused by violence in schools;

Whereas 156 peace officers across the United States were killed in the line of duty during 2005, which is below the decade-long annual average of 167 deaths;

Whereas a number of factors contributed to this reduction in deaths, including—

(1) better equipment and increased use of bullet-resistant vests;

(2) improved training;

(3) longer prison terms for violent offenders; and

(4) advanced emergency medical care;

Whereas every other day, 1 out of every 16 peace officers is assaulted, 1 out of every 56 peace officers is injured, and 1 out of every 5,500 peace officers is killed in the line of duty somewhere in the United States; and

Whereas on May 15, 2006, more than 20,000 peace officers are expected to gather in Washington, D.C., to join with the families of their recently fallen comrades to honor those comrades and all others who went before them: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes May 15, 2006, as ''Peace Officers Memorial Day'', in honor of the Federal, State, and local officers that have been killed or disabled in the line of duty; and

(2) calls on the people of the United States to observe that day with appropriate ceremonies and respect.

NATIONAL POLICE SURVIVORS DAY

Mr. FRIST. I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 473 submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 473) designating May 14, 2006, as National Police Survivors Day.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 473) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 473

Whereas the National Law Enforcement Officers Memorial in Judiciary Square of Washington, D.C., lists on its Wall of Remembrance the names of 17,535 Federal, State and local law enforcement officers who have died in the line of duty;

Whereas, in the United States, 1 law enforcement officer is killed every 53 hours, and between 140 and 160 law enforcement officers lose their lives in the line of duty each year;

Whereas, on May 14, 1983, on the eve of the 2nd annual National Peace Officers' Memorial Service, 10 widows of fallen law enforcement officers came together at dinner to discuss the lack of support for law enforcement survivors;

Whereas, exactly 1 year later, that discussion led to the formation of Concerns of Police Survivors, Inc. at the first annual National Police Survivors Seminar, which drew 110 law enforcement survivors from throughout the United States;

Whereas Concerns of Police Survivors, Inc. has grown to serve over 15,000 surviving families of fallen law enforcement officers by providing healing, love, and the opportunity for a renewed life;

Whereas Concerns of Police Survivors, Inc. and its 48 chapters throughout the United States—

(1) provide a program of peer support and counseling to law enforcement survivors for 365 days a year;

(2) helps survivors obtain the death benefits to which they are entitled; and

(3) sponsors scholarships for children and surviving spouses to pursue post-secondary education;

Whereas Concerns of Police Survivors, Inc. sponsors a year-round series of seminars, meetings and youth activities, including the National Police Survivors' Seminar during National Police Week, retreats for parents, spouses, siblings, and programs and summer activities for young and adolescent children;

Whereas Concerns of Police Survivors, Inc. helps law enforcement agencies cope with the loss of an officer by promoting the adoption of standardized policies and procedures for line-of-duty deaths; and

Whereas Concerns of Police Survivors, Inc. inspires the public to recognize the sacrifices made by law enforcement families by encouraging all citizens of the United States to tie a blue ribbon to their car antenna during National Police Week: Now, therefore, be it

Resolved, That the Senate—

(1) designates May 14, 2006, as ''National Police Survivors Day''; and

(2) calls on the people of the United States to observe National Police Survivors' Day with appropriate ceremonies to pay respect to—

(A) the survivors of the fallen heroes of law enforcement; and

(B) the fallen law enforcement officers who, through their courageous deeds, have made the ultimate sacrifice in service to their community.

HONORING THE NAACP ON THE OCCASION OF ITS 97TH ANNIVERSARY

Mr. FRIST. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of H. Con. Res. 335, and the Senate proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 335) honoring and praising the National Association for the Advancement of Colored People on the occasion of its 97th anniversary.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mrs. CLINTON. Mr. President, I urge my colleagues to support H. Con. Res. 335, a concurrent resolution honoring and praising the National Association for the Advancement of Colored People for 97 years of championing the cause of equality in the United States.

At the dawn of the 20th century—almost 56 years after the end of the Civil War—African Americans were still denied the full rights of citizenship. African Americans were forced to endure the daily humiliation of economic exploitation and social segregation with almost no recourse. Racial tensions boiled over into riots and lynchings. It was at this critical juncture in our nation's history that a group of concerned citizens, answering freedom's call, gathered together to form the National Association for the Advancement of Colored People in New York City.

Since its founding, the NAACP has fought for the social, political, and economic equality of all Americans and has sought to eliminate racial discrimination. And the NAACP has never wavered from its commitment to nonviolence in achieving these goals.

In 1918, the NAACP successfully pressured President Wilson to publicly condemn lynching and continued to raise awareness about the horrific crime. In 1930, the NAACP began its long history of protesting judicial nominees who oppose the advancement of civil rights, with the successful defeat of John Parker to the Supreme Court. The NAACP fought for, and ultimately achieved, desegregation of the military and other federal government institutions. The NAACP was victorious in Buchanan vs. Warley, where the Supreme Court held that states cannot restrict and segregate residential districts. And of course, in the seminal case of Brown v. Board of Education, the NAACP successfully argued that the ''separate, but equal'' doctrine is unconstitutional, thereby making segregation in public schools illegal.

In the 1960s, the NAACP was a leader in the fight to eradicate Jim Crow laws and abolish segregation. And the NAACP was integral to the passage of the Civil Rights Act of 1957, 1960, and 1964, the Voting Rights Act of 1965, and the Fair Housing Rights Act.

In short, the NAACP has been a catalyst for social change in this country, winning landmark court decisions and advocating for civil rights laws that have walked our nation closer to the promise of equality envisioned in our Constitution.

Notwithstanding its powerful voice and extraordinary accomplishments, we must never forget that the NAACP works through the tireless efforts of its individual members, united around a common vision of justice and equality. During desperate times, legendary NAACP members such as Thurgood Marshall, Rosa Parks, and Medger Evars made historic stands in service of the movement of civil rights.

However, equally as important are the ''everyday'' contributions of organizers and activists. One example is Mary Burnett Talbert. Originally a teacher in Little Rock, AR, Talbert eventually moved with her husband to Buffalo, NY, where she received an advanced degree. An active member of her community, Talbert was one of the founders of the NAACP and later its director, vice president, and president. As director the NAACP's Anti-Lynching Campaign, Talbert traveled the Nation giving speeches to black and white audiences. She once wrote that ''By her peculiar position the colored woman has gained clear powers of observation and judgment—exactly the sort of powers which are today peculiarly necessary to the building of an ideal country.'' With every public education campaign, every fight over a judicial nomination, and every lobbying effort to pass progressive legislation, the NAACP takes us one step closer to the ''ideal country'' that Mary Talbert envisioned.

While the NAACP's mission is to fight for the rights of African Americans, it has always been a multiracial and multicultural organization. Many of its founding members were white, including Oswald Garrison Villiard, Mary White Ovington, and Henry Moscowitz.

As we celebrate the accomplishments of the NAACP, we must also honor the values upon which it was founded, for there is much work left to be done, and the same tireless dedication and clarity of purpose will be required to continue onward.

Despite the last century of achievements, substantial racial disparities persist in educational achievement, access to health care, and economic prosperity. Hurricane Katrina highlighted the tragic and enduring link between race and poverty in our country, as well as emphasized our nation's failure to care for those among us least able to provide for themselves. We must continue vigilantly to guard against the resurgence of discriminatory practices that would deprive African Americans of the most fundamental right of democracy—the right to vote. We must continue to work to guarantee that every citizen is able to vote and that every vote is counted. And this summer, we must reauthorize the Voting Rights Act.

The NAACP has always stood ready to face these and other challenges. Ninety-seven years after a group of concerned citizens assembled in New York around the common goal of creating a more just society, the NAACP's half million members continue to lead Freedom's march.

For the battles it has fought, and for the battles it has yet to fight, our nation is forever in debt to the NAACP.

Mr. FRIST. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and that any statements relating thereto be printed in the RECORD, without further intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 335) was agreed to.

The preamble was agreed to.

EXECUTIVE CALENDAR

NOMINATION DISCHARGED

Mr. FRIST. Mr. President, as in executive session, I ask unanimous consent that the nomination of George McDade Staples, PN 1361, be discharged from the Foreign Relations Committee and placed on the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR THURSDAY, MAY 11, 2005

Mr. FRIST. Mr. President, when the Senate completes its business today, I ask unanimous consent that it stand in adjournment until 9:30 a.m. on Thursday, May 11. I further ask that, following the prayer and pledge, the morning hour be deemed to have expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved, and the Senate proceed to the conference report to accompany H.R. 4297, the Tax Relief Extension Reconciliation Act, as under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, tomorrow we will turn to the tax reconciliation conference report under the agreement reached. There will be a maximum of 8 hours of debate prior to a vote on the conference report. I filed cloture on the pending substitute amendment to S. 1955, the small business health plan bill. That vote will occur following the tax relief act vote and sometime before closing remarks.

ORDER FOR ADJOURNMENT

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

Mr. DURBIN. Mr. President, I ask the majority leader if he would give me the option to make a closing statement, and that the Senate adjourn after that option is given.

Mr. FRIST. I have no objection to that.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Illinois is recognized.

HEALTH CARE

Mr. DURBIN. Mr. President, what we have just seen happen is not surprising, but it is disappointing. Health Care Week has come to an end in the Senate on Wednesday evening. We have decided we don't have the time, interest, or inclination to take up other issues. It is a take-it-or-leave-it situation. If we do not accept the Enzi bill, S. 1955, now pending, nothing will be done on health care in the Senate.

It is no wonder to me the American people are cynical about this process. There are so many things we need to do. We are 5 days away from the deadline on Medicare prescription Part D. My best estimate is 50 percent of the people we had hoped would enroll have not done it. They are going to be penalized on May 15 up to 7 percent a year on their premium costs for the rest of their life. We have asked for an extension of time so they can make a choice. We have asked for an extension of time so seniors who have chosen the wrong plan can choose another plan without penalty. Those are not unreasonable. We ask for extensions for people who file income tax without questions asked. To give an extension to an elderly person struggling with 45 different choices for the right prescription drug program is not unreasonable. It would be compassionate. It is the decision of the Senate Republican leadership that we don't have the time or inclination to take up that issue.

I just asked the majority leader: What about stem cell research? Last July, he pledged support for stem cell research. The writing is on the wall: Another year will go by, and this Senate will not go on record on stem cell research.

While millions of Americans and their families are suffering from diseases that could be directly impacted by this research, the Senate doesn't have the time or the inclination to take up this issue. Is it any wonder that people are angry with the Congress as it is presently being conducted? Is it any wonder people are calling for significant change, not only in the direction of this country but in the policies we follow on Capitol Hill? We are going to break our necks to bring up a tax bill before we leave this week to give tax benefits and tax cuts to the wealthiest people in America. We have to get that done, but we don't have time to bring up stem cell research which could give hope and promise for cures and relief to millions of American families?

Where are our priorities? The priorities of this Republican-led Congress are priorities that do not reflect where America is today. The motions we have just heard do not reflect that. To suggest that we don't have time, for example, to even consider the reimportation of drugs so that people struggling with fixed incomes can afford the drugs they need to stay independent, be strong, stay alive—we don't have time for that. No, we have to get on to a tax cut—a tax cut. Let me tell you what the tax cut is.

The tax cut which the Republicans want to force through here before we leave this week—we have to break all records to make sure we get this done—is a tax cut that will mean for people making less than $75,000 a year about on average $100 in tax relief. The good old $100 check is coming back at you, America, if you make less than $75,000 a year; that is your tax cut; be prepared, party on. But if you happen to be making $1 million a year, well, that is another story. This Republican tax cut, which they just have to have, means about $42,000 less in taxes paid by someone making $1 million a year.

No time for drugs imported from Canada for people on fixed incomes who can't afford what they need to stay alive, no time for stem cell research for the millions of families counting on us to push forward on medical research to find cures and relief, no time to deal with Medicare prescription Part D when 7 or 8 million Americans, senior citizens, are about to face penalties in 5 days, no time for that, but plenty of time for tax cuts. It tells the story. No wonder the people across this country and even 30 of the Republicans are saying it is time for a change on Capitol Hill. It is time for new leadership, new direction, and new values. If this is the best we can do, to come up with a tax cut for the wealthiest people in America and ignore the real needs of small business and the elderly, to ignore the real needs of those who are fighting for medical research to give them hope to live another day, it is a sad outcome.

I started this day by praising Senator ENZI and I will end it by doing the same. I respect him. I admire him. He brought an issue to the floor that is a tough one—health care in America. And this debate is long overdue. We have been waiting a long time to address an issue that troubles families and businesses across this Nation. I thank Senator ENZI for his leadership in bringing this to the floor. But I have to tell you, what has happened today procedurally on the floor gives no credit to that effort by Senator ENZI. Shutting down amendments, not even giving us a moment to raise these important issues, even with limited time and limited debate, is unfair. And what a contrast. What a contrast to the immigration bill where the Senator from Tennessee, the Republican majority leader, has argued that we need every possible amendment to be considered before it comes to a conclusion. Wide open; let everybody bring what they want, whether they are for the bill or against it. But when it comes to health care, when it comes to what counts, this man, who has made medicine his profession and his life before he came to the Senate, does not give us an opportunity to go into the issues that are so important to people across America. It is a sad outcome for America, it is a sad outcome for the Senate. This Senate appears to be not only risk averse but work averse, and that is a shame. It is time for a change.

Mr. President, I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:30 a.m. tomorrow.

Thereupon, the Senate, at 8:30 p.m., adjourned until Thursday, May 11, 2006, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate May 10, 2006:

THE JUDICIARY

NEIL M. GORSUCH, OF COLORADO, TO BE UNITED STATES CIRCUIT JUDGE FOR THE TENTH CIRCUIT, VICE DAVID M. EBEL, RETIRED.

IN THE ARMY

THE FOLLOWING NAMED UNITED STATES ARMY RESERVE OFFICER FOR APPOINTMENT AS CHIEF, ARMY RESERVE AND APPOINTMENT TO THE GRADE INDICATED UNDER THE PROVISIONS OF TITLE 10, U.S.C., SECTIONS 3038 AND 601:

To be lieutenant general

MAJ. GEN. JACK C. STULTZ, JR., 0000

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

MICHAEL E. BELCHER, 0000
JAMES COBELL III, 0000
DAVID A. PAULK, 0000
DAVID J. RANDLE, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

SHAWN M. CALLAHAN, 0000
ROSEMARIE J. CONN, 0000
ROBIN L. CSUTI, 0000
SANDRA K. HAIDVOGEL, 0000
PATRICIA B. MOORE, 0000
KAREN J. VIGNERON, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

PATRICK G. BYRNE, 0000
MAXIE Y. DAVIS, 0000
JUDIE A. HEINEMAN, 0000
SYNTHIA S. JONES, 0000
JOSEPH J. KINDER, 0000
MARK T. KOHLHEIM, 0000
JEFFREY P. LINK, 0000
NANCY A. NORTON, 0000
JOHN L. PAGONA, JR., 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

LOUIS M. BORNO III, 0000
DANIEL J. CUFF, 0000
MARTIN W. DEPPE, 0000
SHANE G. GAHAGAN, 0000
ANDREW G. HARTIGAN, 0000
PAUL J. OVERSTREET, 0000
ROBERT S. ROOF, 0000
PAUL A. SOHL, 0000
ARTHUR M. STERRETT, JR., 0000
ERIC J. WATKISS, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

LEONARD M. ABBATIELLO, 0000
RAY A. CROSS, 0000
BRENT J. GRIFFIN, 0000
DOUGLAS J. GROSSMANN, 0000
BRETT C. HEIMBIGNER, 0000
JERRY L. JACOBSON, 0000
ERIC V. KRISTIN, 0000
BRUCE F. LOVELESS, 0000
ROBERT RUPP, 0000
JOHN B. STUBBS, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

STEVEN J. ASHWORTH, 0000
CARL A. BARKSDALE, 0000
RICHARD P. BODZIAK, 0000
JAMES E. BROKAW, 0000
CONNIE L. FRIZZELL, 0000
DIANE K. GRONEWOLD, 0000
GREGORY J. HAWS, 0000
KATHRYN M. K. HELMS, 0000
WILLIE L. METTS, 0000
ROY S. PETTY, 0000
EUGENE P. POTENTE, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

FRANK A. ARATA, 0000
CHARLES E. BAKER, JR., 0000
DAVID T. BISHOP, JR., 0000
MARK BRIDENSTINE, 0000
RONALD E. COOK, 0000
CHARLES A. DAVIS, 0000
ALEXANDER S. DESROCHES, 0000
JAMES P. DOWNEY, 0000
BRIAN B. GANNON, 0000
JON A. HILL, 0000
LLOYD H. JONES, 0000
TIMOTHY J. KELLY, 0000
WILLIAM C. KIESTLER, 0000
WARREN P. LUNDBLAD, 0000
PETER C. LYLE, 0000
TIMOTHY S. MATTINGLY, 0000
STEVE J. MCPHILLIPS, 0000
CHRIS D. MEYER, 0000
DAVID B. OSGOOD, 0000
PER E. PROVENCHER, 0000
JEFFERY S. RIEDEL, 0000
CHRISTOPHER D. SCOFIELD, 0000
FRANK A. SIMEI, JR., 0000
GEORGE M. SUTTON, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be captain

JOHN W. V. AILES, 0000
HENRY D. ANGELINO, JR., 0000
JAMES N. BARATTA, 0000
ROBERT C. BARWIS, 0000
JOSEPH A. BAUKNECHT, 0000
JOSEPH W. BEADLES, 0000
JAMES R. BEAMISH, JR., 0000
MATTHEW S. BEAVER, 0000
JOSEPH J. BEEL, 0000
DON E. BERRY, JR., 0000
STEVEN H. BLAISDELL, 0000
GARY M. B. BOARDMAN, 0000
PATRICK J. BOHAN, 0000
GAIL M. BOVY, 0000
VINCENT C. BOWHERS, JR., 0000
LAURELL A. BRAULT, 0000
JOHN J. BRAUNSCHWEIG, 0000
DENNIS M. BROOKS, 0000
RICHARD A. BROWN, 0000
JAMES F. BUCKLEY, 0000
THOM W. BURKE, 0000
BABETTE B. BUSH, 0000
PATRICK W. BUTLER, 0000
ANDREW A. BUTTERFIELD, 0000
JAMES S. BYNUM, 0000
EDWARD J. CAMPBELL, 0000
DOUGLAS D. CARSTEN, 0000
MATTHEW J. CARTER, 0000
JAMES R. CASTLETON, 0000
DARYL L. CAUDLE, 0000
GARD J. CLARK, 0000
PETER J. CLARKE, 0000
PATRICK R. CLEARY III, 0000
JEFFREY W. CONNOR, 0000
ROBERT E. CONWAY, 0000
JEFFREY S. CORAN, 0000
MICHAEL J. CORRIGAN, 0000
KEVIN J. COUCH, 0000
MICHAEL J. COURY, 0000
JAMES T. COX, 0000
KYLE J. COZAD, 0000
RANDY B. CRITES, 0000
ANDREW F. CULLY, 0000
JAMES J. CUNHA, 0000
GREGORY P. CURTH, 0000
DOUGLAS L. CUTHBERT, 0000
ANGELA W. CYRUS, 0000
TODD H. DEGHETTO, 0000
CHARLES C. DENMAN II, 0000
MARC W. DENNO, 0000
STANTON W. DIETRICH, 0000
JEFFREY A. DODSON, 0000
DANIEL M. DONOVAN, 0000
SCOTT D. DUEKER, 0000
RICHARD J. EASON, 0000
STEWART G. ELLIOTT, 0000
CHARLES G. EMMERT, 0000
GEORGE T. FADOK, JR., 0000
THOMAS J. FASANELLO, JR., 0000
JOHN M. FIGUERRES, 0000
HAROLD T. FINK, 0000
DAVID T. FISHER, 0000
RICHARD T. FITE, 0000
WILLIAM A. FITZGERALD, 0000
MICHAEL J. FITZPATRICK, 0000
STEPHEN R. FOLEY, 0000
LISA M. FRANCHETTI, 0000
JEFFREY D. FREDERICK, 0000
DALE G. FULLER, 0000
LARRY S. GAGE, 0000
ERIC W. GARDNER, 0000
BRETT J. GENOBLE, 0000
RONALD M. GERO, JR., 0000
CHARLES M. GIBSON III, 0000
BAXTER A. GOODLY, 0000
HOLLY A. GRAF, 0000
MICHAEL R. GRAHAM, 0000
PAUL A. HAAS, 0000
HERBERT M. HADLEY, 0000
DAVID J. HAHN, 0000
RICHARD J. HALE, 0000
THOMAS V. HALLEY, JR., 0000
CATHERINE T. HANFT, 0000
PETER H. HANLON, 0000
MARKUS K. HANNAN, 0000
GENE F. HARR, 0000
EDWARD J. HARRINGTON, 0000
WAYNE J. HARRISON, 0000
TROY L. HART, 0000
EDWARD L. HASELL, 0000
JAMES D. HAUGEN, 0000
MIKE A. HAUMER, 0000
JOHN A. HEFTI, 0000
WILLIAM K. HENDERSON, 0000
ROGER H. HENZE, 0000
DAVID J. HERMAN, 0000
DIXON K. HICKS, 0000
MICHAEL S. HILL, 0000
MARCUS A. HITCHCOCK, 0000
DONALD D. HODGE, 0000
BRENDA M. HOLDENER, 0000
CHARLES T. HOLLINGSWORTH, 0000
STEVEN W. HOLMES, 0000
DALE E. HORAN, 0000
JEFFERY W. HOYLE, 0000
MARK A. HUBBARD, 0000
AARON C. JACOBS, 0000
PETER H. JEFFERSON, 0000
WILLIAM J. JENSEN, 0000
KEVIN R. JOHNSON, 0000
WILLIAM C. JOHNSON, 0000
DORIAN F. JONES, 0000
CHRISTOPHER J. KAISER, 0000
ROY J. KELLEY, 0000
STEVEN M. KELLY, 0000
KEVIN M. KENNEY, 0000
COLIN J. KILRAIN, 0000
ROY I. KITCHENER, 0000
JAMES R. KNAPP, 0000
ALEXANDER L. KRONGARD, 0000
STEPHEN C. KROTOW, 0000
ANTHONY L. KRUEGER, 0000
DAVID J. LANDESS, 0000
EDWARD D. LANGFORD, 0000
JOHN T. LAUER III, 0000
WILLIAM L. LAWLER, JR., 0000
ROBERT G. LINEBERRY, JR., 0000
JAMES T. LOEBLEIN, 0000
MATTHEW E. LOUGHLIN, 0000
JOHN P. LUSSIER, 0000
ANTHONY E. MARTIN, 0000
FRANCIS X. MARTIN, 0000
RICK A. MAY, 0000
THOMAS J. MCDONOUGH, JR., 0000
DAVID M. MCDUFFIE, 0000
DOUGLAS A. MCGOWEN, 0000
PAUL F. MCHALE, 0000
STEPHEN P. MCINERNEY, 0000
DANIEL T. MCNAMARA, 0000
THERESA O. MELCHER, 0000
DENNIS C. MIKESKA, 0000
JOHN MILEY, 0000
JOHN W. MOORE, 0000
WILL M. MOORE, JR., 0000
DAVID J. MORGAN, 0000
WILLIAM F. MOSK, 0000
THOMAS M. NEGUS, 0000
STEVEN G. NELSON, 0000
DONALD E. NEUBERT, JR., 0000
JACK S. NOEL II, 0000
JOHN P. NOLAN, 0000
WILLIAM J. NOLAN, 0000
THOMAS E. NOSENZO, 0000
JOHN S. ONEILL, 0000
HAMLIN A. ORTIZMARTY, 0000
GREGORY M. OTT, 0000
MICHAEL J. OTTINGER, 0000
TIM P. PANGONAS, 0000
ERIC A. PATTEN, 0000
ANDREW T. PAUL, 0000
TIMOTHY C. PEDERSEN, 0000
JOHN S. PERRY, JR., 0000
STEVEN L. PETTIT, 0000
PATRICK A. PIERCEY, 0000
RANDOLPH F. PIERSON, 0000
EVAN B. PIRITZ, 0000
PAUL S. POSEY, 0000
CLARK T. PRICE, JR., 0000
DAVID R. PRICE, 0000
MICHAEL V. PROSPERI, 0000
HUMBERTO L. QUINTANILLA, 0000
ROBERT W. RACOOSIN, 0000
RICHARD A. RAINER, JR., 0000
ROBERT D. RANDALL, JR., 0000
CHARLES S. RAUCH, 0000
THERESA M. REA, 0000
RONALD REIS, 0000
BRETT A. REISSENER, 0000
EDWIN J. RUFF, JR., 0000
BRADLEY S. RUSSELL, 0000
MICHAEL B. RYAN, 0000
DAVID A. SCHNELL, 0000
JOHN D. SCHOENECK, 0000
GARY R. SCHRAM, 0000
DAVID D. SCHWEIZER, 0000
GREGG G. SEARS, 0000
KENNETH E. SELIGA, 0000
PAUL J. SEVERS, 0000
JAMES R. SHOAF, 0000
PAUL A. SKARPNESS, 0000
THOMAS A. SLAIS, JR., 0000
ERIC S. SLEZAK, 0000
MICHAEL J. SLOTSKY, 0000
JEFFERY C. SMITH, 0000
DAVID A. SOLMS, 0000
THOMAS P. STANLEY, 0000
TROY A. STONER, 0000
CHARLES L. STUPPARD, 0000
ANTHONY W. SWAIN, 0000
DAVID R. SWAIN, 0000
ROBERT C. SWALLOW, 0000
KENNETH J. SZCZUBLEWSKI, 0000

TIMOTHY G. SZYMANSKI, 0000
MICHAEL P. TAYLOR, 0000
RALPH L. TINDAL III, 0000
PETER A. TOMCZAK, 0000
JEFFREY E. TRUSSLER, 0000
STEVEN S. VAHSEN, 0000
ROBERT M. VANCE, 0000
KARL J. VANDEUSEN, 0000
JAMES L. VANDIVER, 0000
MICHAEL S. VILAND, 0000
HANS T. WALSH, 0000
JASON WASHABAUGH, 0000
DOUGLAS E. WATERS, 0000
OAKLEY K. WATKINS III, 0000
MARK E. WEBER, 0000
MICHAEL B. WHETSTONE, 0000
KENNETH R. WHITESELL, 0000
JOSEPH B. WIEGAND, 0000
CHARLES F. WILLIAMS, 0000
GORDON C. WILLIAMS, 0000
KENNETH L. WILLIAMS, 0000
BRAD WILLIAMSON, 0000
RICKY L. WILLIAMSON, 0000
GARY M. WILSON, 0000
KRIS WINTER, 0000
CHARLES T. WOLF, 0000
ALPHONSO L. WOODS, 0000
LEWIN C. WRIGHT, 0000
CHARLES W. WYDLER, 0000
MARK S. YOUNG, 0000
GLENN W. ZEIDERS III, 0000

DISCHARGED NOMINATION

The Senate Committee on Foreign Relations was discharged from further consideration of the following nomination and the nomination was placed on the Executive Calendar:

GEORGE MCDADE STAPLES, OF KENTUCKY, TO BE DIRECTOR GENERAL OF THE FOREIGN SERVICE.