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111TH CONGRESS
1ST SESSION

H. R. 3067

To amend title XVIII of the Social Security Act to reform Medicare payments to physicians and certain other providers and improve Medicare benefits, to encourage the offering of health coverage by small businesses, to provide tax incentives for the purchase of health insurance by individuals, to increase access to health care for veterans, to address the nursing shortage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mr. LATHAM introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor, Ways and Means, Veterans' Affairs, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to reform Medicare payments to physicians and certain other providers and improve Medicare benefits, to encourage the offering of health coverage by small businesses, to provide tax incentives for the purchase of health insurance by individuals, to increase access to health care for veterans, to address the nursing shortage, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Security for All Americans Act of 2009''.

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

TITLE I—MEDICARE

SEC. 101. MEDICARE PHYSICIAN PAYMENT UPDATE REFORM.

(a) SUBSTITUTION OF MEI INCREASE FOR SGR ADJUSTMENTS.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (1)(A), by inserting ''and before 2010'' after ''beginning with 2001'';

(2) in paragraph (1)(A), by inserting before the period at the end the following: '', and for years beginning with 2010, multiplied by the update established under paragraph (10) applicable to the year involved''; and

(3) in paragraph (4)—

(A) in the heading by striking ''YEARS BEGINNING WITH 2001'' and inserting ''2001, 2002, AND 2003''; and

(B) in subparagraph (A), by inserting ''and ending with 2003'' after ''beginning with 2001''; and

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

''(10) UPDATE BEGINNING WITH 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 and each succeeding year shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved minus 1 percentage point.''.

(b) ENDING APPLICATION OF SUSTAINABLE GROWTH RATE (SGR).—Section 1848(f)(1)(B) of such Act (42 U.S.C. 1395w–4(f)(1)(B)) is amended by inserting ''(and before 2009)'' after ''each succeeding year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for services furnished on or after January 1, 2010.

SEC. 102. MEDICARE GPCI FLOORS.

Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''and (G)'' and inserting ''(G), (H), and (I)''; and

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

''(H) FLOOR AT 1.0 FOR PRACTICE EXPENSE INDEX.—After calculating the practice expense index in subparagraph (A)(ii), for purposes of payment for services furnished on or after January 1, 2010, the Secretary shall in-

crease the practice expense geographic index to 1.00 for any locality for which such practice expense geographic index is less than 1.00.

''(I) FLOOR AT 1.0 FOR WORK EXPENSES INDEX.—After calculating the practice expense index in subparagraph (A)(ii), for purposes of payment for services furnished on or after January 1, 2010, the Secretary shall increase the practice expense geographic index to 1.00 for any locality for which such practice expense geographic index is less than 1.00.''.

SEC. 103. ANNUAL PHYSICAL EXAMINATIONS UNDER MEDICARE.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in each of subparagraphs (W) and (AA)(i) of subsection (s)(2), by striking ''initial'' and inserting ''annual'';

(2) in the heading of subsection (ww), by striking ''Initial'' and inserting ''Annual''; and

(3) by amending paragraph (1) of subsection (ww) to read as follows:

''(1) The term 'annual preventive physical examination' means professional services of a physician, or of a nurse practitioner or physician assist-

ant which the practitioner or assistant is authorized to provide under State law, consisting of a physical examination (including, as medically appropriate, measurement of height, weight, body mass index, and blood pressure) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2) and end-of-life planning (as defined in paragraph (3)) upon the agreement with the individual, as well as related clinical laboratory tests and such other preventive services in connection with the same visit as the Secretary may provide (taking into account services typically included in an annual physical examination covered under private health benefit plans).''.

(b) MODIFICATION OF EXCLUSIONS.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1), by amending subparagraph (K) to read as follows:

''(K) in the case of an annual preventive physical examination, which is performed for an individual more frequently than once in any 12-month period,''; and

(2) in paragraph (7), by inserting ''(other than annual preventive physical examinations)'' after ''routine physical checkups''.

(c) CONFORMING AMENDMENT.—Section 1833(b)(9) of such Act (42 U.S.C. 1395l(b)(9)) is amended by striking ''initial'' and inserting ''annual''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1 of the first year beginning more than 60 days after the date of the enactment of this Act.

SEC. 104. MEDICARE OUTREACH CAMPAIGN ON AVAILABILITY OF WELCOME TO MEDICARE PHYSICALS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a national campaign to provide information to the public on the availability of an initial preventive physical examination (as defined in section 1861(ww) of the Social Security Act (42 U.S.C. 1395x(ww))) for beneficiaries of the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2010 through 2014.

SEC. 105. IMPROVEMENTS TO THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) USE OF NON-WAGE ADJUSTED PPS RATE.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended by adding at the end the following new clause:

''(v) In the case of discharges occurring on or after October 1, 2010, and before October 1, 2012, in determining the amount under paragraph (1)(A)(iii) for purposes of clauses (i) and (ii)(II), such amount shall, if it results in greater payments to the hospital, be determined without regard to any adjustment for different area wage levels under paragraph (3)(E).''.

(b) ENHANCED PAYMENT FOR AMOUNT BY WHICH THE TARGET EXCEEDS THE PPS RATE.—Section 1886(d)(5)(G)(ii)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(ii)(II)) is amended by inserting '', and before October 1, 2010, or 85 percent in the case of discharges occurring on or after October 1, 2010, and before October 1, 2012'' after ''October 1, 2011''.

SEC. 106. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting ''or (D)'' after ''subparagraph (B)'';

(2) in subparagraph (B), by striking ''The Secretary'' and inserting ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'';

(3) in subparagraph (C)(i)—

(A) by inserting ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles''; and

(B) by inserting ''(or, with respect to fiscal years 2011 and 2012, 2,000 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''; and

(4) by adding at the end the following new subparagraph:

''(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 or 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a linear sliding scale ranging from 25 percent for low-volume hospitals with fewer than an appropriate number (as determined by the Secretary)

of discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 2,000 discharges of such individuals in the fiscal year.''.

SEC. 107. ENSURING PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS ON MEDPAC.

(a) IN GENERAL.—Section 1805(c)(2) of the Social Security Act (42 U.S.C. 1395b–6(c)(2)) is amended—

(1) in subparagraph (A), by inserting ''consistent with subparagraph (E)'' after ''rural representatives''; and

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

''(E) PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS.—In order to provide a balance between urban and rural representatives under subparagraph (A), the proportion of members of the Commission who represent the interests of health care providers and Medicare beneficiaries located in rural areas shall be no less than the proportion of the total number of Medicare beneficiaries who reside in rural areas.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to appointments to the Medicare Payment Advisory Commission made after the date of enactment of this Act.

TITLE II—SMALL BUSINESS HEALTH PLANS

Subtitle A—Enhanced Marketplace Pools

SEC. 201. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

(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 ENHANCED MARKETPLACE POOLS

"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. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary, not later than 1 year after the date of enactment of this part, shall promulgate regulations that apply the rules and standards of this part, as necessary, to circumstances in which a pooling entity other (hereinafter 'Alternative Market Pooling Organizations') is not made up principally of employers and their employees, or not a professional organization or such small business health plan entity identified in section 801.

"(b) ADAPTION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—

"(1) adapt the standards of this part, to the maximum degree practicable, to assure balanced and comparable oversight standards for both small busi-

ness health plans and alternative market pooling organizations;

''(2) permit the participation as alternative market pooling organizations unions, churches and other faith-based organizations, or other organizations composed of individuals and groups which may have little or no association with employment, provided however, that such alternative market pooling organizations meet, and continue meeting on an ongoing basis, to satisfy standards, rules, and requirements materially equivalent to those set forth in this part with respect to small business health plans;

''(3) conduct periodic verification of such compliance by alternative market pooling organizations, in consultation with the Secretary of Health and Human Services and the National Association of Insurance Commissioners, except that such periodic verification shall not materially impede market entry or participation as pooling entities comparable to that of small business health plans;

''(4) assure that consistent, clear, and regularly monitored standards are applied with respect to alternative market pooling organizations to avert material risk-selection within or among the composition of such organizations;

''(5) the expedited and deemed certification procedures provided in section 805(d) shall not apply to alternative market pooling organizations until sooner of the promulgation of regulations under this subsection or the expiration of one year following enactment of this Act; and

''(6) make such other appropriate adjustments to the requirements of this part as the Secretary may reasonably deem appropriate to fit the circumstances of an individual alternative market pooling organization or category of such organization, including but not limited to the application of the membership payment requirements of section 801(b)(2) to alternative market pooling organizations composed primarily of church- or faith-based membership.

''SEC. 803. 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 Sec-

retary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

"SEC. 804. 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 this part.

''(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. 805. 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. 806. 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 ma-

terial 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 XXXI of the Public Health Service Act (relating to rating requirements), as added by subtitle B of title II of the Health Security for All Americans Act of 2009.

''(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 XXXI of the Public Health Service Act (relating to lower cost plans), as added by subtitle B of title II of the Health Security for All Americans Act of 2009.

''(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 XXXI of the Public Health Service Act (relating to rating and benefits as added by subtitle B of title II of the

Health Security for All Americans Act of 2009), 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 XXXI of

the Public Health Service Act (relating to rating and benefits added by subtitle B of title II of the Health Security for All Americans Act of 2009)) 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. 807. 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. 808. 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. 809. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this part to accommodate with minimum disruption such changes to State or Federal law provided in this part and the (and the amendments made by such Act) or in regulations issued thereto.

''SEC. 810. 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 XXXI of the Public Health Service Act (as added by title II of the Health Security for All Americans Act of 2009) (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:

SEC. 202. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

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

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

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

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

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

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

SEC. 203. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the

amendments made by this subtitle within 6 months after the date of the enactment of this Act.

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

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

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

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

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

Subtitle B—Market Relief

SEC. 211. MARKET RELIEF.

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

''TITLE XXXI—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 3101. 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.

''SEC. 3102. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may

reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this title to accommodate with minimum disruption such changes to State or Federal law provided in this title and the (and the amendments made by such Act) or in regulations issued thereto.

"Subtitle A—Market Relief

"PART I—RATING REQUIREMENTS

"SEC. 3111. 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 3112(a)(1) or, as applicable, transitional small group rating rules set forth in section 3112(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 3112(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 3112(a)(1)).

''SEC. 3112. 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 nonadopting 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 nonadopting 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 nonadopting 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 nonadopting 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 this title 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 this title.

''SEC. 3113. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—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) 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. 3114. 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 3113.

"(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. 3115. 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 Com-

missioners, 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. 3121. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group, individual, 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 3122(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 de-

scribed 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, individual, 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 3122(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 in-

surance 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 3122(a).

"SEC. 3122. 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, individual, 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 cat-

egory 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, individual, 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, individual, 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, individual, 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 3121(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 re-

quirements 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.

''SEC. 3123. 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 3122(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. 3124. 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 3123.

"(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. 3125. 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 nonadopting 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.''.

Subtitle C—Harmonization of Health Insurance Standards

SEC. 221. HEALTH INSURANCE STANDARDS HARMONIZATION.

Title XXXI of the Public Health Service Act (as added by section 211) is amended by adding at the end the following:

''Subtitle B—Standards Harmonization

''SEC. 3131. 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 con-

sistent 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 3133(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 3133(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 3133(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. 3132. 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 two shall be Democrats and two 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 organiza-

tions 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 excep-

tions 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 3122(a).

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

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

surance 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 pro-

tect 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) APPLICATION AND EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall apply and become 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 applied under this section 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. 3133. APPLICATION AND PREEMPTION.

''(a) SUPERCEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle and applied as provided for in section 3133(d)(3), shall supersede any and all State laws of a nonadopting 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 non-

adopting 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. 3134. 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 3133.

''(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 judg-

ment, 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. 3135. 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 any benefits below the deductible levels set for any health savings account-qualified health plan pursuant to section 223 of the Internal Revenue Code of 1986.''.

TITLE III—TAX-RELATED HEALTH INCENTIVES

SEC. 301. SECA TAX DEDUCTION FOR HEALTH INSURANCE COSTS.

(a) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to special

rules for health insurance costs of self-employed individuals) is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 302. DEDUCTION FOR QUALIFIED HEALTH INSURANCE COSTS OF INDIVIDUALS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. COSTS OF QUALIFIED HEALTH INSURANCE.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the amount paid during the taxable year for coverage for the taxpayer, his spouse, and dependents under qualified health insurance.

"(b) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means insurance which constitutes medical care, other than insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c).

"(c) SPECIAL RULES.—

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

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''.

(b) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Subsection (a) of section 62 of such Code is amended by inserting before the last sentence the following new paragraph:

''(22) COSTS OF QUALIFIED HEALTH INSURANCE.—The deduction allowed by section 224.''.

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by redesignating the item relating to section

224 as an item relating to section 225 and inserting before such item the following new item:

''Sec. 224. Costs of qualified health insurance.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

TITLE IV—INCREASING ACCESS TO VA HEALTH CARE

SEC. 401. REQUIREMENT FOR PAYMENTS TO FACILITIES OTHER THAN THE DEPARTMENT OF VETERANS AFFAIRS FOR COVERED HEALTH SERVICES.

(a) REQUIREMENT TO AUTHORIZE RECEIPT OF COVERED HEALTH SERVICES AT NON-DEPARTMENT FACILITIES PURSUANT TO CONTRACTS WITH SUCH FACILITIES.—Subsection (a) of section 1703 of title 38, United States Code, is amended to read as follows:

''(a) An enrolled veteran may elect to receive covered health services through a non-Department facility. Such an election shall be made by submission to the Secretary of an application in accordance with such regulations as the Secretary prescribes. The Secretary shall authorize such services to be furnished to such veteran pursuant to contracting with such a facility to furnish such services to such a veteran, as authorized in section 1710 of this title.''.

(b) DESCRIPTIONS OF COVERED HEALTH SERVICES AND ENROLLED VETERANS.—Such section is further amended by adding at the end the following new subsection:

''(e) For purposes of subsection (a)—

''(1) a covered health service is any hospital care, medical service, rehabilitative service, or preventative health service for which the veteran described in such subsection is eligible under this title; and

''(2) an enrolled veteran is a veteran who is enrolled in the system of patient enrollment established under section 1705(a) of this title.''.

(c) EFFECTIVE DATE.—The Secretary of Veterans Affairs shall implement the amendments made by subsections (a) and (b) in order for enrolled veterans described in section 1703(e)(2) of title 38, United States Code, as added by subsection (b), to receive covered health services in accordance with section 1703(a) of such title, as amended by subsection (a), not later than 180 days after the date of the enactment of this Act.

SEC. 402. AUTHORITY OF DEPARTMENT OF VETERANS AFFAIRS PHARMACIES TO DISPENSE MEDICATIONS TO VETERANS ON PRESCRIPTIONS WRITTEN BY PRIVATE PRACTITIONERS.

Section 1712 of title 38, United States Code, is amended by adding at the end the following new subsection:

''(f) Subject to section 1722A of this title, the Secretary shall furnish to a veteran, through a Department health care facility, such drugs and medicines as may be ordered on prescription of a duly licensed physician in the treatment of any illness or injury of the veteran provided pursuant to the authority to contract with a non-Department facility for such treatment under section 1703 of this title.''.

TITLE V—NURSING SHORTAGE

SEC. 501. CHILD CARE ASSISTANCE FOR INDIVIDUALS PURSUING ADVANCED NURSING DEGREES.

Part E of title VIII of the Public Health Service Act (42 U.S.C. 297a et seq.) is amended—

(1) by redesignating section 810 (relating to a prohibition against discrimination by schools) as section 846B; and

(2) by adding at the end the following:

"SEC. 846C. CHILD CARE ASSISTANCE FOR INDIVIDUALS PURSUING ADVANCED NURSING DEGREES.

''(a) IN GENERAL.—The Secretary may carry out a program of entering into contracts with eligible individuals under which—

''(1) the Secretary agrees to provide child care vouchers to the eligible individual for each month during which the individual is a student in an advanced nursing degree program; and

''(2) the eligible individual agrees to serve, at the completion of such program, as a faculty member at a school of nursing for a period of 4 years.

''(b) VOUCHERS.—Vouchers provided to an eligible individual under this section—

''(1) shall be for child care expenses; and

''(2) shall be for not more than $500 per month.

''(c) DEFINITION.—In this section, the term 'eligible individual' means an individual who is enrolled or accepted for enrollment as a full-time student in an advanced nursing degree program.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 502. NURSE FACULTY PROGRAM.

Title VII of the Higher Education Act of 1965 (20 U.S.C. 1133 et seq.) is amended by adding at the end the following new part:

"PART E—NURSE FACULTY PROJECT

"SEC. 771. PURPOSES.

''The purposes of this part are to create a program—

''(1) to provide scholarships to qualified nurses in pursuit of an advanced degree with the goal of becoming faculty members in an accredited nursing program; and

''(2) to provide grants to partnerships between accredited schools of nursing and hospitals or health facilities to fund release time for qualified nurse employees, so that those employees can earn a salary while obtaining an advanced degree in nursing with the goal of becoming nurse faculty.

"SEC. 772. ASSISTANCE AUTHORIZED.

''(a) COMPETITIVE GRANTS AUTHORIZED.—The Secretary may, on a competitive basis, award grants to, and enter into contracts and cooperative agreements with, partnerships composed of an accredited school of nursing at an institution of higher education and a hospital or health facility to establish projects to enable such hospital or health facility to retain its staff of experienced nurses while providing a mechanism to have these individuals be-

come, through an accelerated nursing education program, faculty members of an accredited school of nursing.

''(b) DURATION; EVALUATION AND DISSEMINATION.—

''(1) DURATION.—Grants under this part shall be awarded for a period of 3 to 5 years.

''(2) MANDATORY EVALUATION AND DISSEMINATION.—Grants under this part shall be primarily used for evaluation, and dissemination to other institutions of higher education, of the information obtained through the activities described in section 771(2).

''(c) CONSIDERATIONS IN MAKING AWARDS.—In awarding grants and entering into contracts and cooperative agreements under this section, the Secretary shall consider the following:

''(1) GEOGRAPHIC DISTRIBUTION.—Providing an equitable geographic distribution of such grants.

''(2) RURAL AND URBAN AREAS.—Distributing such grants to urban and rural areas.

''(3) RANGE AND TYPE OF INSTITUTION.—Ensuring that the activities to be assisted are developed for a range of types and sizes of institutions of higher education.

''(4) PRIOR EXPERIENCE OR EXCEPTIONAL PROGRAMS.—Institutions of higher education with demonstrated prior experience in providing advanced nursing education programs to prepare nurses interested in pursuing a faculty role.

''(d) USES OF FUNDS.—Funds made available by grant, contract, or cooperative agreement under this part may be used—

''(1) to develop a new national demonstration initiative to align nursing education with the emerging challenges of health care delivery; and

''(2) for any one or more of the following innovations in educational programs:

''(A) to develop a clinical simulation laboratory in a hospital, health facility, or accredited school of nursing;

''(B) to purchase distance learning technologies;

''(C) to fund release time for qualified nurses enrolled in the graduate nursing program;

''(D) to provide for faculty salaries; and

''(E) to collect and analyze data on educational outcomes.

"SEC. 773. APPLICATIONS.

''Each partnership desiring to receive a grant, contract, or cooperative agreement under this part shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require. Each application shall include assurances that—

''(1) the individuals enrolled in the program will be qualified nurses in pursuit of a master's or doctoral degree in nursing and have a contractual obligation with the hospital or health facility that is in partnership with the institution of higher education;

''(2) the hospital or health facility of employment would be the clinical site for the accredited school of nursing program;

''(3) individuals will also maintain their employment on a part-time basis to the hospital or health facility that allowed them to participate in the program, and will receive an income from the hospital or health facility, as a part-time employee, and release times or flexible schedules to accommodate their class schedule; and

''(4) upon completion of the program, individuals agree to teach for 2 years in an accredited school of nursing for each year of support the individual received under this program.

''SEC. 774. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated for this part not more than $10,000,000 for fiscal year 2009 and such sums as may be necessary for each of the 4 succeeding fiscal years.

''SEC. 775. DEFINITION.

''For purposes of this part, the term 'health facility' means an Indian Health Service health service center, a Native Hawaiian health center, a hospital, a federally qualified health center, a rural health clinic, a nursing home, a home health agency, a hospice program, a public health clinic, a State or local department of public health, a skilled nursing facility, or ambulatory surgical center.''.

SEC. 503. NURSE FACULTY LOAN REPAYMENT PROGRAM.

Part E of title VIII of the Public Health Service Act (42 U.S.C. 297a et seq.) is amended by inserting after section 846C, as added by section 501, the following new section:

''SEC. 846D. NURSE FACULTY LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under subsection (a) shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing for a total period, in the aggregate, of at least four years during the six-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under subsection (a).

''(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (a) shall be entered into on such terms and conditions as the Secretary may determine, except that—

''(1) not more than ten months after the date on which the six-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing, the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

''(2) for an individual who has completed a master's degree in nursing—

''(A) payments may not exceed $10,000 per calendar year; and

''(B) total payments may not exceed $40,000; and

''(3) for an individual who has completed a doctorate degree in nursing—

''(A) payments may not exceed $20,000 per calendar year; and

''(B) total payments may not exceed $80,000.

''(d) BREACH OF AGREEMENT.—

''(1) IN GENERAL.—In the case of any agreement made under subsection (a), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under subsection (b).

''(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability

under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

''(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

''(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

''(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

''(1) is a United States citizen, national, or lawful permanent resident;

''(2) holds an unencumbered license as a registered nurse; and

''(3) has either already completed a master's or doctorate nursing program at an accredited school of

nursing or is currently enrolled on a full-time or part-time basis in such a program.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary for each of fiscal years 2010 through 2014 to carry out this Act. Such sums shall remain available until expended.''.

SEC. 504. PROGRAMS TO INCREASE THE NUMBER OF NURSES WITHIN THE ARMED FORCES.

(a) IN GENERAL.—The Secretary of Defense may provide for the carrying out of each of the programs described in subsections (b) through (f).

(b) SERVICE OF NURSE OFFICERS AS FACULTY IN EXCHANGE FOR COMMITMENT TO ADDITIONAL SERVICE IN THE ARMED FORCES.—

(1) IN GENERAL.—One of the programs under this section may be a program in which covered commissioned officers with a graduate degree in nursing or a related field who are in the nurse corps of the Armed Force concerned serve a tour of duty of two years as a full-time faculty member of an accredited school of nursing.

(2) COVERED OFFICERS.—A commissioned officer of the nurse corps of the Armed Forces described in this paragraph is a nurse officer on active

duty who has served for more than nine years on active duty in the Armed Forces as an officer of the nurse corps at the time of the commencement of the tour of duty described in paragraph (1).

(3) BENEFITS AND PRIVILEGES.—An officer serving on the faculty of an accredited school or nursing under this subsection shall be accorded all the benefits, privileges, and responsibilities (other than compensation and compensation-related benefits) of any other comparably situated individual serving a full-time faculty member of such school.

(4) AGREEMENT FOR ADDITIONAL SERVICE.—Each officer who serves a tour of duty on the faculty of a school of nursing under this subsection shall enter into an agreement with the Secretary to serve upon the completion of such tour of duty for a period of four years for such tour of duty as a member of the nurse corps of the Armed Force concerned. Any service agreed to by an officer under this paragraph is in addition to any other service required of the officer under law.

(c) SERVICE OF NURSE OFFICERS AS FACULTY IN EXCHANGE FOR SCHOLARSHIPS FOR NURSE OFFICER CANDIDATES.—

(1) IN GENERAL.—One of the programs under this section may be a program in which commissioned officers with a graduate degree in nursing or a related field who are in the nurse corps of the Armed Force concerned serve while on active duty a tour of duty of two years as a full-time faculty member of an accredited school of nursing.

(2) BENEFITS AND PRIVILEGES.—An officer serving on the faculty of an accredited school of nursing under this subsection shall be accorded all the benefits, privileges, and responsibilities (other than compensation and compensation-related benefits) of any other comparably situated individual serving as a full-time faculty member of such school.

(3) SCHOLARSHIPS FOR NURSE OFFICER CANDIDATES.—(A) Each accredited school of nursing at which an officer serves on the faculty under this subsection shall provide scholarships to individuals undertaking an educational program at such school leading to a degree in nursing who agree, upon completion of such program, to accept a commission as an officer in the nurse corps of the Armed Forces.

(B) The total amount of funds made available for scholarships by an accredited school of nursing under subparagraph (A) for each officer serving on

the faculty of that school under this subsection shall be not less than the amount equal to an entry-level full-time faculty member of that school for each year that such officer so serves on the faculty of that school.

(C) The total number of scholarships provided by an accredited school of nursing under subparagraph (A) for each officer serving on the faculty of that school under this subsection shall be such number as the Secretary of Defense shall specify for purposes of this subsection.

(d) SCHOLARSHIPS FOR CERTAIN NURSE OFFICERS FOR EDUCATION AS NURSES.—

(1) IN GENERAL.—One of the programs under this section may be a program in which the Secretary provides scholarships to commissioned officers of the nurse corps of the Armed Force concerned described in paragraph (2) who enter into an agreement described in paragraph (4) for the participation of such officers in an educational program of an accredited school of nursing leading to a graduate degree in nursing.

(2) COVERED NURSE OFFICERS.—A commissioned officer of the nurse corps of the Armed Forces described in this paragraph is a nurse officer

who has served not less than 20 years on active duty in the Armed Forces and is otherwise eligible for retirement from the Armed Forces.

(3) SCOPE OF SCHOLARSHIPS.—Amounts in a scholarship provided a nurse officer under this subsection may be utilized by the officer to pay the costs of tuition, fees, and other educational expenses of the officer in participating in an educational program described in paragraph (1).

(4) AGREEMENT.—An agreement of a nurse officer described in this paragraph is the agreement of the officer—

(A) to participate in an educational program described in paragraph (1); and

(B) upon graduation from such educational program—

(i) to serve not less than two years as a full-time faculty member of an accredited school of nursing; and

(ii) to undertake such activities as the Secretary considers appropriate to encourage current and prospective nurses to pursue service in the nurse corps of the Armed Forces.

(e) TRANSITION ASSISTANCE FOR RETIRING NURSE OFFICERS QUALIFIED AS FACULTY.—

(1) IN GENERAL.—One of the programs under this section may be a program in which the Secretary provides to commissioned officers of the nurse corps of the Armed Force concerned described in paragraph (2) the assistance described in paragraph (3) to assist such officers in obtaining and fulfilling positions as full-time faculty members of an accredited school of nursing after retirement from the Armed Forces.

(2) COVERED NURSE OFFICERS.—A commissioned officer of the nurse corps of the Armed Forces described in this paragraph is a nurse officer who—

(A) has served an aggregate of at least 20 years on active duty or in reserve active status in the Armed Forces;

(B) is eligible for retirement from the Armed Forces; and

(C) possesses a doctoral or master degree in nursing or a related field which qualifies the nurse officer to discharge the position of nurse instructor at an accredited school of nursing.

(3) ASSISTANCE.—The assistance described in this paragraph is assistance as follows:

(A) Career placement assistance.

(B) Continuing education.

(C) Stipends (in an amount specified by the Secretary).

(4) AGREEMENT.—A nurse officer provided assistance under this subsection shall enter into an agreement with the Secretary to serve as a full-time faculty member of an accredited school of nursing for such period as the Secretary shall provide in the agreement.

(f) BENEFITS FOR RETIRED NURSE OFFICERS ACCEPTING APPOINTMENT AS FACULTY.—

(1) IN GENERAL.—One of the programs under this section may be a program in which the Secretary provides to any individual described in paragraph (2) the benefits specified in paragraph (3).

(2) COVERED INDIVIDUALS.—An individual described in this paragraph is an individual who—

(A) is retired from the Armed Forces after service as a commissioned officer in the nurse corps of the Armed Forces;

(B) holds a graduate degree in nursing; and

(C) serves as a full-time faculty member of an accredited school of nursing.

(3) BENEFITS.—The benefits specified in this paragraph shall include the following:

(A) Payment of retired or retirement pay without reduction based on receipt of pay or other compensation from the institution of higher education concerned.

(B) Payment by the institution of higher education concerned of a salary and other compensation to which other similarly situated faculty members of the institution of higher education would be entitled.

(C) If the amount of pay and other compensation payable by the institution of higher education concerned for service as an associate full-time faculty member is less than the basic pay to which the individual was entitled immediately before retirement from the Armed Forces, payment of an amount equal to the difference between such basic pay and such payment and other compensation.

(g) ADMINISTRATION AND DURATION OF PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish requirements and procedures for the administration of the programs authorized by this section. Such requirements and procedures shall include procedures for selecting participating schools of nursing.

(2) DURATION.—Any program carried out under this section shall continue for not less than two years.

(3) ASSESSMENT.—Not later than two years after commencing any program under this section, the Secretary shall assess the results of such program and determine whether or not to continue such program. The assessment of any program shall be based on measurable criteria, information concerning results, and such other matters as the Secretary considers appropriate.

(4) CONTINUATION.—The Secretary may continue carrying out any program under this section that the Secretary determines, pursuant to an assessment under paragraph (3), to continue to carry out. In continuing to carry out a program, the Secretary may modify the terms of the program within the scope of this section. The continuation of any program may include its expansion to include additional participating schools of nursing.

(h) DEFINITIONS.—In this section, the terms ''school of nursing'' and ''accredited'' have the meaning given those terms in section 801 of the Public Health Service Act (42 U.S.C. 296).

TITLE VI—RESERVE COMPONENTS OF THE ARMED FORCES

SEC. 601. EFFECTIVE DATE OF ACTIVE DUTY FOR PURPOSES OF ENTITLEMENT TO ACTIVE DUTY HEALTH CARE OF MEMBERS OF THE RESERVE COMPONENTS OF THE ARMED FORCES RECEIVING ALERT ORDER ANTICIPATING A CALL OR ORDER TO ACTIVE DUTY IN SUPPORT OF A CONTINGENCY OPERATION.

Subsection (d) of section 1074 of title 10, United States Code, is amended to read as follows:

''(d)(1) For purposes of this chapter, a member of a reserve component of the Armed Forces shall be treated as a member of the Armed Forces on active duty as follows:

''(A) On the date of the issuance of the alert order for the member's unit in anticipation of the mobilization of the unit for service for a period of

more than 30 days in support of a contingency operation.

''(B) On the date of the issuance of the order providing for the assignment or attachment of the member to a unit subject to an alert order described in paragraph (1).

''(2) If the alert order for a member's unit (or the unit to which the member is assigned or attached) is rescinded, the member shall cease to be treated on active duty for purposes of this chapter as of the date of the issuance of the order rescinding such alert order.''.

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