107TH CONGRESS
1ST SESSION

S. 24

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 22, 2001

Mr. LOTT (for Mr. SPECTER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, 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 Care Assurance Act of 2001''.

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

TITLE I—EXPANDED MEDICAID COVERAGE FOR LOW-INCOME INDIVIDUALS

SEC. 101. EXPANDED MEDICAID COVERAGE FOR LOW-INCOME INDIVIDUALS.

(a) REQUIRED COVERAGE OF INDIVIDUALS UP TO 133 PERCENT OF POVERTY.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(1) by striking ''or'' at the end of subclause (VI);

(2) by inserting ''or'' after the semicolon at the end of subclause (VII); and

(3) by adding at the end the following:

"(VIII) whose family income does not exceed 133 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;".

(b) OPTIONAL COVERAGE OF INDIVIDUALS UP TO 200 PERCENT OF POVERTY.—Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, as added by subsection (a)(3), is amended by inserting "(200 percent, at State option)" after "133 percent".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section take effect on October 1, 2001.

(2) EXTENSION IF STATE LAW AMENDMENT REQUIRED.—In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be re-

garded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

TITLE II—EXPANSION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 201. INCREASE IN INCOME ELIGIBILITY.

(a) DEFINITION OF LOW-INCOME CHILD.—Section 2110(c)(4) of the Social Security Act (42 U.S.C. 42 U.S.C. 1397jj(c)(4)) is amended by striking ''200'' and inserting ''235''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2001.

TITLE III—EXPANDED HEALTH SERVICES FOR DISABLED INDIVIDUALS

SEC. 301. COVERAGE OF COMMUNITY ATTENDANT SERVICES AND SUPPORTS UNDER THE MEDICAID PROGRAM.

(a) REQUIRED COVERAGE FOR INDIVIDUALS ENTITLED TO NURSING FACILITY SERVICES OR ELIGIBLE FOR INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED.—Section 1902(a)(10)(D) of the Social Security Act (42 U.S.C. 1396a(a)(10)(D)) is amended—

(1) by inserting ''(i)'' after ''(D)'';

(2) by adding ''and'' after the semicolon; and

(3) by adding at the end the following:

''(ii) subject to section 1935, for the inclusion of community attendant services and supports for any individual who is eligible for medical assistance under the State plan and with respect to whom there has been a determination that the individual requires the level of care provided in a nursing facility or an intermediate care facility for the mentally retarded (whether or not coverage of such intermediate care facility is provided under the State plan) and who requires such community attendant services and

supports based on functional need and without regard to age or disability;''.

(b) MEDICAID COVERAGE OF COMMUNITY ATTENDANT SERVICES AND SUPPORTS.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following:

''COMMUNITY ATTENDANT SERVICES AND SUPPORTS

''SEC. 1935. (a) DEFINITIONS.—In this title:

''(1) COMMUNITY ATTENDANT SERVICES AND SUPPORTS.—

''(A) IN GENERAL.—The term 'community attendant services and supports' means attendant services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related functions through hands-on assistance, supervision, or cueing—

''(i) under a plan of services and supports that is based on an assessment of functional need and that is agreed to by

the individual or, as appropriate, the individual's representative;

''(ii) in a home or community setting, which may include a school, workplace, or recreation or religious facility, but does not include a nursing facility, an intermediate care facility for the mentally retarded, or other congregate facility;

''(iii) under an agency-provider model or other model (as defined in paragraph (2)(C)); and

''(iv) the furnishing of which is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative.

''(B) INCLUDED SERVICES AND SUPPORTS.—Such term includes—

''(i) tasks necessary to assist an individual in accomplishing activities of daily living, instrumental activities of daily living, and health-related functions;

''(ii) acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily liv-

ing, instrumental activities of daily living, and health-related functions;

"(iii) backup systems or mechanisms (such as the use of beepers) to ensure continuity of services and supports; and

"(iv) voluntary training on how to select, manage, and dismiss attendants.

"(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), such term does not include—

"(i) provision of room and board for the individual;

"(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

"(iii) assistive technology devices and assistive technology services;

"(iv) durable medical equipment; or

"(v) home modifications.

"(D) FLEXIBILITY IN TRANSITION TO COMMUNITY-BASED HOME SETTING.—Such term may include expenditures for transitional costs, such as rent and utility deposits, first

months's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides.

''(2) ADDITIONAL DEFINITIONS.—

''(A) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' includes eating, toileting, grooming, dressing, bathing, and transferring.

''(B) CONSUMER DIRECTED.—The term 'consumer directed' means a method of providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the community attendant services and supports, regardless of who acts as the employer of record.

''(C) DELIVERY MODELS.—

''(i) AGENCY-PROVIDER MODEL.—The term 'agency-provider model' means, with respect to the provision of community attendant services and supports for an individual, a method of providing consumer-directed services and supports under which

entities contract for the provision of such services and supports.

''(ii) OTHER MODELS.—The term 'other models' means methods, other than an agency-provider model, for the provision of consumer-directed services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

''(D) HEALTH-RELATED FUNCTIONS.—The term 'health-related functions' means functions that can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

''(E) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' includes meal planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores, communicating by phone and other media, and getting around and participating in the community.

''(F) INDIVIDUAL'S REPRESENTATIVE.—The term 'individual's representative' means a

parent, a family member, a guardian, an advocate, or an authorized representative of an individual.

"(b) LIMITATION ON AMOUNTS OF EXPENDITURES UNDER THIS TITLE.—In carrying out section 1902(a)(10)(D)(ii), a State shall permit an individual who has a level of severity of physical or mental impairment that entitles such individual to medical assistance with respect to nursing facility services or qualifies the individual for intermediate care facility services for the mentally retarded to choose to receive medical assistance for community attendant services and supports (rather than medical assistance for such institutional services and supports), in the most integrated setting appropriate to the needs of the individual, so long as the aggregate amount of the Federal expenditures for community attendant services and supports for all such individuals in a fiscal year does not exceed the total that would have been expended for such individuals to receive such institutional services and supports in the year.

"(c) MAINTENANCE OF EFFORT.—With respect to a fiscal year quarter, no Federal funds may be paid to a State for medical assistance provided to individuals described in section 1902(a)(10)(D)(ii) for such fiscal year quarter if the Secretary determines that the total of the

State expenditures for programs to enable such individuals with disabilities to receive community attendant services and supports (or services and supports that are similar to such services and supports) under other provisions of this title for the preceding fiscal year quarter is less than the total of such expenditures for the same fiscal year quarter for the preceding fiscal year.

''(d) STATE QUALITY ASSURANCE PROGRAM.—In order to continue to receive Federal financial participation for providing community attendant services and supports under this section, a State shall, at a minimum, establish and maintain a quality assurance program that provides for the following:

''(1) The State shall establish requirements, as appropriate, for agency-based and other models that include—

''(A) minimum qualifications and training requirements, as appropriate for agency-based and other models;

''(B) financial operating standards; and

''(C) an appeals procedure for eligibility denials and a procedure for resolving disagreements over the terms of an individualized plan.

''(2) The State shall modify the quality assurance program, where appropriate, to maximize con-

sumer independence and consumer direction in both agency-provided and other models.

''(3) The State shall provide a system that allows for the external monitoring of the quality of services by entities consisting of consumers and their representatives, disability organizations, providers, family, members of the community, and others.

''(4) The State provides ongoing monitoring of the health and well-being of each recipient.

''(5) The State shall require that quality assurance mechanisms appropriate for the individual should be included in the individual's written plan.

''(6) The State shall establish a process for mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation.

''(7) The State shall obtain meaningful consumer input, including consumer surveys, that measure the extent to which a participant receives the services and supports described in the individual's plan and the participant's satisfaction with such services and supports.

''(8) The State shall make available to the public the findings of the quality assurance program.

''(9) The State shall establish an on-going public process for the development, implementation, and review of the State's quality assurance program.

''(10) The State shall develop and implement a program of sanctions.

''(e) FEDERAL ROLE IN QUALITY ASSURANCE.—The Secretary shall conduct a periodic sample review of outcomes for individuals based upon the individual's plan of support and based upon the quality assurance program of the State. The Secretary may conduct targeted reviews upon receipt of allegations of neglect, abuse, or exploitation. The Secretary shall develop guidelines for States to use in developing sanctions.

''(f) REQUIREMENT TO EXPAND ELIGIBILITY.—Effective October 1, 2002, a State may not exercise the option of coverage of individuals under section 1902(a)(10)(A)(ii)(V) without providing coverage under section 1902(a)(10)(A)(ii)(VI).

''(g) REPORT ON IMPACT OF SECTION.—The Secretary shall submit to Congress periodic reports on the impact of this section on beneficiaries, States, and the Federal Government.''.

(c) INCLUSION IN OPTIONAL ELIGIBILITY CLASSIFICATION.—Section 1902(a)(10)(A)(ii)(VI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is

amended by inserting ''or community attendant services and supports described in section 1935'' after ''section 1915'' each place such term appears.

(d) COVERAGE AS MEDICAL ASSISTANCE.—

(1) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) by striking ''and'' at the end of paragraph (26);

(B) by redesignating paragraph (27) as paragraph (28); and

(C) by inserting after paragraph (26) the following:

''(27) community attendant services and supports (to the extent allowed and as defined in section 1935); and''.

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by inserting ''and (27)'' after ''(24)''.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2001, and apply to medical assistance provided under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after that date.

SEC. 302. GRANTS TO DEVELOP AND ESTABLISH REAL CHOICE SYSTEMS CHANGE INITIATIVES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants described in subsection (b) to States for a fiscal year to support real choice systems change initiatives that establish specific action steps and specific timetables to provide consumer-responsive long term services and supports to eligible individuals in the most integrated setting appropriate based on the unique strengths and needs of the individual and the priorities and concerns of the individual (or, as appropriate, the individual's representative).

(2) ELIGIBILITY.—To be eligible for a grant under this section, a State shall—

(A) establish the Consumer Task Force in accordance with subsection (d); and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may determine. The application shall be jointly developed and signed by the designated State official and the chairperson of such Task Force, acting on behalf of and at the direction of the Task Force.

(3) DEFINITION OF STATE.—In this section, the term ''State'' means each of the 50 States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(b) GRANTS FOR REAL CHOICE SYSTEMS CHANGE INITIATIVES.—

(1) IN GENERAL.—From funds appropriated under subsection (g), the Secretary shall award grants to States for a fiscal year to—

(A) support the establishment, implementation, and operation of the State real choice systems change initiatives described in subsection (a); and

(B) conduct outreach campaigns regarding the existence of such initiatives.

(2) DETERMINATION OF AWARDS; STATE ALLOTMENTS.—The Secretary shall develop a formula for the distribution of funds to States for each fiscal year under subsection (a). Such formula shall give preference to States that have a relatively higher proportion of long-term services and supports furnished to individuals in an institutional setting but

who have a plan described in an application submitted under subsection (a)(2).

(c) AUTHORIZED ACTIVITIES.—A State that receives a grant under this section shall use the funds made available through the grant to accomplish the purposes described in subsection (a) and, in accomplishing such purposes, may carry out any of the following systems change activities:

(1) NEEDS ASSESSMENT AND DATA GATHERING.—The State may use funds to conduct a statewide needs assessment that may be based on data in existence on the date on which the assessment is initiated and may include information about the number of individuals within the State who are receiving long-term services and supports in unnecessarily segregated settings, the nature and extent to which current programs respond to the preferences of individuals with disabilities to receive services in home and community-based settings as well as in institutional settings, and the expected change in demand for services provided in home and community settings as well as institutional settings.

(2) INSTITUTIONAL BIAS.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that

unnecessarily bias the provision of long-term services and supports toward institutional settings and away from home and community-based settings, including policies, practices, and procedures governing statewideness, comparability in amount, duration, and scope of services, financial eligibility, individualized functional assessments and screenings (including individual and family involvement), and knowledge about service options.

(3) OVER MEDICALIZATION OF SERVICES.—The State may use funds to identify, develop, and implement strategies for modifying policies, practices, and procedures that unnecessarily bias the provision of long-term services and supports by health care professionals to the extent that quality services and supports can be provided by other qualified individuals, including policies, practices, and procedures governing service authorization, case management, and service coordination, service delivery options, quality controls, and supervision and training.

(4) INTERAGENCY COORDINATION; SINGLE POINT OF ENTRY.—The State may support activities to identify and coordinate Federal and State policies, resources, and services, relating to the provision of long-term services and supports, including the

convening of interagency work groups and the entering into of interagency agreements that provide for a single point of entry and the design and implementation of a coordinated screening and assessment system for all persons eligible for long-term services and supports.

(5) TRAINING AND TECHNICAL ASSISTANCE.—The State may carry out directly, or may provide support to a public or private entity to carry out training and technical assistance activities that are provided for individuals with disabilities, and, as appropriate, their representatives, attendants, and other personnel (including professionals, paraprofessionals, volunteers, and other members of the community).

(6) PUBLIC AWARENESS.—The State may support a public awareness program that is designed to provide information relating to the availability of choices available to individuals with disabilities for receiving long-term services and support in the most integrated setting appropriate.

(7) DOWNSIZING OF LARGE INSTITUTIONS.—The State may use funds to support the per capita increased fixed costs in institutional settings directly related to the movement of individuals with disabil-

ities out of specific facilities and into community-based settings.

(8) TRANSITIONAL COSTS.—The State may use funds to provide transitional costs described in section 1935(a)(1)(D) of the Social Security Act, as added by section 301(b) of this Act.

(9) TASK FORCE.—The State may use funds to support the operation of the Consumer Task Force established under subsection (d).

(10) DEMONSTRATIONS OF NEW APPROACHES.—The State may use funds to conduct, on a time-limited basis, the demonstration of new approaches to accomplishing the purposes described in subsection (a).

(11) OTHER ACTIVITIES.—The State may use funds for any systems change activities that are not described in any of the preceding paragraphs of this subsection and that are necessary for developing, implementing, or evaluating the comprehensive statewide system of long term services and supports.

(d) CONSUMER TASK FORCE.—

(1) ESTABLISHMENT AND DUTIES.—To be eligible to receive a grant under this section, each State shall establish a Consumer Task Force (referred to in this section as the ''Task Force'') to as-

sist the State in the development, implementation, and evaluation of real choice systems change initiatives.

(2) APPOINTMENT.—Members of the Task Force shall be appointed by the Chief Executive Officer of the State in accordance with the requirements of paragraph (3), after the solicitation of recommendations from representatives of organizations representing a broad range of individuals with disabilities and organizations interested in individuals with disabilities.

(3) COMPOSITION.—

(A) IN GENERAL.—The Task Force shall represent a broad range of individuals with disabilities from diverse backgrounds and shall include representatives from Developmental Disabilities Councils, State Independent Living Councils, Commissions on Aging, organizations that provide services to individuals with disabilities and consumers of long-term services and supports.

(B) INDIVIDUALS WITH DISABILITIES.—A majority of the members of the Task Force shall be individuals with disabilities or the representatives of such individuals.

(C) LIMITATION.—The Task Force shall not include employees of any State agency providing services to individuals with disabilities other than employees of agencies described in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.).

(e) AVAILABILITY OF FUNDS.—

(1) FUNDS ALLOTTED TO STATES.—Funds allotted to a State under a grant made under this section for a fiscal year shall remain available until expended.

(2) FUNDS NOT ALLOTTED TO STATES.—Funds not allotted to States in the fiscal year for which they are appropriated shall remain available in succeeding fiscal years for allotment by the Secretary using the allotment formula established by the Secretary under subsection (b)(2).

(f) ANNUAL REPORT.—A State that receives a grant under this section shall submit an annual report to the Secretary on the use of funds provided under the grant. Each report shall include the percentage increase in the number of eligible individuals in the State who receive long-term services and supports in the most integrated setting appropriate, including through community attend-

ant services and supports and other community-based settings.

(g) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is authorized to be appropriated and there is appropriated to make grants under this section for—

(1) fiscal year 2002, $25,000,000; and

(2) for fiscal year 2003 and each fiscal year thereafter, such sums as may be necessary to carry out this section.

SEC. 303. STATE OPTION FOR ELIGIBILITY FOR INDIVIDUALS.

(a) IN GENERAL.—Section 1903(f) of the Social Security Act (42 U.S.C. 1396b(f)) is amended—

(1) in paragraph (4)(C), by inserting ''subject to paragraph (5),'' after ''does not exceed'', and

(2) by adding at the end the following:

''(5)(A) A State may waive the income, resources, and deeming limitations described in paragraph (4)(C) in such cases as the State finds the potential for employment opportunities would be enhanced through the provision of medical assistance for community attendant services and supports in accordance with section 1935.

''(B) In the case of an individual who is eligible for medical assistance described in subparagraph (A) only as

a result of the application of such subparagraph, the State may, notwithstanding section 1916(b), impose a premium based on a sliding scale related to income.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance provided for community attendant services and supports described in section 1935 of the Social Security Act, as added by section 301(b) of this Act, furnished on or after October 1, 2001.

SEC. 304. STUDIES AND REPORTS.

(a) REVIEW OF, AND REPORT ON, REGULATIONS.—The National Council on Disability established under title IV of the Rehabilitation Act of 1973 (29 U.S.C. 780 et seq.) shall review regulations in existence under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on the date of enactment of this Act insofar as such regulations regulate the provision of home health services, personal care services, and other services in home and community-based settings and, not later than 1 year after such date, submit a report to Congress on the results of such study, together with any recommendations for legislation that the Council determines to be appropriate as a result of the study.

(b) REPORT ON REDUCED TITLE XIX EXPENDITURES.—Not later than 1 year after the date of enact-

ment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on how expenditures under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) can be reduced by the furnishing of community attendant services and supports in accordance with section 1935 of the Social Security Act (as added by section 301(b) of this Act).

SEC. 305. TASK FORCE ON FINANCING OF LONG-TERM CARE SERVICES.

The Secretary of Health and Human Services shall establish a task force to examine appropriate methods for financing long-term services and supports. The task force shall include significant representation of individuals (and representatives of individuals) who receive such services and supports.

TITLE IV—HEALTH CARE INSURANCE COVERAGE

Subtitle A—General Provisions

SEC. 401. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B, the following:

''SUBPART C—GENERAL INSURANCE COVERAGE REFORMS

"CHAPTER 1—INCREASED AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

"SEC. 721. DEFINITION.

''As used in this subpart, the term 'qualified group health plan' means a group health plan, and a health insurance issuer offering group health insurance coverage, that is designed to provide standard coverage (consistent with section 721A(b)).

"SEC. 721A. ACTUARIAL EQUIVALENCE IN BENEFITS PERMITTED.

''(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

''(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this subpart, a set of rules which the NAIC determines is sufficient for determining, in the case of any group health plan, or a health insurance issuer offering group health insurance coverage, and for purposes of this section, the actuarial value of the coverage offered by the plan or coverage.

''(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules

that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this subpart. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

''(b) STANDARD COVERAGE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall be considered to provide standard coverage consistent with this subsection if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (a), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (2).

''(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

''(A) INITIAL DETERMINATION.—

''(i) IN GENERAL.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this subpart, a target actuarial value for standard coverage equal to the average ac-

tuarial value of the coverage described in clause (ii). No specific procedure or treatment, or classes thereof, is required to be considered in such determination by this subpart or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors.

''(ii) COVERAGE DESCRIBED.—The coverage described in this clause is coverage for medically necessary and appropriate services consisting of medical and surgical services, medical equipment, preventive services, and emergency transportation in frontier areas. No specific procedure or treatment, or classes thereof, is required to be covered in such a plan, by this subpart or through regulations.

''(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for standard coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such value for

use under this chapter. If the Secretary determines that a target actuarial value has not been submitted or does not comply with the requirements of subparagraph (A), the Secretary shall promptly determine a target actuarial value that meets such requirements.

''(c) SUBSEQUENT REVISIONS.—

''(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence and target actuarial values previously established or determined under this section if the NAIC determines that revisions are necessary to take into account changes in the relevant types of health benefits provisions or in demographic conditions which form the basis for the set of rules of actuarial equivalence or the target actuarial values. The provisions of subsection (a)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

''(2) SECRETARY.—The Secretary may by regulation revise the set of rules of actuarial equivalence and target actuarial values from time to time if the Secretary determines such revisions are necessary to take into account changes described in paragraph (1).

"SEC. 721B. ESTABLISHMENT OF PLAN STANDARDS.

''(a) ESTABLISHMENT OF GENERAL STANDARDS.—

''(1) ROLE OF NAIC.—The NAIC is requested to submit to the Secretary, within 9 months after the date of the enactment of this subpart, model regulations that specify standards for making qualified group health plans available to small employers. If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary. Such standards shall be nonbinding (except as provided in chapter 4).

''(2) CONTINGENCY.—If the NAIC does not develop such model regulations within the period described in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this subpart, model regulations that specify standards for insurers with regard to making qualified group health plans available to small employers. Such standards shall be nonbinding (except as provided in chapter 4).

''(3) EFFECTIVE DATE.—The standards specified in the model regulations shall apply to group health plans and health insurance issuers offering group health insurance coverage in a State on or after the respective date the standards are implemented in the State.

''(b) NO PREEMPTION OF STATE LAW.—A State may implement standards for group health plans available, and health insurance issuers offering group health insurance coverage offered, to small employers that are more stringent than the standards under this section, except that a State may not implement standards that prevent the offering of at least one group health plan that provides standard coverage (as described in section 721A(b)).

''SEC. 721C. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

''(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—Each group health plan offered, and each health insurance issuer offering group health insurance coverage, to a small employer shall establish within each community rating area in which the plan is to be offered, a standard premium for enrollment of eligible employees and eli-

gible individuals for the standard coverage (as defined under section 721A(b)).

''(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

''(A) IN GENERAL.—Not later than January 1, 2002, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

''(B) GEOGRAPHIC AREA VARIATIONS.—For purposes of subparagraph (A), a State—

''(i) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area;

''(ii) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered; and

''(iii) may, upon agreement with one or more adjacent States, identify multi-State geographic areas consistent with clauses (i) and (ii).

"(3) ELIGIBLE INDIVIDUALS.—For purposes of this section, the term 'eligible individuals' includes certain uninsured individuals (as described in section 721G).

"(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each group health plan to which this section applies shall be the same, but shall not include the costs of premium processing and enrollment that may vary depending on whether the method of enrollment is through a qualified small employer purchasing group, through a small employer, or through a broker.

"(2) APPLICATION TO ENROLLEES.—

"(A) IN GENERAL.—The premium charged for coverage in a group health plan which covers eligible employees and eligible individuals shall be the product of—

"(i) the standard premium (established under paragraph (1));

"(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

''(iii) the age adjustment factor (specified under subparagraph (C)).

''(B) FAMILY ADJUSTMENT FACTOR.—

''(i) IN GENERAL.—The standards established under section 721B shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

''(ii) CLASSES OF ENROLLMENT.—For purposes of this subpart, there are 4 classes of enrollment:

''(I) Coverage only of an individual (referred to in this subpart as the 'individual' enrollment or class of enrollment).

''(II) Coverage of a married couple without children (referred to in this subpart as the 'couple-only' enrollment or class of enrollment).

''(III) Coverage of an individual and one or more children (referred to in this subpart as the 'single parent' enrollment or class of enrollment).

''(IV) Coverage of a married couple and one or more children (referred to in this subpart as the 'dual parent' enrollment or class of enrollment).

''(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this subpart:

''(I) FAMILY.—The terms 'family enrollment' and 'family class of enrollment' refer to enrollment in a class of enrollment described in any subclause of clause (ii) (other than subclause (I)).

''(II) COUPLE.—The term 'couple class of enrollment' refers to enrollment in a class of enrollment described in subclause (II) or (IV) of clause (ii).

''(iv) SPOUSE; MARRIED; COUPLE.—

''(I) IN GENERAL.—In this subpart, the terms 'spouse' and 'married' mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as

determined under applicable State law.

"(II) COUPLE.—The term 'couple' means an individual and the individual's spouse.

"(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.

"(3) ADMINISTRATIVE CHARGES.—

"(A) IN GENERAL.—In accordance with the standards established under section 721B, a group health plan which covers eligible employees and eligible individuals may add a separately-stated administrative charge which is based on identifiable differences in legitimate administrative costs and which is applied uniformly for individuals enrolling through the same method of enrollment. Nothing in this subparagraph may be construed as preventing a

qualified small employer purchasing group from negotiating a unique administrative charge with an insurer for a group health plan.

''(B) ENROLLMENT THROUGH A QUALIFIED SMALL EMPLOYER PURCHASING GROUP.—In the case of an administrative charge under subparagraph (A) for enrollment through a qualified small employer purchasing group, such charge may not exceed the lowest charge of such plan for enrollment other than through a qualified small employer purchasing group in such area.

''(c) TREATMENT OF NEGOTIATED RATE AS COMMUNITY RATE.—Notwithstanding any other provision of this section, a group health plan and a health insurance issuer offering health insurance coverage that negotiates a premium rate (exclusive of any administrative charge described in subsection (b)(3)) with a qualified small employer purchasing group in a community rating area shall charge the same premium rate to all eligible employees and eligible individuals.

''SEC. 721D. RATING PRACTICES AND PAYMENT OF PREMIUMS.

''(a) FULL DISCLOSURE OF RATING PRACTICES.—

''(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall fully disclose rating practices for the plan to the appropriate certifying authority.

''(2) NOTICE ON EXPIRATION.—A group health plan and a health insurance issuer offering health insurance coverage shall provide for notice of the terms for renewal of a plan at the time of the offering of the plan and at least 90 days before the date of expiration of the plan.

''(3) ACTUARIAL CERTIFICATION.—Each group health plan and health insurance issuer offering health insurance coverage shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) who is not an employee of the group health plan or issuer certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of such plan or insurer and methods used by the plan or insurer in establishing premium rates and administrative charges for group health plans—

''(A) such plan or insurer is in compliance with the applicable provisions of this subpart; and

''(B) the rating methods are actuarially sound.

Each plan and insurer shall retain a copy of such statement at its principal place of business for examination by any individual.

''(b) PAYMENT OF PREMIUMS.—

''(1) IN GENERAL.—With respect to a new enrollee in a group health plan, the plan may require advanced payment of an amount equal to the monthly applicable premium for the plan at the time such individual is enrolled.

''(2) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a group health plan or a health insurance issuer offering health insurance coverage fails to receive payment on a premium due with respect to an eligible employee or eligible individual covered under the plan involved, the plan or issuer shall provide notice of such failure to the employee or individual within the 20-day period after the date on which such premium payment was due. A plan or issuer may not terminate the enrollment of an eligible employee or eligible individual unless such em-

ployee or individual has been notified of any overdue premiums and has been provided a reasonable opportunity to respond to such notice.

"SEC. 721E. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

"(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUPS DESCRIBED.—

"(1) IN GENERAL.—A qualified small employer purchasing group is an entity that—

"(A) is a nonprofit entity certified under State law;

"(B) has a membership consisting solely of small employers;

"(C) is administered solely under the authority and control of its member employers;

"(D) with respect to each State in which its members are located, consists of not fewer than the number of small employers established by the State as appropriate for such a group;

"(E) offers a program under which qualified group health plans are offered to eligible employees and eligible individuals through its member employers and to certain uninsured individuals in accordance with section 721D; and

"(F) an insurer, agent, broker, or any other individual or entity engaged in the sale of insurance—

"(i) does not form or underwrite; and

"(ii) does not hold or control any right to vote with respect to.

"(2) STATE CERTIFICATION.—A qualified small employer purchasing group formed under this section shall submit an application to the State for certification. The State shall determine whether to issue a certification and otherwise ensure compliance with the requirements of this subpart.

"(3) SPECIAL RULE.—Notwithstanding paragraph (1)(B), an employer member of a small employer purchasing group that has been certified by the State as meeting the requirements of paragraph (1) may retain its membership in the group if the number of employees of the employer increases such that the employer is no longer a small employer.

"(b) BOARD OF DIRECTORS.—Each qualified small employer purchasing group established under this section shall be governed by a board of directors or have active input from an advisory board consisting of individuals and businesses participating in the group.

''(c) DOMICILIARY STATE.—For purposes of this section, a qualified small employer purchasing group operating in more than one State shall be certified by the State in which the group is domiciled.

''(d) MEMBERSHIP.—

''(1) IN GENERAL.—A qualified small employer purchasing group shall accept all small employers and certain uninsured individuals residing within the area served by the group as members if such employers or individuals request such membership.

''(2) VOTING.—Members of a qualified small employer purchasing group shall have voting rights consistent with the rules established by the State.

''(e) DUTIES OF QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.—Each qualified small employer purchasing group shall—

''(1) enter into agreements with insurers offering qualified group health plans;

''(2) enter into agreements with small employers under section 721F;

''(3) enroll only eligible employees, eligible individuals, and certain uninsured individuals in qualified group health plans, in accordance with section 721G;

''(4) provide enrollee information to the State;

''(5) meet the marketing requirements under section 721I; and

''(6) carry out other functions provided for under this subpart.

''(f) LIMITATION ON ACTIVITIES.—A qualified small employer purchasing group shall not—

''(1) perform any activity involving approval or enforcement of payment rates for providers;

''(2) perform any activity (other than the reporting of noncompliance) relating to compliance of qualified group health plans with the requirements of this subpart;

''(3) assume financial risk in relation to any such health plan; or

''(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this subpart.

''(g) RULES OF CONSTRUCTION.—

''(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

''(A) that a State organize, operate or otherwise establish a qualified small employer purchasing group, or otherwise require the establishment of purchasing groups; and

''(B) that there be only one qualified small employer purchasing group established with respect to a community rating area.

''(2) SINGLE ORGANIZATION SERVING MULTIPLE AREAS AND STATES.—Nothing in this section shall be construed as preventing a single entity from being a qualified small employer purchasing group in more than one community rating area or in more than one State.

''(3) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any individual or small employer to purchase a qualified group health plan exclusively through a qualified small employer purchasing group.

''SEC. 721F. AGREEMENTS WITH SMALL EMPLOYERS.

''(a) IN GENERAL.—A qualified small employer purchasing group shall offer to enter into an agreement under this section with each small employer that employs eligible employees in the area served by the group.

''(b) PAYROLL DEDUCTION.—

''(1) IN GENERAL.—Under an agreement under this section between a small employer and a qualified small employer purchasing group, the small employer shall deduct premiums from an eligible employee's wages.

''(2) ADDITIONAL PREMIUMS.—If the amount withheld under paragraph (1) is not sufficient to cover the entire cost of the premiums, the eligible employee shall be responsible for paying directly to the qualified small employer purchasing group the difference between the amount of such premiums and the amount withheld.

"SEC. 721G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE INDIVIDUALS, AND CERTAIN UNINSURED INDIVIDUALS IN QUALIFIED GROUP HEALTH PLANS.

''(a) IN GENERAL.—Each qualified small employer purchasing group shall offer—

''(1) eligible employees,

''(2) eligible individuals, and

''(3) certain uninsured individuals,

the opportunity to enroll in any qualified group health plan which has an agreement with the qualified small employer purchasing group for the community rating area in which such employees and individuals reside.

''(b) UNINSURED INDIVIDUALS.—For purposes of this section, an individual is described in subsection (a)(3) if such individual is an uninsured individual who is not an eligible employee of a small employer that is a member

of a qualified small employer purchasing group or a dependent of such individual.

"SEC. 721H. RECEIPT OF PREMIUMS.

"(a) ENROLLMENT CHARGE.—The amount charged by a qualified small employer purchasing group for coverage under a qualified group health plan shall be equal to the sum of—

"(1) the premium rate offered by such health plan;

"(2) the administrative charge for such health plan; and

"(3) the purchasing group administrative charge for enrollment of eligible employees, eligible individuals and certain uninsured individuals through the group.

"(b) DISCLOSURE OF PREMIUM RATES AND ADMINISTRATIVE CHARGES.—Each qualified small employer purchasing group shall, prior to the time of enrollment, disclose to enrollees and other interested parties the premium rate for a qualified group health plan, the administrative charge for such plan, and the administrative charge of the group, separately.

"SEC. 721I. MARKETING ACTIVITIES.

"Each qualified small employer purchasing group shall market qualified group health plans to members

through the entire community rating area served by the purchasing group.

"SEC. 721J. GRANTS TO STATES AND QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

"(a) IN GENERAL.—The Secretary shall award grants to States and small employer purchasing groups to assist such States and groups in planning, developing, and operating qualified small employer purchasing groups.

"(b) APPLICATION REQUIREMENTS.—To be eligible to receive a grant under this section, a State or small employer purchasing group shall prepare and submit to the Secretary an application in such form, at such time, and containing such information, certifications, and assurances as the Secretary shall reasonably require.

"(c) USE OF FUNDS.—Amounts awarded under this section may be used to finance the costs associated with planning, developing, and operating a qualified small employer purchasing group. Such costs may include the costs associated with—

"(1) engaging in education and outreach efforts to inform small employers, insurers, and the public about the small employer purchasing group;

"(2) soliciting bids and negotiating with insurers to make available group health plans;

''(3) preparing the documentation required to receive certification by the Secretary as a qualified small employer purchasing group; and

''(4) such other activities determined appropriate by the Secretary.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for awarding grants under this section such sums as may be necessary.

''SEC. 721K. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS ESTABLISHED BY A STATE.

''A State may establish a system in all or part of the State under which qualified small employer purchasing groups are the sole mechanism through which health care coverage for the eligible employees of small employers shall be purchased or provided.

''SEC. 721L. EFFECTIVE DATES.

''(a) IN GENERAL.—Except as provided in this chapter, the provisions of this chapter are effective on the date of the enactment of this subpart.

''(b) EXCEPTION.—The provisions of section 721C(b) shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this subpart.

"CHAPTER 2—REQUIRED COVERAGE OPTIONS FOR ELIGIBLE EMPLOYEES AND DEPENDENTS OF SMALL EMPLOYERS

"SEC. 722. REQUIRING SMALL EMPLOYERS TO OFFER COVERAGE FOR ELIGIBLE INDIVIDUALS.

''(a) REQUIREMENT TO OFFER.—Each small employer shall make available with respect to each eligible employee a group health plan under which—

''(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year;

''(2) coverage is provided for at least the standard coverage specified in section 721A(b); and

''(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

''(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An employer is not required under subsection (a) to make any contribution to the cost of coverage under a group health plan described in such subsection.

''(c) SPECIAL RULES.—

''(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN VERY SMALL EMPLOYERS.—Subsection (a) shall not apply to any small employer for any plan year if, as of the beginning of such plan year—

''(A) such employer (including any predecessor thereof) has been an employer for less than 2 years;

''(B) such employer has no more than 2 eligible employees; or

''(C) no more than 2 eligible employees are not covered under any group health plan.

''(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of a small employer may be, at the election of the employer, excluded from consideration as an eligible employee for purposes of applying the requirements of subsection (a). In the case of a small employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

''(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan and a health insurance issuer offering group health insurance coverage shall not be treated as failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is re-

quired under the plan for coverage under the plan of eligible individuals with respect to such employee.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as limiting the group health plans, or types of coverage under such a plan, that an employer may offer to an employee.

''SEC. 722A. COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

''(a) IN GENERAL.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 722(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (b) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

''(b) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a group health plan with respect to an eligible employee if—

''(1) the employee is eligible under the plan to elect coverage on an annual basis and is provided a reasonable opportunity to make the election in such

form and manner and at such times as are provided by the plan;

''(2) coverage is provided for at least the standard coverage specified in section 721A(b);

''(3) the employer facilitates collection of any employee contributions under the plan and permits the employee to elect to have employee contributions under the plan collected through payroll deduction; and

''(4) in the case of a plan to which part 1 does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) in the form and manner and at such times as are required under such part 1 with respect to employee welfare benefit plans.

''CHAPTER 3—REQUIRED COVERAGE OPTIONS FOR INDIVIDUALS INSURED THROUGH ASSOCIATION PLANS

''Subchapter A—Qualified Association Plans

''SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

''(a) GENERAL RULE.—For purposes of this chapter, in the case of a qualified association plan—

''(1) except as otherwise provided in this subchapter, the plan shall meet all applicable require-

ments of chapter 1 and chapter 2 for group health plans offered to and by small employers;

''(2) if such plan is certified as meeting such requirements and the requirements of this subchapter, such plan shall be treated as a plan established and maintained by a small employer, and individuals enrolled in such plan shall be treated as eligible employees; and

''(3) any individual who is a member of the association not enrolling in the plan shall not be treated as an eligible employee solely by reason of membership in such association.

''(b) ELECTION TO BE TREATED AS PURCHASING COOPERATIVE.—Subsection (a) shall not apply to a qualified association plan if—

''(1) the health insurance issuer makes an irrevocable election to be treated as a qualified small employer purchasing group for purposes of section 721D; and

''(2) such sponsor meets all requirements of this subpart applicable to a purchasing cooperative.

''SEC. 723A. QUALIFIED ASSOCIATION PLAN DEFINED.

''(a) GENERAL RULE.—For purposes of this chapter, a plan is a qualified association plan if the plan is a mul-

tiple employer welfare arrangement or similar arrangement—

''(1) which is maintained by a qualified association;

''(2) which has at least 500 participants in the United States;

''(3) under which the benefits provided consist solely of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986);

''(4) which may not condition participation in the plan, or terminate coverage under the plan, on the basis of the health status or health claims experience of any employee or member or dependent of either;

''(5) which provides for bonding, in accordance with regulations providing rules similar to the rules under section 412, of all persons operating or administering the plan or involved in the financial affairs of the plan; and

''(6) which notifies each participant or provider that it is certified as meeting the requirements of this chapter applicable to it.

''(b) SELF-INSURED PLANS.—In the case of a plan which is not fully insured (within the meaning of section

514(b)(6)(D)), the plan shall be treated as a qualified association plan only if—

''(1) the plan meets minimum financial solvency and cash reserve requirements for claims which are established by the Secretary and which shall be in lieu of any other such requirements under this chapter;

''(2) the plan provides an annual funding report (certified by an independent actuary) and annual financial statements to the Secretary and other interested parties; and

''(3) the plan appoints a plan sponsor who is responsible for operating the plan and ensuring compliance with applicable Federal and State laws.

''(c) CERTIFICATION.—

''(1) IN GENERAL.—A plan shall not be treated as a qualified association plan for any period unless there is in effect a certification by the Secretary that the plan meets the requirements of this subchapter. For purposes of this chapter, the Secretary shall be the appropriate certifying authority with respect to the plan.

''(2) FEE.—The Secretary shall require a $5,000 fee for the original certification under paragraph (1) and may charge a reasonable annual fee

to cover the costs of processing and reviewing the annual statements of the plan.

''(3) EXPEDITED PROCEDURES.—The Secretary may by regulation provide for expedited registration, certification, and comment procedures.

''(4) AGREEMENTS.—The Secretary of Labor may enter into agreements with the States to carry out the Secretary's responsibilities under this subchapter.

''(d) AVAILABILITY.—Notwithstanding any other provision of this chapter, a qualified association plan may limit coverage to individuals who are members of the qualified association establishing or maintaining the plan, an employee of such member, or a dependent of either.

''(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 2001—

''(1) the requirements of subsection (a) (other than paragraphs (4), (5), and (6) thereof) shall not apply;

''(2) no original certification shall be required under this subchapter; and

''(3) no annual report or funding statement shall be required before January 1, 2003, but the plan shall file with the Secretary a description of the plan and the name of the health insurance issuer.

"SEC. 723B. DEFINITIONS AND SPECIAL RULES.

''(a) QUALIFIED ASSOCIATION.—For purposes of this subchapter, the term 'qualified association' means any organization which—

''(1) is organized and maintained in good faith by a trade association, an industry association, a professional association, a chamber of commerce, a religious organization, a public entity association, or other business association serving a common or similar industry;

''(2) is organized and maintained for substantial purposes other than to provide a health plan;

''(3) has a constitution, bylaws, or other similar governing document which states its purpose; and

''(4) receives a substantial portion of its financial support from its active, affiliated, or federation members.

''(b) COORDINATION.—The term 'qualified association plan' shall not include a plan to which subchapter B applies.

"Subchapter B—Special Rule for Church, Multiemployer, and Cooperative Plans

"SEC. 723F. SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND COOPERATIVE PLANS.

''(a) GENERAL RULE.—For purposes of this chapter, in the case of a group health plan to which this section applies—

''(1) except as otherwise provided in this subchapter, the plan shall be required to meet all applicable requirements of chapter 1 and chapter 2 for group health plans offered to and by small employers;

''(2) if such plan is certified as meeting such requirements, such plan shall be treated as a plan established and maintained by a small employer and individuals enrolled in such plan shall be treated as eligible employees; and

''(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated as an eligible employee solely by reason of being eligible to enroll in the plan.

''(b) MODIFIED STANDARDS.—

''(1) CERTIFYING AUTHORITY.—For purposes of this chapter, the Secretary shall be the appropriate certifying authority with respect to a plan to which this section applies.

''(2) AVAILABILITY.—Rules similar to the rules of subsection (e) of section 723A shall apply to a plan to which this section applies.

''(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described in subsection (c)(2) shall not be required to make any other plan available to the employee.

''(4) TREATMENT UNDER STATE LAWS.—A church plan described in subsection (c)(1) which is certified as meeting the requirements of this section shall not be deemed to be a multiple employer welfare arrangement or an insurance company or other insurer, or to be engaged in the business of insurance, for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(c) PLANS TO WHICH SECTION APPLIES.—This section shall apply to a health plan which—

''(1) is a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) which has at least 100 participants in the United States;

''(2) is a multiemployer plan which is maintained by a health plan sponsor described in section 3(16)(B)(iii) and which has at least 500 participants in the United States; or

''(3) is a plan which is maintained by a rural electric cooperative or a rural telephone cooperative association and which has at least 500 participants in the United States.''.

(b) CONFORMING AMENDMENTS.—Section 731(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1186(d)) is amended by adding at the end the following:

''(3) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

''(4) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to an eligible employee, such employee, and any dependent of such employee.

''(5) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

''(6) QUALIFIED GROUP HEALTH PLAN.—The term 'qualified group health plan' shall have the meaning given the term in section 721.''.

SEC. 402. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended—

(1) by inserting after the subpart heading the following:

"CHAPTER 1—MISCELLANEOUS REQUIREMENTS";

and

(2) by adding at the end the following:

"CHAPTER 2—GENERAL INSURANCE COVERAGE REFORMS

"Subchapter A—Increased Availability and Continuity of Health Coverage

"SEC. 2707. DEFINITION.

''As used in this chapter, the term 'qualified group health plan' means a group health plan, and a health insurance issuer offering group health insurance coverage, that is designed to provide standard coverage (consistent with section 2707A(b)).

"SEC. 2707A. ACTUARIAL EQUIVALENCE IN BENEFITS PERMITTED.

''(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

''(1) INITIAL DETERMINATION.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this chap-

ter, a set of rules which the NAIC determines is sufficient for determining, in the case of any group health plan, or a health insurance issuer offering group health insurance coverage, and for purposes of this section, the actuarial value of the coverage offered by the plan or coverage.

''(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use under this chapter. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

''(b) STANDARD COVERAGE.—

''(1) IN GENERAL.—A a group health plan, and a health insurance issuer offering group health insurance coverage, shall be considered to provide standard coverage consistent with this subsection if the benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (a), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (2).

''(2) INITIAL DETERMINATION OF TARGET ACTUARIAL VALUE FOR STANDARD COVERAGE.—

''(A) INITIAL DETERMINATION.—

''(i) IN GENERAL.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this chapter, a target actuarial value for standard coverage equal to the average actuarial value of the coverage described in clause (ii). No specific procedure or treatment, or classes thereof, is required to be considered in such determination by this chapter or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors.

''(ii) COVERAGE DESCRIBED.—The coverage described in this clause is coverage for medically necessary and appropriate services consisting of medical and surgical services, medical equipment, preventive services, and emergency transportation in frontier areas. No specific proce-

dure or treatment, or classes thereof, is required to be covered in such a plan, by this chapter or through regulations.

''(B) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a target actuarial value for standard coverage that complies with the requirements of subparagraph (A), the Secretary shall certify such value for use under this chapter. If the Secretary determines that a target actuarial value has not been submitted or does not comply with the requirements of subparagraph (A), the Secretary shall promptly determine a target actuarial value that meets such requirements.

''(c) SUBSEQUENT REVISIONS.—

''(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence and target actuarial values previously established or determined under this section if the NAIC determines that revisions are necessary to take into account changes in the relevant types of health benefits provisions or in demographic conditions which form the basis for the set of rules of actuarial equivalence or the target actuarial values. The provisions of subsection (a)(2) shall apply

to such a revision in the same manner as they apply to the initial determination of the set of rules.

''(2) SECRETARY.—The Secretary may by regulation revise the set of rules of actuarial equivalence and target actuarial values from time to time if the Secretary determines such revisions are necessary to take into account changes described in paragraph (1).

''SEC. 2707B. ESTABLISHMENT OF PLAN STANDARDS.

''(a) ESTABLISHMENT OF GENERAL STANDARDS.—

''(1) ROLE OF NAIC.—The NAIC is requested to submit to the Secretary, within 9 months after the date of the enactment of this chapter, model regulations that specify standards for making qualified group health plans available to small employers. If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Such standards shall serve as the standards under this section, with such amendments as the Secretary deems necessary. Such standards shall be nonbinding (except as provided in chapter 4).

''(2) CONTINGENCY.—If the NAIC does not develop such model regulations within the period described in paragraph (1), the Secretary shall specify, within 15 months after the date of the enactment of this chapter, model regulations that specify standards for insurers with regard to making qualified group health plans available to small employers. Such standards shall be nonbinding (except as provided in chapter 4).

''(3) EFFECTIVE DATE.—The standards specified in the model regulations shall apply to group health plans and health insurance issuers offering group health insurance coverage in a State on or after the respective date the standards are implemented in the State.

''(b) NO PREEMPTION OF STATE LAW.—A State may implement standards for group health plans available, and health insurance issuers offering group health insurance coverage offered, to small employers that are more stringent than the standards under this section, except that a State may not implement standards that prevent the offering of at least one group health plan that provides standard coverage (as described in section 2707A(b)).

"SEC. 2707C. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

"(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE INDIVIDUALS.—

"(1) IN GENERAL.—Each group health plan offered, and each health insurance issuer offering group health insurance coverage, to a small employer shall establish within each community rating area in which the plan is to be offered, a standard premium for enrollment of eligible employees and eligible individuals for the standard coverage (as defined under section 2707A(b)).

"(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

"(A) IN GENERAL.—Not later than January 1, 2002, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

"(B) GEOGRAPHIC AREA VARIATIONS.—For purposes of subparagraph (A), a State—

''(i) may not identify an area that divides a 3-digit zip code, a county, or all portions of a metropolitan statistical area;

''(ii) shall not permit premium rates for coverage offered in a portion of an interstate metropolitan statistical area to vary based on the State in which the coverage is offered; and

''(iii) may, upon agreement with one or more adjacent States, identify multi-State geographic areas consistent with clauses (i) and (ii).

''(3) ELIGIBLE INDIVIDUALS.—For purposes of this section, the term 'eligible individuals' includes certain uninsured individuals (as described in section 2707G).

''(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the standard premium for each group health plan to which this section applies shall be the same, but shall not include the costs of premium processing and enrollment that may vary depending on whether the method of enrollment is through a

qualified small employer purchasing group, through a small employer, or through a broker.

''(2) APPLICATION TO ENROLLEES.—

''(A) IN GENERAL.—The premium charged for coverage in a group health plan which covers eligible employees and eligible individuals shall be the product of—

''(i) the standard premium (established under paragraph (1));

''(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

''(iii) the age adjustment factor (specified under subparagraph (C)).

''(B) FAMILY ADJUSTMENT FACTOR.—

''(i) IN GENERAL.—The standards established under section 2707B shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

''(ii) CLASSES OF ENROLLMENT.—For purposes of this chapter, there are 4 classes of enrollment:

''(I) Coverage only of an individual (referred to in this chapter as the 'individual' enrollment or class of enrollment).

''(II) Coverage of a married couple without children (referred to in this chapter as the 'couple-only' enrollment or class of enrollment).

''(III) Coverage of an individual and one or more children (referred to in this chapter as the 'single parent' enrollment or class of enrollment).

''(IV) Coverage of a married couple and one or more children (referred to in this chapter as the 'dual parent' enrollment or class of enrollment).

''(iii) REFERENCES TO FAMILY AND COUPLE CLASSES OF ENROLLMENT.—In this chapter:

''(I) FAMILY.—The terms 'family enrollment' and 'family class of enrollment' refer to enrollment in a class of

enrollment described in any subclause of clause (ii) (other than subclause (I)).

''(II) COUPLE.—The term 'couple class of enrollment' refers to enrollment in a class of enrollment described in subclause (II) or (IV) of clause (ii).

''(iv) SPOUSE; MARRIED; COUPLE.—

''(I) IN GENERAL.—In this chapter, the terms 'spouse' and 'married' mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as determined under applicable State law.

''(II) COUPLE.—The term 'couple' means an individual and the individual's spouse.

''(C) AGE ADJUSTMENT FACTOR.—The Secretary, in consultation with the NAIC, shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals

who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.

''(3) ADMINISTRATIVE CHARGES.—

''(A) IN GENERAL.—In accordance with the standards established under section 2707B, a group health plan which covers eligible employees and eligible individuals may add a separately-stated administrative charge which is based on identifiable differences in legitimate administrative costs and which is applied uniformly for individuals enrolling through the same method of enrollment. Nothing in this subparagraph may be construed as preventing a qualified small employer purchasing group from negotiating a unique administrative charge with an insurer for a group health plan.

''(B) ENROLLMENT THROUGH A QUALIFIED SMALL EMPLOYER PURCHASING GROUP.—In the case of an administrative charge under subparagraph (A) for enrollment through a qualified small employer purchasing group, such charge may not exceed the lowest charge of such plan for enrollment other than through a

qualified small employer purchasing group in such area.

''(c) TREATMENT OF NEGOTIATED RATE AS COMMUNITY RATE.—Notwithstanding any other provision of this section, a group health plan and a health insurance issuer offering health insurance coverage that negotiates a premium rate (exclusive of any administrative charge described in subsection (b)(3)) with a qualified small employer purchasing group in a community rating area shall charge the same premium rate to all eligible employees and eligible individuals.

''SEC. 2707D. RATING PRACTICES AND PAYMENT OF PREMIUMS.

''(a) FULL DISCLOSURE OF RATING PRACTICES.—

''(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall fully disclose rating practices for the plan to the appropriate certifying authority.

''(2) NOTICE ON EXPIRATION.—A group health plan and a health insurance issuer offering health insurance coverage shall provide for notice of the terms for renewal of a plan at the time of the offering of the plan and at least 90 days before the date of expiration of the plan.

''(3) ACTUARIAL CERTIFICATION.—Each group health plan and health insurance issuer offering health insurance coverage shall file annually with the appropriate certifying authority a written statement by a member of the American Academy of Actuaries (or other individual acceptable to such authority) who is not an employee of the group health plan or issuer certifying that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of such plan or insurer and methods used by the plan or insurer in establishing premium rates and administrative charges for group health plans—

''(A) such plan or insurer is in compliance with the applicable provisions of this chapter; and

''(B) the rating methods are actuarially sound.

Each plan and insurer shall retain a copy of such statement at its principal place of business for examination by any individual.

''(b) PAYMENT OF PREMIUMS.—

''(1) IN GENERAL.—With respect to a new enrollee in a group health plan, the plan may require advanced payment of an amount equal to the month-

ly applicable premium for the plan at the time such individual is enrolled.

''(2) NOTIFICATION OF FAILURE TO RECEIVE PREMIUM.—If a group health plan or a health insurance issuer offering health insurance coverage fails to receive payment on a premium due with respect to an eligible employee or eligible individual covered under the plan involved, the plan or issuer shall provide notice of such failure to the employee or individual within the 20-day period after the date on which such premium payment was due. A plan or issuer may not terminate the enrollment of an eligible employee or eligible individual unless such employee or individual has been notified of any overdue premiums and has been provided a reasonable opportunity to respond to such notice.

''SEC. 2707E. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

''(a) QUALIFIED SMALL EMPLOYER PURCHASING GROUPS DESCRIBED.—

''(1) IN GENERAL.—A qualified small employer purchasing group is an entity that—

''(A) is a nonprofit entity certified under State law;

"(B) has a membership consisting solely of small employers;

"(C) is administered solely under the authority and control of its member employers;

"(D) with respect to each State in which its members are located, consists of not fewer than the number of small employers established by the State as appropriate for such a group;

"(E) offers a program under which qualified group health plans are offered to eligible employees and eligible individuals through its member employers and to certain uninsured individuals in accordance with section 2707D; and

"(F) an insurer, agent, broker, or any other individual or entity engaged in the sale of insurance—

"(i) does not form or underwrite; and

"(ii) does not hold or control any right to vote with respect to.

"(2) STATE CERTIFICATION.—A qualified small employer purchasing group formed under this section shall submit an application to the State for certification. The State shall determine whether to

issue a certification and otherwise ensure compliance with the requirements of this chapter.

''(3) SPECIAL RULE.—Notwithstanding paragraph (1)(B), an employer member of a small employer purchasing group that has been certified by the State as meeting the requirements of paragraph (1) may retain its membership in the group if the number of employees of the employer increases such that the employer is no longer a small employer.

''(b) BOARD OF DIRECTORS.—Each qualified small employer purchasing group established under this section shall be governed by a board of directors or have active input from an advisory board consisting of individuals and businesses participating in the group.

''(c) DOMICILIARY STATE.—For purposes of this section, a qualified small employer purchasing group operating in more than one State shall be certified by the State in which the group is domiciled.

''(d) MEMBERSHIP.—

''(1) IN GENERAL.—A qualified small employer purchasing group shall accept all small employers and certain uninsured individuals residing within the area served by the group as members if such employers or individuals request such membership.

''(2) VOTING.—Members of a qualified small employer purchasing group shall have voting rights consistent with the rules established by the State.

''(e) DUTIES OF QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.—Each qualified small employer purchasing group shall—

''(1) enter into agreements with insurers offering qualified group health plans;

''(2) enter into agreements with small employers under section 2707F;

''(3) enroll only eligible employees, eligible individuals, and certain uninsured individuals in qualified group health plans, in accordance with section 2707G;

''(4) provide enrollee information to the State;

''(5) meet the marketing requirements under section 2707I; and

''(6) carry out other functions provided for under this chapter.

''(f) LIMITATION ON ACTIVITIES.—A qualified small employer purchasing group shall not—

''(1) perform any activity involving approval or enforcement of payment rates for providers;

''(2) perform any activity (other than the reporting of noncompliance) relating to compliance of

qualified group health plans with the requirements of this chapter;

''(3) assume financial risk in relation to any such health plan; or

''(4) perform other activities identified by the State as being inconsistent with the performance of its duties under this chapter.

''(g) RULES OF CONSTRUCTION.—

''(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

''(A) that a State organize, operate or otherwise establish a qualified small employer purchasing group, or otherwise require the establishment of purchasing groups; and

''(B) that there be only one qualified small employer purchasing group established with respect to a community rating area.

''(2) SINGLE ORGANIZATION SERVING MULTIPLE AREAS AND STATES.—Nothing in this section shall be construed as preventing a single entity from being a qualified small employer purchasing group in more than one community rating area or in more than one State.

''(3) VOLUNTARY PARTICIPATION.—Nothing in this section shall be construed as requiring any indi-

vidual or small employer to purchase a qualified group health plan exclusively through a qualified small employer purchasing group.

"SEC. 2707F. AGREEMENTS WITH SMALL EMPLOYERS.

"(a) IN GENERAL.—A qualified small employer purchasing group shall offer to enter into an agreement under this section with each small employer that employs eligible employees in the area served by the group.

"(b) PAYROLL DEDUCTION.—

"(1) IN GENERAL.—Under an agreement under this section between a small employer and a qualified small employer purchasing group, the small employer shall deduct premiums from an eligible employee's wages.

"(2) ADDITIONAL PREMIUMS.—If the amount withheld under paragraph (1) is not sufficient to cover the entire cost of the premiums, the eligible employee shall be responsible for paying directly to the qualified small employer purchasing group the difference between the amount of such premiums and the amount withheld.

"SEC. 2707G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE INDIVIDUALS, AND CERTAIN UNINSURED INDIVIDUALS IN QUALIFIED GROUP HEALTH PLANS.

''(a) IN GENERAL.—Each qualified small employer purchasing group shall offer—

''(1) eligible employees,

''(2) eligible individuals, and

''(3) certain uninsured individuals,

the opportunity to enroll in any qualified group health plan which has an agreement with the qualified small employer purchasing group for the community rating area in which such employees and individuals reside.

''(b) UNINSURED INDIVIDUALS.—For purposes of this section, an individual is described in subsection (a)(3) if such individual is an uninsured individual who is not an eligible employee of a small employer that is a member of a qualified small employer purchasing group or a dependent of such individual.

"SEC. 2707H. RECEIPT OF PREMIUMS.

''(a) ENROLLMENT CHARGE.—The amount charged by a qualified small employer purchasing group for coverage under a qualified group health plan shall be equal to the sum of—

''(1) the premium rate offered by such health plan;

''(2) the administrative charge for such health plan; and

''(3) the purchasing group administrative charge for enrollment of eligible employees, eligible individuals and certain uninsured individuals through the group.

''(b) DISCLOSURE OF PREMIUM RATES AND ADMINISTRATIVE CHARGES.—Each qualified small employer purchasing group shall, prior to the time of enrollment, disclose to enrollees and other interested parties the premium rate for a qualified group health plan, the administrative charge for such plan, and the administrative charge of the group, separately.

''SEC. 2707I. MARKETING ACTIVITIES.

''Each qualified small employer purchasing group shall market qualified group health plans to members through the entire community rating area served by the purchasing group.

''SEC. 2707J. GRANTS TO STATES AND QUALIFIED SMALL EMPLOYER PURCHASING GROUPS.

''(a) IN GENERAL.—The Secretary shall award grants to States and small employer purchasing groups to assist such States and groups in planning, developing, and operating qualified small employer purchasing groups.

''(b) APPLICATION REQUIREMENTS.—To be eligible to receive a grant under this section, a State or small employer purchasing group shall prepare and submit to the Secretary an application in such form, at such time, and containing such information, certifications, and assurances as the Secretary shall reasonably require.

''(c) USE OF FUNDS.—Amounts awarded under this section may be used to finance the costs associated with planning, developing, and operating a qualified small employer purchasing group. Such costs may include the costs associated with—

''(1) engaging in education and outreach efforts to inform small employers, insurers, and the public about the small employer purchasing group;

''(2) soliciting bids and negotiating with insurers to make available group health plans;

''(3) preparing the documentation required to receive certification by the Secretary as a qualified small employer purchasing group; and

''(4) such other activities determined appropriate by the Secretary.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for awarding grants under this section such sums as may be necessary.

"SEC. 2707K. QUALIFIED SMALL EMPLOYER PURCHASING GROUPS ESTABLISHED BY A STATE.

''A State may establish a system in all or part of the State under which qualified small employer purchasing groups are the sole mechanism through which health care coverage for the eligible employees of small employers shall be purchased or provided.

"SEC. 2707L. EFFECTIVE DATES.

''(a) IN GENERAL.—Except as provided in this chapter, the provisions of this chapter are effective on the date of the enactment of this chapter.

''(b) EXCEPTION.—The provisions of section 2707C(b) shall apply to contracts which are issued, or renewed, after the date which is 18 months after the date of the enactment of this chapter.

"Subchapter B—Required Coverage Options for Eligible Employees and Dependents of Small Employers

"SEC. 2708. REQUIRING SMALL EMPLOYERS TO OFFER COVERAGE FOR ELIGIBLE INDIVIDUALS.

''(a) REQUIREMENT TO OFFER.—Each small employer shall make available with respect to each eligible employee a group health plan under which—

''(1) coverage of each eligible individual with respect to such an eligible employee may be elected on an annual basis for each plan year;

''(2) coverage is provided for at least the standard coverage specified in section 2707A(b); and

''(3) each eligible employee electing such coverage may elect to have any premiums owed by the employee collected through payroll deduction.

''(b) NO EMPLOYER CONTRIBUTION REQUIRED.—An employer is not required under subsection (a) to make any contribution to the cost of coverage under a group health plan described in such subsection.

''(c) SPECIAL RULES.—

''(1) EXCLUSION OF NEW EMPLOYERS AND CERTAIN VERY SMALL EMPLOYERS.—Subsection (a) shall not apply to any small employer for any plan year if, as of the beginning of such plan year—

''(A) such employer (including any predecessor thereof) has been an employer for less than 2 years;

''(B) such employer has no more than 2 eligible employees; or

''(C) no more than 2 eligible employees are not covered under any group health plan.

''(2) EXCLUSION OF FAMILY MEMBERS.—Under such procedures as the Secretary may prescribe, any relative of a small employer may be, at the election of the employer, excluded from consideration as an

eligible employee for purposes of applying the requirements of subsection (a). In the case of a small employer that is not an individual, an employee who is a relative of a key employee (as defined in section 416(i)(1) of the Internal Revenue Code of 1986) of the employer may, at the election of the key employee, be considered a relative excludable under this paragraph.

''(3) OPTIONAL APPLICATION OF WAITING PERIOD.—A group health plan and a health insurance issuer offering group health insurance coverage shall not be treated as failing to meet the requirements of subsection (a) solely because a period of service by an eligible employee of not more than 60 days is required under the plan for coverage under the plan of eligible individuals with respect to such employee.

''(d) CONSTRUCTION.—Nothing in this section shall be construed as limiting the group health plans, or types of coverage under such a plan, that an employer may offer to an employee.

''SEC. 2708A. COMPLIANCE WITH APPLICABLE REQUIREMENTS THROUGH MULTIPLE EMPLOYER HEALTH ARRANGEMENTS.

''(a) IN GENERAL.—In any case in which an eligible employee is, for any plan year, a participant in a group

health plan which is a multiemployer plan, the requirements of section 2722(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (b) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

''(b) EMPLOYER REQUIREMENTS.—The employer requirements of this subsection are met under a group health plan with respect to an eligible employee if—

''(1) the employee is eligible under the plan to elect coverage on an annual basis and is provided a reasonable opportunity to make the election in such form and manner and at such times as are provided by the plan;

''(2) coverage is provided for at least the standard coverage specified in section 2707A(b);

''(3) the employer facilitates collection of any employee contributions under the plan and permits the employee to elect to have employee contributions under the plan collected through payroll deduction; and

''(4) in the case of a plan to which subchapter A does not otherwise apply, the employer provides to the employee a summary plan description described

in section 102(a)(1) of the Employee Retirement Income Security Act of 1974 in the form and manner and at such times as are required under such subchapter A with respect to employee welfare benefit plans.

"Subchapter C—Required Coverage Options for Individuals Insured Through Association Plans

"SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

''(a) GENERAL RULE.—For purposes of this chapter, in the case of a qualified association plan—

''(1) except as otherwise provided in this subchapter, the plan shall meet all applicable requirements of chapter 1 and chapter 2 for group health plans offered to and by small employers;

''(2) if such plan is certified as meeting such requirements and the requirements of this subchapter, such plan shall be treated as a plan established and maintained by a small employer, and individuals enrolled in such plan shall be treated as eligible employees; and

''(3) any individual who is a member of the association not enrolling in the plan shall not be treated as an eligible employee solely by reason of membership in such association.

''(b) ELECTION TO BE TREATED AS PURCHASING COOPERATIVE.—Subsection (a) shall not apply to a qualified association plan if—

''(1) the health insurance issuer makes an irrevocable election to be treated as a qualified small employer purchasing group for purposes of section 2707D; and

''(2) such sponsor meets all requirements of this chapter applicable to a purchasing cooperative.

''SEC. 2709A. QUALIFIED ASSOCIATION PLAN DEFINED.

''(a) GENERAL RULE.—For purposes of this chapter, a plan is a qualified association plan if the plan is a multiple employer welfare arrangement or similar arrangement—

''(1) which is maintained by a qualified association;

''(2) which has at least 500 participants in the United States;

''(3) under which the benefits provided consist solely of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986);

''(4) which may not condition participation in the plan, or terminate coverage under the plan, on the basis of the health status or health claims expe-

rience of any employee or member or dependent of either;

''(5) which provides for bonding, in accordance with regulations providing rules similar to the rules under section 412, of all persons operating or administering the plan or involved in the financial affairs of the plan; and

''(6) which notifies each participant or provider that it is certified as meeting the requirements of this chapter applicable to it.

''(b) SELF-INSURED PLANS.—In the case of a plan which is not fully insured (within the meaning of section 514(b)(6)(D)), the plan shall be treated as a qualified association plan only if—

''(1) the plan meets minimum financial solvency and cash reserve requirements for claims which are established by the Secretary and which shall be in lieu of any other such requirements under this chapter;

''(2) the plan provides an annual funding report (certified by an independent actuary) and annual financial statements to the Secretary and other interested parties; and

''(3) the plan appoints a plan sponsor who is responsible for operating the plan and ensuring compliance with applicable Federal and State laws.

''(c) CERTIFICATION.—

''(1) IN GENERAL.—A plan shall not be treated as a qualified association plan for any period unless there is in effect a certification by the Secretary that the plan meets the requirements of this subchapter. For purposes of this chapter, the Secretary shall be the appropriate certifying authority with respect to the plan.

''(2) FEE.—The Secretary shall require a $5,000 fee for the original certification under paragraph (1) and may charge a reasonable annual fee to cover the costs of processing and reviewing the annual statements of the plan.

''(3) EXPEDITED PROCEDURES.—The Secretary may by regulation provide for expedited registration, certification, and comment procedures.

''(4) AGREEMENTS.—The Secretary of Labor may enter into agreements with the States to carry out the Secretary's responsibilities under this subchapter.

''(d) AVAILABILITY.—Notwithstanding any other provision of this chapter, a qualified association plan may

limit coverage to individuals who are members of the qualified association establishing or maintaining the plan, an employee of such member, or a dependent of either.

''(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 2001—

''(1) the requirements of subsection (a) (other than paragraphs (4), (5), and (6) thereof) shall not apply;

''(2) no original certification shall be required under this subchapter; and

''(3) no annual report or funding statement shall be required before January 1, 2003, but the plan shall file with the Secretary a description of the plan and the name of the health insurance issuer.

''SEC. 2709B. DEFINITIONS AND SPECIAL RULES.

''(a) QUALIFIED ASSOCIATION.—For purposes of this subchapter, the term 'qualified association' means any organization which—

''(1) is organized and maintained in good faith by a trade association, an industry association, a professional association, a chamber of commerce, a religious organization, a public entity association, or other business association serving a common or similar industry;

''(2) is organized and maintained for substantial purposes other than to provide a health plan;

''(3) has a constitution, bylaws, or other similar governing document which states its purpose; and

''(4) receives a substantial portion of its financial support from its active, affiliated, or federation members.

''(b) COORDINATION.—The term 'qualified association plan' shall not include a plan to which subchapter B applies.

''SEC. 2709C. SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND COOPERATIVE PLANS.

''(a) GENERAL RULE.—For purposes of this chapter, in the case of a group health plan to which this section applies—

''(1) except as otherwise provided in this subchapter, the plan shall be required to meet all applicable requirements of subchapter A and subchapter B for group health plans offered to and by small employers;

''(2) if such plan is certified as meeting such requirements, such plan shall be treated as a plan established and maintained by a small employer and individuals enrolled in such plan shall be treated as eligible employees; and

''(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated as an eligible employee solely by reason of being eligible to enroll in the plan.

''(b) MODIFIED STANDARDS.—

''(1) CERTIFYING AUTHORITY.—For purposes of this chapter, the Secretary shall be the appropriate certifying authority with respect to a plan to which this section applies.

''(2) AVAILABILITY.—Rules similar to the rules of subsection (e) of section 2709A shall apply to a plan to which this section applies.

''(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described in subsection (c)(2) shall not be required to make any other plan available to the employee.

''(4) TREATMENT UNDER STATE LAWS.—A church plan described in subsection (c)(1) which is certified as meeting the requirements of this section shall not be deemed to be a multiple employer welfare arrangement or an insurance company or other insurer, or to be engaged in the business of insurance, for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(c) PLANS TO WHICH SECTION APPLIES.—This section shall apply to a health plan which—

''(1) is a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) which has at least 100 participants in the United States;

''(2) is a multiemployer plan which is maintained by a health plan sponsor described in section 3(16)(B)(iii) of the Employee Retirement Income Security Act of 1974 and which has at least 500 participants in the United States; or

''(3) is a plan which is maintained by a rural electric cooperative or a rural telephone cooperative association and which has at least 500 participants in the United States.''.

(b) CONFORMING AMENDMENTS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) ELIGIBLE EMPLOYEE.—The term 'eligible employee' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for that employer.

''(16) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means, with respect to an eligible em-

ployee, such employee, and any dependent of such employee.

''(17) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

''(18) QUALIFIED GROUP HEALTH PLAN.—The term 'qualified group health plan' shall have the meaning given the term in section 2707.''.

SEC. 403. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

''SEC. 2753. APPLICABILITY OF GENERAL INSURANCE MARKET REFORMS.

''The provisions of chapter 2 of subpart 2 of part A shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

SEC. 404. EFFECTIVE DATE.

The amendments made by this subtitle shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated on or after January 1, 2002.

Subtitle B—Tax Provisions

SEC. 411. ENFORCEMENT WITH RESPECT TO HEALTH INSURANCE ISSUERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding at the end the following:

"SEC. 4980F. FAILURE OF INSURER TO COMPLY WITH CERTAIN STANDARDS FOR HEALTH INSURANCE COVERAGE.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a health insurance issuer to comply with the requirements applicable to such issuer under—

''(A) chapter 2 of subpart 2 of part A of title XXVII of the Public Health Service Act;

''(B) section 2753 of the Public Health Service Act; and

''(C) subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a health insurance issuer in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such an issuer.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each person to which such failure relates. A rule similar to the rule of section 4980D(b)(3) shall apply for purposes of this section.

''(2) LIMITATION.—The amount of the tax imposed by subsection (a) for a health insurance issuer with respect to health insurance coverage shall not exceed 25 percent of the amounts received under the coverage for coverage during the period such failure persists.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the health insurance issuer.

''(d) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date the health insurance issuer knows, or exercising reasonable diligence could have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(e) DEFINITIONS.—For purposes of this section, the terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms in section 2791 of the Public Health Service Act and section 733 of the Employee Retirement Income Security Act of 1974.''.

(b) CONFORMING AMENDMENT.—The table of sections for such chapter 43 is amended by adding at the end the following new item:

"Sec. 4980F. Failure of insurer to comply with certain standards for health insurance coverage.".

SEC. 412. ENFORCEMENT WITH RESPECT TO SMALL EMPLOYERS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on certain group health plans) is amended by inserting after section 5000 the following new section:

"SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.

"(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any small employer to comply with the requirements applicable to such employer under—

"(1) subchapter C of chapter 2 of subpart 2 of part A of title XXVII of the Public Health Service Act;

"(2) section 2753 of the Public Health Service Act; and

"(3) chapter 2 of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

"(b) AMOUNT OF TAX.—The amount of tax imposed by subsection (a) shall be equal to $100 for each day for each individual for which such a failure occurs.

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the 1st date any of the individuals on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.''.

(b) CONFORMING AMENDMENT.—The table of sections for such chapter 47 is amended by adding at the end the following new item:

''Sec. 5000A. Small employer requirements.''.

SEC. 413. ENFORCEMENT BY EXCISE TAX ON QUALIFIED ASSOCIATIONS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans), as amended by section 411, is amended by adding at the end the following new section:

"SEC. 4980G. FAILURE OF QUALIFIED ASSOCIATIONS, ETC., TO COMPLY WITH CERTAIN STANDARDS FOR HEALTH INSURANCE COVERAGE.

"(a) IMPOSITION OF TAX.—

"(1) IN GENERAL.—There is hereby imposed a tax on the failure of a qualified association (as defined in section 2709A of the Public Health Service Act and section 723A of the Employee Retirement Income Security Act of 1974), church plan (as defined in section 414(e)), multiemployer plan, or plan maintained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of the Employee Retirement Income Security Act of 1974) to comply with the requirements applicable to such association or plans under—

"(A) subchapter C of chapter 2 of subpart 2 of part A of title XXVII of the Public Health Service Act;

''(B) section 2753 of the Public Health Service Act; and

''(C) subchapters A and B of chapter 3 of subpart C of part 7 of the Employee Retirement Income Security Act of 1974.

''(2) EXCEPTION.—Paragraph (1) shall not apply to a failure by a qualified association, church plan, multiemployer plan, or plan maintained by a rural electric cooperative or a rural telephone cooperative association in a State if the Secretary of Health and Human Services determines that the State has in effect a regulatory enforcement mechanism that provides adequate sanctions with respect to such a failure by such a qualified association or plan.

''(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) shall be $100 for each day during which such failure persists for each person to which such failure relates. A rule similar to the rule of section 4980D(b)(3) shall apply for purposes of this section.

''(c) LIABILITY FOR TAX.—The tax imposed by this section shall be paid by the qualified association or plan.

''(d) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period (or such period as the Secretary may determine appropriate) beginning on the first date the qualified association, church plan, multiemployer plan, or plan maintained by a rural electric cooperative or a rural telephone cooperative association knows, or exercising reasonable diligence could have known, that such failure existed.

''(2) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.''.

(b) CONFORMING AMENDMENT.—The table of sections for such chapter 43, as amended by section 411, is amended by adding at the end the following new item:

''Sec. 4980G. Failure of qualified associations, etc., to comply with certain standards for health insurance plans.''.

SEC. 414. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) FULL DEDUCTION IN 2002.—The table contained in section 162(*l*)(1)(B) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended—

(1) by striking ''2001'' and inserting ''2000'';

(2) by striking ''2002'' and all that follows; and

(3) by adding at the end the following:

''2001	70
''2002 and thereafter	100.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 415. AMENDMENTS TO COBRA.

(a) AMENDMENTS TO INTERNAL REVENUE CODE OF 1986.—

(1) LOWER COST COVERAGE OPTIONS.—Subparagraph (A) of section 4980B(f)(2) of the Internal Revenue Code of 1986 (relating to continuation coverage requirements of group health plans) is amended to read as follows:

''(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

''(i) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(ii) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(iii) is so identical, except such coverage is offered with an annual $3,000 deductible.

If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.''.

(2) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (relating to period of coverage) is amended—

(A) by striking ''or'' at the end of subclause (I);

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following:

"(II) eligible for such employer-based coverage for more than 90 days, or".

(3) REDUCTION OF PERIOD OF COVERAGE.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (relating to period of coverage) is amended by striking "18 months" each place it appears and inserting "24 months".

(4) CONTINUATION COVERAGE FOR DEPENDENT CHILD.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"(VI) SPECIAL RULE FOR DEPENDENT CHILD.—In the case of a qualifying event described in paragraph (3)(E), the date that is 36 months after the date on which the dependent child of the covered employee ceases to be a dependent child under the plan.".

(b) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) LOWER COST COVERAGE OPTIONS.—Paragraph (1) of section 602 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(1)) (relating to continuation coverage requirements of group health plans) is amended to read as follows:

''(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

''(A) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(B) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(C) is so identical, except such coverage is offered with an annual $3,000 deductible.

If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.''.

(2) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Subparagraph (D) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(D)) (relating to period of coverage) is amended—

(A) by striking ''or'' at the end of clause (i);

(B) by redesignating clause (ii) as clause (iii); and

(C) by inserting after clause (i) the following:

''(ii) eligible for such employer-based coverage for more than 90 days, or''.

(3) REDUCTION OF PERIOD OF COVERAGE.—Subparagraph (A) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) (relating to period of coverage) is amended by striking ''18 months'' each place it appears and inserting ''24 months''.

(4) CONTINUATION COVERAGE FOR DEPENDENT CHILD.—Subparagraph (A) of section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)(A)) is amended by adding at the end the following:

''(vi) SPECIAL RULE FOR DEPENDENT CHILD.—In the case of a qualifying event described in section 603(5), the date that is 36 months after the date on which the dependent child of the covered employee ceases to be a dependent child under the plan.''.

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

(1) LOWER COST COVERAGE OPTIONS.—Paragraph (1) of section 2202 of the Public Health Service Act (42 U.S.C. 300bb-2(1)) (relating to continuation coverage requirements of group health plans) is amended to read as follows:

''(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided—

''(A) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(B) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(C) is so identical, except such coverage is offered with an annual $3,000 deductible.

If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this subsection in connection with such group.''.

(2) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Subparagraph (D) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(D)) (relating to period of coverage) is amended—

(A) by striking ''or'' at the end of clause (i);

(B) by redesignating clause (ii) as clause (iii); and

(C) by inserting after clause (i) the following:

''(ii) eligible for such employer-based coverage for more than 90 days, or''.

(3) REDUCTION OF PERIOD OF COVERAGE.—Subparagraph (A) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(A)) (re-

lating to period of coverage) is amended by striking ''18 months'' each place it appears and inserting ''24 months''.

(4) CONTINUATION COVERAGE FOR DEPENDENT CHILD.—Subparagraph (A) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(A)) is amended by adding at the end the following:

''(vi) SPECIAL RULE FOR DEPENDENT CHILD.—In the case of a qualifying event described in section 2203(5), the date that is 36 months after the date on which the dependent child of the covered employee ceases to be a dependent child under the plan.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to qualifying events occurring after the date of the enactment of this Act.

TITLE V—PRIMARY AND PREVENTIVE CARE SERVICES

SEC. 501. IMPROVEMENT OF MEDICARE PREVENTIVE CARE SERVICES.

(a) WAIVER OF COINSURANCE FOR SCREENING AND DIAGNOSTIC MAMMOGRAPHY.—

(1) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 223(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended—

(A) by striking ''and (U)'' and inserting ''(U)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (V) with respect to screening mammography (as defined in section 1861(jj)) and diagnostic mammography, 100 percent of the payment basis determined under section 1848;''.

(2) WAIVER OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', with respect to screening mammography (as defined in section 1861(jj)) and diagnostic mammography,''.

(b) COVERAGE OF INSULIN PUMPS.—

(1) INCLUSION AS ITEM OF DURABLE MEDICAL EQUIPMENT.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by insert-

ing before the semicolon the following: ", and includes insulin infusion pumps (as defined in subsection (ww)) prescribed by the physician of an individual with Type I diabetes who is experiencing severe swings of high and low blood glucose levels and has successfully completed a training program that meets standards established by the Secretary or who has used such a pump without interruption for at least 18 months immediately before enrollment under part B".

(2) DEFINITION OF INSULIN INFUSION PUMP.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 105(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by adding at the end the following:

"Insulin Infusion Pump

"(ww) The term 'insulin infusion pump' means an infusion pump, approved by the Federal Food and Drug Administration, that provides for the computerized delivery of insulin for individuals with diabetes in lieu of multiple daily manual insulin injections.".

(3) PAYMENT FOR SUPPLIES RELATING TO INFUSION PUMPS.—Section 1834(a)(2)(A) of the So-

cial Security Act (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) in clause (ii), by striking ''or'' at the end;

(B) in clause (iii), by inserting ''or'' at the end; and

(C) by inserting after clause (iii) the following:

''(iv) which is an accessory used in conjunction with an insulin infusion pump (as defined in section 1861(ww)),''.

(c) ANNUAL SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) IN GENERAL.—Section 1861(nn) of the Social Security Act (42 U.S.C. 1395x(nn), as amended by section 101(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended to read as follows:

''Screening Pap Smear; Screening Pelvic Exam

''(nn)(1) The term 'screening pap smear' means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and includes a physician's interpretation of the results of

the test, if the individual involved has not had such a test during the preceding year.

''(2) The term 'screening pelvic exam' means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding year, and includes a clinical breast examination, relevant history-taking, medical decision-making, and patient counseling.''.

(2) WAIVER OF COINSURANCE FOR PELVIC EXAMS.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a)(1) and section 223(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended—

(A) by striking ''and (V)'' and inserting ''(V)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (W) with respect to services described in section 1861(nn)(2), 100 percent of the payment basis determined under section 1848;''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the first day of the first calendar quarter begin-

ning on or after the date that is 6 months after the date of enactment of this Act.

SEC. 502. AUTHORIZATION OF APPROPRIATIONS FOR HEALTHY START PROGRAM.

(a) AUTHORIZATION OF APPROPRIATIONS.—To enable the Secretary of Health and Human Services to carry out the healthy start program established under the authority of section 301 of the Public Health Service Act (42 U.S.C. 241), there are authorized to be appropriated $115,000,000 for fiscal year 2002, $150,000,000 for fiscal year 2003, $250,000,000 for fiscal year 2004, and $300,000,000 for each of the fiscal years 2005 through 2007.

(b) MODEL PROJECTS.—

(1) IN GENERAL.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall reserve $50,000,000 for such fiscal year to be distributed to model projects determined to be eligible under paragraph (2).

(2) ELIGIBILITY.—To be eligible to receive funds under paragraph (1), a model project shall—

(A) have been one of the original 15 Healthy Start projects; and

(B) be determined by Secretary of Health and Human Services to have been successful in serving needy areas and reducing infant mortality.

(3) USE OF PROJECTS.—A model project that receives funding under paragraph (1) shall be utilized as a resource center to assist in the training of those individuals to be involved in projects established under subsection (c). It shall be the goal of such projects to become self-sustaining within the project area.

(4) PROVISION OF MATCHING FUNDS.—In providing assistance to a project under this subsection, the Secretary of Health and Human Services shall ensure that—

(A) with respect to fiscal year 2002, the project shall make non-Federal contributions (in cash or in-kind) towards the costs of such project in an amount equal to not less than 20 percent of such costs;

(B) with respect to fiscal year 2003, the project shall make non-Federal contributions (in cash or in-kind) towards the costs of such project in an amount equal to not less than 30 percent of such costs;

(C) with respect to fiscal year 2004, the project shall make non-Federal contributions (in cash or in-kind) towards the costs of such project in an amount equal to not less than 40 percent of such costs; and

(D) with respect to each of the fiscal years 2005 through 2007, the project shall make non-Federal contributions (in cash or in-kind) towards the costs of such project in an amount equal to not less than 50 percent of such costs for each such fiscal year.

(c) NEW PROJECTS.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary of Health and Human Services shall allocate amounts remaining after the reservation under subsection (b) for such fiscal year among new demonstration projects and existing special projects that have proven to be successful as determined by the Secretary of Health and Human Services. Such projects shall be community-based and shall attempt to replicate healthy start model projects that have been determined by the Secretary of Health and Human Services to be successful.

SEC. 503. REAUTHORIZATION OF CERTAIN PROGRAMS PROVIDING PRIMARY AND PREVENTIVE CARE.

(a) TUBERCULOSIS PREVENTION GRANTS.—Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)), as amended by section 1711 of the Children's Health Act of 2000 (Public Law 106-310), is amended by striking ''2005'' and inserting ''2007''.

(b) SEXUALLY TRANSMITTED DISEASES.—Section 318(e)(1) of the Public Health Service Act (42 U.S.C. 247c(e)(1)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums'';

(2) by striking ''1998'' and inserting ''2001''; and

(3) by inserting before the period the following: '', $130,000,000 for each of the fiscal years 2002 and 2003, and such sums as may be necessary for each of the fiscal years 2004 through 2006''.

(c) FAMILY PLANNING PROJECT GRANTS.—Section 1001(d) of the Public Health Service Act (42 U.S.C. 300(d)) is amended—

(1) by striking ''and $158,400,000'' and inserting ''$158,400,000''; and

(2) by inserting before the period the following: ''; $430,000,000 for fiscal year 2002; and such sums

as may be necessary for each of the fiscal years 2003 through 2005''.

(d) BREAST AND CERVICAL CANCER PREVENTION.—Section 1510(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended—

(1) by striking ''and such sums'' and inserting ''such sums''; and

(2) by inserting before the period the following: '', $200,000,000 for fiscal year 2002, and such sums as may be necessary for each of the fiscal years 2003 through 2005''.

(e) PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT.—Section 1901(a) of the Public Health Service Act (42 U.S.C. 300w(a)) is amended by striking ''$205,000,000'' and inserting ''$235,000,000''.

(f) MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT.—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking ''fiscal year 2001 and each fiscal year thereafter'' and inserting ''each of fiscal years 2001 and 2002, and such sums as may be necessary for each of the fiscal years 2003 through 2005''.

SEC. 504. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.

(a) PURPOSE.—It is the purpose of this section to establish a comprehensive school health education and pre-

vention program for elementary and secondary school students.

(b) PROGRAM AUTHORIZED.—The Secretary of Education (referred to in this section as the ''Secretary''), through the Office of Comprehensive School Health Education established in subsection (e), shall award grants to States from allotments under subsection (c) to enable such States to—

(1) award grants to local or intermediate educational agencies, and consortia thereof, to enable such agencies or consortia to establish, operate, and improve local programs of comprehensive health education and prevention, early health intervention, and health education, in elementary and secondary schools (including preschool, kindergarten, intermediate, and junior high schools); and

(2) develop training, technical assistance, and coordination activities for the programs assisted pursuant to paragraph (1).

(c) RESERVATIONS AND STATE ALLOTMENTS.—

(1) RESERVATIONS.—From the sums appropriated pursuant to the authority of subsection (f) for any fiscal year, the Secretary shall reserve—

(A) 1 percent for payments to Guam, American Samoa, the Virgin Islands, the Re-

public of the Marshall Islands, the Federated States of Micronesia, the Northern Mariana Islands, and the Republic of Palau, to be allotted in accordance with their respective needs; and

(B) 1 percent for payments to the Bureau of Indian Affairs.

(2) STATE ALLOTMENTS.—From the remainder of the sums not reserved under paragraph (1), the Secretary shall allot to each State an amount which bears the same ratio to the amount of such remainder as the school-age population of the State bears to the school-age population of all States, except that no State shall be allotted less than an amount equal to 0.5 percent of such remainder.

(3) REALLOTMENT.—The Secretary may reallot any amount of any allotment to a State to the extent that the Secretary determines that the State will not be able to obligate such amount within 2 years of allotment. Any such reallotment shall be made on the same basis as an allotment under paragraph (2).

(d) USE OF FUNDS.—Grant funds provided to local or intermediate educational agencies, or consortia thereof, under this section may be used to improve elementary and secondary education in the areas of—

(1) personal health and fitness;

(2) prevention of chronic diseases;

(3) prevention and control of communicable diseases;

(4) nutrition;

(5) substance use and abuse;

(6) accident prevention and safety;

(7) community and environmental health;

(8) mental and emotional health;

(9) parenting and the challenges of raising children; and

(10) the effective use of the health services delivery system.

(e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The Secretary shall establish within the Office of the Secretary an Office of Comprehensive School Health Education which shall have the following responsibilities:

(1) To recommend mechanisms for the coordination of school health education programs conducted by the various departments and agencies of the Federal Government.

(2) To advise the Secretary on formulation of school health education policy within the Department of Education.

(3) To disseminate information on the benefits to health education of utilizing a comprehensive health curriculum in schools.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $50,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 and 2004 to carry out this section.

(2) AVAILABILITY.—Funds appropriated pursuant to the authority of paragraph (1) in any fiscal year shall remain available for obligation and expenditure until the end of the fiscal year succeeding the fiscal year for which such funds were appropriated.

SEC. 505. COMPREHENSIVE EARLY CHILDHOOD HEALTH EDUCATION PROGRAM.

(a) PURPOSE.—It is the purpose of this section to establish a comprehensive early childhood health education program.

(b) PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall conduct a program of awarding grants to agencies conducting Head Start training to enable such agencies to provide training and technical assistance to Head Start

teachers and other child care providers. Such program shall—

(1) establish a training system through the Head Start agencies and organizations conducting Head Start training for the purpose of enhancing teacher skills and providing comprehensive early childhood health education curriculum;

(2) enable such agencies and organizations to provide training to day care providers in order to strengthen the skills of the early childhood workforce in providing health education;

(3) provide technical support for health education programs and curricula; and

(4) provide cooperation with other early childhood providers to ensure coordination of such programs and the transition of students into the public school environment.

(c) USE OF FUNDS.—Grant funds under this section may be used to provide training and technical assistance in the areas of—

(1) personal health and fitness;

(2) prevention of chronic diseases;

(3) prevention and control of communicable diseases;

(4) dental health;

(5) nutrition;

(6) substance use and abuse;

(7) accident prevention and safety;

(8) community and environmental health;

(9) mental and emotional health; and

(10) strengthening the role of parent involvement.

(d) RESERVATION FOR INNOVATIVE PROGRAMS.—The Secretary shall reserve 5 percent of the funds appropriated pursuant to the authority of subsection (e) in each fiscal year for the development of innovative model health education programs or curricula.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $40,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 and 2004 to carry out this section.

SEC. 506. ADOLESCENT FAMILY LIFE AND ABSTINENCE.

(a) DEFINITIONS.—Section 2002(a)(4)(G)(i) of the Public Health Service Act (42 U.S.C. 300z–1(a)(4)(G)(i)) is amended by inserting ''and abstinence'' after ''adoption''.

(b) GEOGRAPHIC DIVERSITY.—Section 2005 of the Public Health Service Act (42 U.S.C. 300z–4) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively; and

(2) by inserting after subsection (a) the following:

''(b) In approving applications for grants for demonstration projects for services under this title, the Secretary shall, to the maximum extent practicable, ensure adequate representation of both urban and rural areas.''.

(c) SIMPLIFIED APPLICATION PROCESS.—Section 2006 of the Public Health Service Act (42 U.S.C. 300z–5) is amended by adding at the end following:

''(g) The Secretary shall develop and implement a simplified and expedited application process for applicants seeking less than $15,000 of funds available under this title for a demonstration project.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 2010(a) of the Public Health Service Act (42 U.S.C. 300z–9) is amended to read as follows:

''(a) For the purpose of carrying out this title, there are authorized to be appropriated $75,000,000 for each of the fiscal years 2002 through 2006.''.

TITLE VI—PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT

SEC. 601. PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT.

(a) RIGHT TO DECLINE MEDICAL TREATMENT.—

(1) RIGHTS OF COMPETENT ADULTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a State may not restrict the right of a competent adult to consent to, or to decline, medical treatment.

(B) LIMITATIONS.—

(i) AFFECT ON THIRD PARTIES.—A State may impose limitations on the right of a competent adult to decline treatment if such limitations protect third parties (including minor children) from harm.

(ii) TREATMENT WHICH IS NOT MEDICALLY INDICATED.—Nothing in this subsection shall be construed to require that any individual be offered, or to state that any individual may demand, medical treatment which the health care provider does not have available, or which is, under prevailing medical standards, either futile or otherwise not medically indicated.

(2) RIGHTS OF INCAPACITATED ADULTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B)(i) of paragraph (1), States may not restrict the right of an incapacitated adult to consent to, or to decline, medical treatment as exercised through the documents specified in this paragraph, or through similar documents or other written methods of directive which evidence the adult's treatment choices.

(B) ADVANCE DIRECTIVES AND POWERS OF ATTORNEY.—

(i) IN GENERAL.—In order to facilitate the communication, despite incapacity, of an adult's treatment choices, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with the Attorney General, shall develop a national advance directive form that—

(I) shall not limit or otherwise restrict, except as provided in subparagraph (B)(i) of paragraph (1), an adult's right to consent to, or to decline, medical treatment; and

(II) shall, at minimum—

(aa) provide the means for an adult to declare such adult's own treatment choices in the event of a terminal condition;

(bb) provide the means for an adult to declare, at such adult's option, treatment choices in the event of other conditions which are medically incurable, and from which such adult likely will not recover; and

(cc) provide the means by which an adult may, at such adult's option, declare such adult's wishes with respect to all forms of medical treatment, including forms of medical treatment such as the provision of nutrition and hydration by artificial means which may be, in some circumstances, relatively nonburdensome.

(ii) NATIONAL DURABLE POWER OF ATTORNEY FORM.—The Secretary, in consultation with the Attorney General, shall

develop a national durable power of attorney form for health care decisionmaking. The form shall provide a means for any adult to designate another adult or adults to exercise the same decisionmaking powers which would otherwise be exercised by the patient if the patient were competent.

(iii) HONORED BY ALL HEALTH CARE PROVIDERS.—The national advance directive and durable power of attorney forms developed by the Secretary shall be honored by all health care providers.

(iv) LIMITATIONS.—No individual shall be required to execute an advance directive. This section makes no presumption concerning the intention of an individual who has not executed an advance directive. An advance directive shall be sufficient, but not necessary, proof of an adult's treatment choices with respect to the circumstances addressed in the advance directive.

(C) DEFINITION.—For purposes of this paragraph, the term ''incapacity'' means the inability to understand or to communicate con-

cerning the nature and consequences of a health care decision (including the intended benefits and foreseeable risks of, and alternatives to, proposed treatment options), and to reach an informed decision concerning health care.

(3) HEALTH CARE PROVIDERS.—

(A) IN GENERAL.—No health care provider may provide treatment to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form or another written method of directive which clearly and convincingly evidence the adult's treatment choices. A health care provider who acts in good faith pursuant to the preceding sentence shall be immune from criminal or civil liability or discipline for professional misconduct.

(B) HEALTH CARE PROVIDERS UNDER THE MEDICARE AND MEDICAID PROGRAMS.—Any health care provider who knowingly provides services to an adult contrary to the adult's wishes as expressed personally, by an advance directive as provided for in paragraph (2)(B), or by a similar written advance directive form

or another written method of directive which clearly and convincingly evidence the adult's treatment choices, shall be denied payment for such services under titles XVIII and XIX of the Social Security Act.

(C) TRANSFERS.—Health care providers who object to the provision of medical care in accordance with an adult's wishes shall transfer the adult to the care of another health care provider.

(4) DEFINITION.—For purposes of this subsection, the term ''adult'' means—

(A) an individual who is 18 years of age or older; or

(B) an emancipated minor.

(b) FEDERAL RIGHT ENFORCEABLE IN FEDERAL COURTS.—The rights recognized in this section may be enforced by filing a civil action in an appropriate district court of the United States.

(c) SUICIDE AND HOMICIDE.—Nothing in this section shall be construed to permit, condone, authorize, or approve suicide or mercy killing, or any affirmative act to end a human life.

(d) RIGHTS GRANTED BY STATES.—Nothing in this section shall impair or supersede rights granted by State law which exceed the rights recognized by this section.

(e) EFFECT ON OTHER LAWS.—

(1) IN GENERAL.—Except as specified in paragraph (2), written policies and written information adopted by health care providers pursuant to sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), shall be modified within 6 months after the enactment of this section to conform to the provisions of this section.

(2) DELAY PERIOD FOR UNIFORM FORMS.—Health care providers shall modify any written forms distributed as written information under sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) not later than 6 months after promulgation of the forms referred to in clauses (i) and (ii) of subsection (a)(2)(B) by the Secretary.

(f) INFORMATION PROVIDED TO CERTAIN INDIVIDUALS.—The Secretary shall provide on a periodic basis written information regarding an individual's right to consent to, or to decline, medical treatment as provided in

this section to individuals who are beneficiaries under titles II, XVI, XVIII, and XIX of the Social Security Act.

(g) RECOMMENDATIONS TO CONGRESS ON ISSUES RELATING TO A PATIENT'S RIGHT OF SELF-DETERMINATION.—Not later than 180 days after the date of the enactment of this Act, and annually thereafter for a period of 3 years, the Secretary shall provide recommendations to Congress concerning the medical, legal, ethical, social, and educational issues related to in this section. In developing recommendations under this subsection the Secretary shall address the following issues:

(1) The contents of the forms referred to in clauses (i) and (ii) of subsection (a)(2)(B).

(2) Issues pertaining to the education and training of health care professionals concerning patients' self-determination rights.

(3) Issues pertaining to health care professionals' duties with respect to patients' rights, and health care professionals' roles in identifying, assessing, and presenting for patient consideration medically indicated treatment options.

(4) Issues pertaining to the education of patients concerning their rights to consent to, and decline, treatment, including how individuals might best be informed of such rights prior to hospitaliza-

tion and how uninsured individuals, and individuals not under the regular care of a physician or another provider, might best be informed of their rights.

(5) Issues relating to appropriate standards to be adopted concerning decisionmaking by incapacitated adult patients whose treatment choices are not known.

(6) Such other issues as the Secretary may identify.

(h) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section shall take effect on the date that is 6 months after the date of enactment of this Act.

(2) SUBSECTION (g).—The provisions of subsection (g) shall take effect on the date of enactment of this Act.

TITLE VII—PRIMARY AND PREVENTIVE CARE PROVIDERS

SEC. 701. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.

(a) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C.

1395l(a)(1)(O)) is amended by striking ''85 percent'' and inserting ''90 percent'' each place it appears.

(b) TECHNICAL AMENDMENT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395l(a)(1)(O)) is amended by striking ''clinic'' and inserting ''clinical''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 2002.

SEC. 702. REQUIRING COVERAGE OF CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 301(c)(1), is amended—

(1) in paragraph (27), by striking ''and'' at the end;

(2) by redesignating paragraph (28) as paragraph (29); and

(3) by inserting after paragraph (27) the following:

''(28) services furnished by a physician assistant, nurse practitioner, clinical nurse specialist (as defined in section 1861(aa)(5)), or certified reg-

istered nurse anesthetist (as defined in section 1861(bb)(2)); and''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 301(c)(3), is amended by striking ''and (27)'' and inserting '', (27), and (28)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance furnished under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) beginning with the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 703. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.) is amended by adding at the end thereof the following:

''SEC. 749. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible schools of medicine or osteopathic medicine to enable such schools to provide medical students for tutorial programs or as participants in clinics designed to interest high school or college students in careers in general medical practice.

''(b) APPLICATION.—To be eligible to receive a grant under this section, a school of medicine or osteopathic medicine shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the school will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be used to—

''(A) fund programs under which students of the grantee are provided as tutors for high school and college students in the areas of mathematics, science, health promotion and prevention, first aid, nutrition and prenatal care;

''(B) fund programs under which students of the grantee are provided as participants in clinics and seminars in the areas described in paragraph (1); and

''(C) conduct summer institutes for high school and college students to promote careers in medicine.

''(2) DESIGN OF PROGRAMS.—The programs, institutes, and other activities conducted by grantees under paragraph (1) shall be designed to—

''(A) give medical students desiring to practice general medicine access to the local community;

''(B) provide information to high school and college students concerning medical school and the general practice of medicine; and

''(C) promote careers in general medicine.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2002, and such sums as may be necessary for fiscal year 2003.''.

SEC. 704. GENERAL MEDICAL PRACTICE GRANTS.

Part C of title VII of the Public Health Service Act (as amended by section 703) is further amended by adding at the end thereof the following:

''SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible public or private nonprofit schools of medicine or osteopathic medicine, hospitals, residency programs in family medicine or pediatrics, or to a consortium of such entities, to enable such entities to develop effective strategies for recruiting med-

ical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(b) APPLICATION.—To be eligible to receive a grant under this section, an entity of the type described in subsection (a) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the entity will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—Amounts received under a grant awarded under this section shall be used to fund programs under which effective strategies are developed and implemented for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $25,000,000 for each of the fiscal years 2002 through 2004, and such sums as may be necessary for fiscal years thereafter.''.

TITLE VIII—SAFE AND COST-EFFECTIVE MEDICAL TREATMENT

SEC. 801. ENHANCING INVESTMENT IN COST-EFFECTIVE METHODS OF HEALTH CARE.

(a) ESTABLISHMENT OF TRUST FUND FOR MEDICAL TREATMENT OUTCOMES RESEARCH.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following:

"SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUTCOMES RESEARCH.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Trust Fund for Medical Treatment Outcomes Research' (referred to in this section as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Trust Fund an amount equivalent to the taxes received in the Treasury under section 4491 (relating to tax on health insurance policies).

''(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—On an annual basis and without further appropriation the Secretary shall distribute the amounts in the Trust Fund to the Secretary of Health and Human Services for use by the Agency for Healthcare Research and Quality. Such amounts shall be available to pay for research activities related to medical treatment outcomes and shall be in addition to any other amounts appropriated for such purposes.''.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following:

''Sec. 9511. Trust Fund for Medical Treatment Outcomes Research.''.

(b) IMPOSITION OF TAX ON HEALTH INSURANCE POLICIES.—

(1) IN GENERAL.—Chapter 36 of the Internal Revenue Code of 1986 (relating to certain other excise taxes) is amended by adding at the end the following:

''Subchapter F—Tax on Health Insurance Policies

''Sec. 4491. Imposition of tax.
''Sec. 4492. Liability for tax.

''SEC. 4491. IMPOSITION OF TAX.

''(a) GENERAL RULE.—There is hereby imposed a tax equal to .001 cent on each dollar, or fractional part

thereof, of the premium paid on a policy of health insurance.

''(b) DEFINITION.—For purposes of subsection (a), the term 'policy of health insurance' means any policy or other instrument by whatever name called whereby a contract of insurance is made, continued, or renewed with respect to the health of an individual or group of individuals.

''SEC. 4492. LIABILITY FOR TAX.

''The tax imposed by this subchapter shall be paid, on the basis of a return, by any person who makes, signs, issues, or sells any of the documents and instruments subject to the tax, or for whose use or benefit the same are made, signed, issued, or sold. The United States or any agency or instrumentality thereof shall not be liable for the tax.''.

(2) CONFORMING AMENDMENT.—The table of subchapters for chapter 36 of such Code is amended by adding at the end the following:

''SUBCHAPTER F. Tax on health insurance policies.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to policies issued after December 31, 2001.

SEC. 802. MEDICAL ERRORS REDUCTION.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part C as part D;

(2) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(3) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(4) by inserting after part B the following:

''PART C—REDUCING ERRORS IN HEALTH CARE

''SEC. 921. DEFINITIONS.

''In this part:

''(1) ADVERSE EVENT.—The term 'adverse event' means an injury resulting from medical management rather than the underlying condition of the patient.

''(2) ERROR.—The term 'error' means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve the desired outcome.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means an individual or entity that provides medical services and is a participant in a demonstration program under this part.

''(4) HEALTH CARE-RELATED ERROR.—The term ''health care-related error'' means a preventable adverse event related to a health care intervention or a failure to intervene appropriately.

''(5) MEDICATION-RELATED ERROR.—The term 'medication-related error' means a preventable adverse event related to the administration of a medication.

''(6) SAFETY.—The term 'safety' with respect to an individual means that such individual has a right to be free from preventable serious injury.

''(7) SENTINEL EVENT.—The term 'sentinel event' means an unexpected occurrence involving an individual that results in death or serious physical injury that is unrelated to the natural course of the individual's illness or underlying condition.

"SEC. 922. ESTABLISHMENT OF STATE-BASED MEDICAL ERROR REPORTING SYSTEMS.

''(a) IN GENERAL.—The Secretary shall make grants available to States to enable such States to establish reporting systems designed to reduce medical errors and improve health care quality.

''(b) REQUIREMENT.—

''(1) IN GENERAL.—To be eligible to receive a grant under subsection (a), the State involved shall provide assurances to the Secretary that amounts received under the grant will be used to establish and implement a medical error reporting system using guidelines (including guidelines relating to the con-

fidentiality of the reporting system) developed by the Agency for Healthcare Research and Quality with input from interested, non-governmental parties including patient, consumer and health care provider groups.

''(2) GUIDELINES.—Not later than 90 days after the date of enactment of this part, the Agency for Healthcare Research and Quality shall develop and publish the guidelines described in paragraph (1).

''(c) DATA.—

''(1) AVAILABILITY.—A State that receives a grant under subsection (a) shall make the data provided to the medical error reporting system involved available only to the Agency for Healthcare Research and Quality and may not otherwise disclose such information.

''(2) CONFIDENTIALITY.—Nothing in this part shall be construed to supersede any State law that is inconsistent with this part.

''(d) APPLICATION.—To be eligible for a grant under this section, a State shall prepare and submit to the Secretary an application at such time, in such manner and containing, such information as the Secretary shall require.

"SEC. 923. DEMONSTRATION PROJECTS TO REDUCE MEDICAL ERRORS, IMPROVE PATIENT SAFETY, AND EVALUATE REPORTING.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in conjunction with the Administrator of the Health Care Financing Administration, may establish a program under which funding will be provided for not less than 15 demonstration projects, to be competitively awarded, in health care facilities and organizations in geographically diverse locations, including rural and urban areas (as determined by the Secretary), to determine the causes of medical errors and to—

''(1) use technology, staff training, and other methods to reduce such errors;

''(2) develop replicable models that minimize the frequency and severity of medical errors;

''(3) develop mechanisms that encourage reporting, prompt review, and corrective action with respect to medical errors; and

''(4) develop methods to minimize any additional paperwork burden on health care professionals.

''(b) ACTIVITIES.—

''(1) IN GENERAL.—A health care provider participating in a demonstration project under subsection (a) shall—

''(A) utilize all available and appropriate technologies to reduce the probability of future medical errors; and

''(B) carry out other activities consistent with subsection (a).

''(2) REPORTING TO PATIENTS.—In carrying out this section, the Secretary shall ensure that—

''(A) 5 of the demonstration projects permit the voluntary reporting by participating health care providers of any adverse events, sentinel events, health care-related errors, or medication-related errors to the Secretary;

''(B) 5 of the demonstration projects require participating health care providers to report any adverse events, sentinel events, health care-related errors, or medication-related errors to the Secretary; and

''(C) 5 of the demonstration projects require participating health care providers to report any adverse events, sentinel events, health care-related errors, or medication-related errors

to the Secretary and to the patient involved and a family member or guardian of the patient.

''(3) CONFIDENTIALITY.—

''(A) IN GENERAL.—The Secretary and the participating grantee organization shall ensure that information reported under this section remains confidential.

''(B) USE.—The Secretary may use the information reported under this section only for the purpose of evaluating the ability to reduce errors in the delivery of care. Such information shall not be used for enforcement purposes.

''(C) DISCLOSURE.—The Secretary may not disclose the information reported under this section.

''(D) NONADMISSIBILITY.—Information reported under this section shall be privileged, confidential, shall not be admissible as evidence or discoverable in any civil or criminal action or proceeding or subject to disclosure, and shall not be subject to the Freedom of Information Act (5 U.S.C. App). This paragraph shall apply to all information maintained by the reporting entity and the entities who receive such reports.

''(c) USE OF TECHNOLOGIES.—The Secretary shall encourage, as part of the demonstration projects conducted under subsection (a), the use of appropriate technologies to reduce medical errors, such as hand-held electronic prescription pads, training simulators for medical education, and bar-coding of prescription drugs and patient bracelets.

''(d) DATABASE.—The Secretary shall provide for the establishment and operation of a national database of medical errors to be used as provided for by the Secretary. The information provided to the Secretary under subsection (b)(2) shall be contained in the database.

''(e) EVALUATION.—The Secretary shall evaluate the progress of each demonstration project established under this section in reducing the incidence of medical errors and submit the results of such evaluations as part of the reports under section 926(b).

''(f) REPORTING.—Prior to October 1, of the third fiscal year for which funds are made available under this section, the Secretary shall prepare and submit to the appropriate committees of Congress an interim report concerning the results of such demonstration projects.

''SEC. 924. PATIENT SAFETY IMPROVEMENT.

''(a) IN GENERAL.—The Secretary shall provide information to educate patients and family members about

their role in reducing medical errors. Such information shall be provided to all individuals who participate in Federally-funded health care programs.

''(b) DEVELOPMENT OF PROGRAMS.—The Secretary shall develop programs that encourage patients to take a more active role in their medical treatment, including encouraging patients to provide information to health care providers concerning pre-existing conditions and medications.

''SEC. 925. PRIVATE, NONPROFIT EFFORTS TO REDUCE MEDICAL ERRORS.

''(a) IN GENERAL.—The Secretary shall make grants to health professional associations and other organizations to provide training in ways to reduce medical errors, including curriculum development, technology training, and continuing medical education.

''(b) APPLICATION.—To be eligible for a grant under this section, an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing, such information as the Secretary shall require.

''SEC. 926. REPORT TO CONGRESS.

''(a) INITIAL REPORT.—Not later than 180 days after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees

of Congress a report concerning the costs associated with implementing a program that identifies factors that contribute to errors and which includes upgrading the health care computer systems and other technologies in the United States in order to reduce medical errors, including computerizing hospital systems for the coordination of prescription drugs and handling of laboratory specimens, and contains recommendation on ways in which to reduce those factors.

''(b) OTHER REPORTS.—Not later than 180 days after the completion of all demonstration projects under section 923, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning—

''(1) how successful each demonstration project was in reducing medical errors;

''(2) the data submitted by States under section 922(c);

''(3) the best methods for reducing medical errors;

''(4) the costs associated with applying such best methods on a nationwide basis; and

''(5) the manner in which other Federal agencies can share information on best practices in order to reduce medical errors in all Federal health care programs.

''SEC. 927. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this part.''.

TITLE IX—TAX INCENTIVES FOR PURCHASE OF QUALIFIED LONG-TERM CARE INSURANCE

SEC. 901. CREDIT FOR QUALIFIED LONG-TERM CARE PREMIUMS.

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following:

''SEC. 35. LONG-TERM CARE INSURANCE CREDIT.

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the premiums for a qualified long-term care insurance contract (as defined in section 7702B(b)) paid during such taxable year for such individual or the spouse of such individual.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of this section, the term 'applicable percentage' means 28 percent reduced (but not below zero) by 1 percentage

point for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds the base amount.

"(2) BASE AMOUNT.—For purposes of paragraph (1) the term 'base amount' means—

"(A) except as otherwise provided in this paragraph, $25,000,

"(B) $40,000 in the case of a joint return, and

"(C) zero in the case of a taxpayer who—

"(i) is married at the close of the taxable year (within the meaning of section 7703) but does not file a joint return for such taxable year, and

"(ii) does not live apart from the taxpayer's spouse at all times during the taxable year.

"(c) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount allowed as a credit under this section shall not be taken into account under section 213.".

(b) CONFORMING AMENDMENT.—The table of sections for such subpart C is amended by striking the item relating to section 35 and inserting the following:

"Sec. 35. Long-term care insurance credit.
"Sec. 36. Overpayments of tax.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 902. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) CAFETERIA PLANS.—The last sentence of section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by striking ''shall not'' and inserting ''shall''.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106(c) of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended—

(1) in paragraph (1), by striking ''include'' and inserting ''shall not''; and

(2) in the heading, by striking ''INCLUSION'' and inserting ''EXCLUSION''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2000.

SEC. 903. EXCLUSION FROM GROSS INCOME FOR AMOUNTS RECEIVED ON CANCELLATION OF LIFE INSURANCE POLICIES AND USED FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—

(1) EXCLUSION FROM GROSS INCOME.—

(A) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 139 as section 140 and by inserting after section 138 the following new section:

"SEC. 139. AMOUNTS RECEIVED ON CANCELLATION, ETC. OF LIFE INSURANCE CONTRACTS AND USED TO PAY PREMIUMS FOR QUALIFIED LONG-TERM CARE INSURANCE.

''No amount (which but for this section would be includible in the gross income of an individual) shall be included in gross income on the whole or partial surrender, cancellation, or exchange of any life insurance contract during the taxable year if—

''(1) such individual has attained age 59½ on or before the date of the transaction, and

''(2) the amount otherwise includible in gross income is used during such year to pay for any

qualified long-term care insurance contract (as defined in section 7702B(b)) which—

''(A) is for the benefit of such individual or the spouse of such individual if such spouse has attained age 59½ on or before the date of the transaction, and

''(B) may not be surrendered for cash.''.

(B) CONFORMING AMENDMENT.—The table of sections for such part III is amended by striking the item relating to section 139 and inserting the following:

''Sec. 139. Amounts received on cancellation, etc. of life insurance contracts and used to pay premiums for qualified long-term care insurance.
''Sec. 140. Cross references to other Acts.''.

(2) CERTAIN EXCHANGES NOT TAXABLE.—Section 1035(a) of such Code (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end the following:

''(4) in the case of an individual who has attained age 59½, a contract of life insurance or an endowment or annuity contract for a qualified long-term care insurance contract (as defined in section 7702B(b)), if the qualified long-term care insurance contract may not be surrendered for cash.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 904. USE OF GAIN FROM SALE OF PRINCIPAL RESIDENCE FOR PURCHASE OF QUALIFIED LONG-TERM HEALTH CARE INSURANCE.

(a) IN GENERAL.—Subsection (d) of section 121 of the Internal Revenue Code of 1986 (relating to exclusion of gain from sale of principal) is amended by adding at the end the following:

''(9) ELIGIBILITY OF HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION FOR EXCLUSION.—

''(A) IN GENERAL.—For purposes of this section, the term 'sale or exchange' includes a home equity conversion sale-leaseback transaction.

''(B) HOME EQUITY CONVERSION SALE-LEASEBACK TRANSACTION.—For purposes of subparagraph (A), the term 'home equity conversion sale-leaseback' means a transaction in which—

''(i) the seller-lessee—

''(I) sells property which during the 5-year period ending on the date

of the transaction has been owned and used as a principal residence by such seller-lessee for periods aggregating 2 years or more,

''(II) uses a portion of the proceeds from such sale to purchase a qualified long-term care insurance contract (as defined in section 7702B(b)), which contract may not be surrendered for cash,

''(III) obtains occupancy rights in such property pursuant to a written lease requiring a fair rental, and

''(IV) receives no option to repurchase the property at a price less than the fair market price of the property unencumbered by any leaseback at the time such option is exercised, and

''(ii) the purchaser-lessor—

''(I) is a person,

''(II) is contractually responsible for the risks and burdens of ownership and receives the benefits of ownership (other than the seller-lessee's

occupancy rights) after the date of such transaction, and

"(III) pays a purchase price for the property that is not less than the fair market price of such property encumbered by a leaseback, and taking into account the terms of the lease.

"(C) ADDITIONAL DEFINITIONS.—For purposes of subparagraph (B)—

"(i) OCCUPANCY RIGHTS.—The term 'occupancy rights' means the right to occupy the property for any period of time, including a period of time measured by the life of the seller-lessee on the date of the sale-leaseback transaction (or the life of the surviving seller-lessee, in the case of jointly held occupancy rights), or a periodic term subject to a continuing right of renewal by the seller-lessee (or by the surviving seller-lessee, in the case of jointly held occupancy rights).

"(ii) FAIR RENTAL.—The term 'fair rental' means a rental for any subsequent year which equals or exceeds the rental for

the 1st year of a sale-leaseback transaction.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to sales after December 31, 2001, in taxable years beginning after such date.

TITLE X—NATIONAL FUND FOR HEALTH RESEARCH

SEC. 1001. ESTABLISHMENT OF FUND.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund, to be known as the ''National Fund for Health Research'' (in this section referred to as the ''Fund''), consisting of such amounts as are transferred to the Fund under subsection (b) and any interest earned on investment of amounts in the Fund.

(b) TRANSFERS TO FUND.—

(1) IN GENERAL.—The Secretary of the Treasury shall transfer to the Fund amounts equivalent to amounts designated under paragraph (2) and received in the Treasury.

(2) AMOUNTS.—

(A) HEALTH PLAN SET ASIDE.—With respect to each calendar year beginning with the first full calendar year after the date of enactment of this Act, each health plan shall set

aside and transfer to the Treasury of the United States an amount equal to—

(i) for the first full calendar year, 0.25 percent of all health premiums received with respect to the plan for such year;

(ii) for the second full calendar year, 0.5 percent of all health premiums received with respect to the plan for such year;

(iii) for the third full calendar year, 0.75 percent of all health premiums received with respect to the plan for such year; and

(iv) for the fourth and each succeeding full calendar year, 1 percent of all health premiums received with respect to the plan for such year.

(3) TRANSFERS BASED ON ESTIMATES.—The amounts transferred by paragraph (1) shall annually be transferred to the Fund within 30 days after the President signs an appropriations Act for the Departments of Labor, Health and Human Services, and Education, and related agencies, or by the end of the first quarter of the fiscal year. Proper adjustment shall be made in amounts subsequently trans-

ferred to the extent prior estimates were in excess of or less than the amounts required to be transferred.

(4) DEFINITION.—As used in this subsection, the term ''health plan'' means a group health plan (as defined in section 2791(a) of the Public Health Service Act and any individual health insurance (as defined in section 2791(b)(5) of such Act) operated by a health insurance issuer.

(c) OBLIGATIONS FROM FUND.—

(1) IN GENERAL.—Subject to the provisions of paragraph (4), with respect to the amounts made available in the Fund in a fiscal year, the Secretary of Health and Human Services shall distribute—

(A) 2 percent of such amounts during any fiscal year to the Office of the Director of the National Institutes of Health to be allocated at the Director's discretion for the following activities:

(i) for carrying out the responsibilities of the Office of the Director, including the Office of Research on Women's Health and the Office of Research on Minority Health, the Office of Rare Disease Research, the Office of Behavioral and Social Sciences

Research (for use for efforts to reduce tobacco use), the Office of Dietary Supplements, and the Office for Disease Prevention; and

(ii) for construction and acquisition of equipment for or facilities of or used by the National Institutes of Health;

(B) 2 percent of such amounts for transfer to the National Center for Research Resources to carry out section 1502 of the National Institutes of Health Revitalization Act of 1993 concerning Biomedical and Behavioral Research Facilities;

(C) 1 percent of such amounts during any fiscal year for carrying out section 301 and part D of title IV of the Public Health Service Act with respect to health information communications; and

(D) the remainder of such amounts during any fiscal year to member institutes and centers, including the Office of AIDS Research, of the National Institutes of Health in the same proportion to the total amount received under this section, as the amount of annual appropriations under appropriations Acts for each

member institute and Centers for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and Centers of the National Institutes of Health for the fiscal year.

(2) PLANS OF ALLOCATION.—The amounts transferred under paragraph (1)(D) shall be allocated by the Director of the National Institutes of Health or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

(3) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under paragraph (1), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

(4) TRIGGER AND RELEASE OF MONIES AND PHASE-IN.—

(A) TRIGGER AND RELEASE.—No expenditure shall be made under paragraph (1) during any fiscal year in which the annual amount ap-

propriated for the National Institutes of Health is less than the amount so appropriated for the prior fiscal year.

(B) PHASE-IN.—The Secretary of Health and Human Services shall phase-in the distributions required under paragraph (1) so that—

(i) 25 percent of the amount in the Fund is distributed in the first fiscal year for which funds are available;

(ii) 50 percent of the amount in the Fund is distributed in the second fiscal year for which funds are available;

(iii) 75 percent of the amount in the Fund is distributed in the third fiscal year for which funds are available; and

(iv) 100 percent of the amount in the Fund is distributed in the fourth and each succeeding fiscal year for which funds are available.

(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the Fund shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget

Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.

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