

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

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Assurance Act of 2001”.

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

Sec. 1. Short title; table of contents.

TITLE I—EXPANDED MEDICAID COVERAGE FOR LOW-INCOME INDIVIDUALS

Sec. 101. Expanded medicaid coverage for low-income individuals.

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

Sec. 201. Increase in income eligibility.

TITLE III—EXPANDED HEALTH SERVICES FOR DISABLED INDIVIDUALS

Sec. 301. Coverage of community-based attendant services and supports under the medicaid program.

Sec. 302. Grants to develop and establish real choice systems change initiatives.

Sec. 303. State option for eligibility for individuals.

Sec. 304. Studies and reports.

Sec. 305. Task force on financing of long-term care services.

TITLE IV—HEALTH CARE INSURANCE COVERAGE

Subtitle A—General Provisions

Sec. 401. Amendments to the Employee Retirement Income Security Act of 1974.

Sec. 402. Amendments to the Public Health Service Act relating to the group market.

Sec. 403. Amendment to the Public Health Service Act relating to the individual market.

Sec. 404. Effective date.

Subtitle B—Tax Provisions

Sec. 411. Enforcement with respect to health insurance issuers.

Sec. 412. Enforcement with respect to small employers.

Sec. 413. Enforcement by excise tax on qualified associations.

Sec. 414. Deduction for health insurance costs of self-employed individuals.

Sec. 415. Amendments to COBRA.

TITLE V—PRIMARY AND PREVENTIVE CARE SERVICES

Sec. 501. Improvement of medicare preventive care services.

Sec. 502. Authorization of appropriations for healthy start program.

Sec. 503. Reauthorization of certain programs providing primary and preventive care.

Sec. 504. Comprehensive school health education program.

Sec. 505. Comprehensive early childhood health education program.

Sec. 506. Adolescent family life and abstinence.

TITLE VI—PATIENT’S RIGHT TO DECLINE MEDICAL TREATMENT

Sec. 601. Patient’s right to decline medical treatment.

TITLE VII—PRIMARY AND PREVENTIVE CARE PROVIDERS

- Sec. 701. Increased medicare reimbursement for physician assistants, nurse practitioners, and clinical nurse specialists.
- Sec. 702. Requiring coverage of certain nonphysician providers under the medicaid program.
- Sec. 703. Medical student tutorial program grants.
- Sec. 704. General medical practice grants.

TITLE VIII—SAFE AND COST-EFFECTIVE MEDICAL TREATMENT

- Sec. 801. Enhancing investment in cost-effective methods of health care.
- Sec. 802. Medical Errors Reduction.

TITLE IX—TAX INCENTIVES FOR PURCHASE OF QUALIFIED
LONG-TERM CARE INSURANCE

- Sec. 901. Credit for qualified long-term care premiums.
- Sec. 902. Inclusion of qualified long-term care insurance in cafeteria plans and flexible spending arrangements.
- Sec. 903. Exclusion from gross income for amounts received on cancellation of life insurance policies and used for qualified long-term care insurance contracts.
- Sec. 904. Use of gain from sale of principal residence for purchase of qualified long-term health care insurance.

TITLE X—NATIONAL FUND FOR HEALTH RESEARCH

- Sec. 1001. Establishment of Fund.

1 **TITLE I—EXPANDED MEDICAID**
2 **COVERAGE FOR LOW-INCOME**
3 **INDIVIDUALS**

4 **SEC. 101. EXPANDED MEDICAID COVERAGE FOR LOW-IN-**
5 **COME INDIVIDUALS.**

6 (a) REQUIRED COVERAGE OF INDIVIDUALS UP TO
7 133 PERCENT OF POVERTY.—Section 1902(a)(10)(A)(i)
8 of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i))
9 is amended—

10 (1) by striking “or” at the end of subclause
11 (VI);

12 (2) by inserting “or” after the semicolon at the
13 end of subclause (VII); and

1 (3) by adding at the end the following:

2 “(VIII) whose family income does
3 not exceed 133 percent of the income
4 official poverty line (as defined by the
5 Office of Management and Budget,
6 and revised annually in accordance
7 with section 673(2) of the Omnibus
8 Budget Reconciliation Act of 1981)
9 applicable to a family of the size in-
10 volved;”.

11 (b) OPTIONAL COVERAGE OF INDIVIDUALS UP TO
12 200 PERCENT OF POVERTY.—Section
13 1902(a)(10)(A)(i)(VIII) of the Social Security Act, as
14 added by subsection (a)(3), is amended by inserting “(200
15 percent, at State option)” after “133 percent”.

16 (c) EFFECTIVE DATE.—

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

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

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

11 **TITLE II—EXPANSION OF THE**
12 **STATE CHILDREN’S HEALTH**
13 **INSURANCE PROGRAM**

14 **SEC. 201. INCREASE IN INCOME ELIGIBILITY.**

15 (a) DEFINITION OF LOW-INCOME CHILD.—Section
16 2110(c)(4) of the Social Security Act (42 U.S.C. 42
17 U.S.C. 1397jj(c)(4)) is amended by striking “200” and
18 inserting “235”.

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

1 **TITLE III—EXPANDED HEALTH**
2 **SERVICES FOR DISABLED IN-**
3 **DIVIDUALS**

4 **SEC. 301. COVERAGE OF COMMUNITY ATTENDANT SERV-**
5 **ICES AND SUPPORTS UNDER THE MEDICAID**
6 **PROGRAM.**

7 (a) REQUIRED COVERAGE FOR INDIVIDUALS ENTI-
8 TLED TO NURSING FACILITY SERVICES OR ELIGIBLE FOR
9 INTERMEDIATE CARE FACILITY SERVICES FOR THE MEN-
10 TALLY RETARDED.—Section 1902(a)(10)(D) of the Social
11 Security Act (42 U.S.C. 1396a(a)(10)(D)) is amended—

- 12 (1) by inserting “(i)” after “(D)”;
13 (2) by adding “and” after the semicolon; and
14 (3) by adding at the end the following:

15 “(ii) subject to section 1935, for the inclu-
16 sion of community attendant services and sup-
17 ports for any individual who is eligible for med-
18 ical assistance under the State plan and with
19 respect to whom there has been a determination
20 that the individual requires the level of care
21 provided in a nursing facility or an intermediate
22 care facility for the mentally retarded (whether
23 or not coverage of such intermediate care facil-
24 ity is provided under the State plan) and who
25 requires such community attendant services and

1 supports based on functional need and without
 2 regard to age or disability;”.

3 (b) MEDICAID COVERAGE OF COMMUNITY ATTEND-
 4 ANT SERVICES AND SUPPORTS.—

5 (1) IN GENERAL.—Title XIX of the Social Se-
 6 curity Act (42 U.S.C. 1396 et seq.) is amended—

7 (A) by redesignating section 1935 as sec-
 8 tion 1936; and

9 (B) by inserting after section 1934 the fol-
 10 lowing:

11 “COMMUNITY ATTENDANT SERVICES AND SUPPORTS

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

13 “(1) COMMUNITY ATTENDANT SERVICES AND
 14 SUPPORTS.—

15 “(A) IN GENERAL.—The term ‘community
 16 attendant services and supports’ means attend-
 17 ant services and supports furnished to an indi-
 18 vidual, as needed, to assist in accomplishing ac-
 19 tivities of daily living, instrumental activities of
 20 daily living, and health-related functions
 21 through hands-on assistance, supervision, or
 22 cueing—

23 “(i) under a plan of services and sup-
 24 ports that is based on an assessment of
 25 functional need and that is agreed to by

1 the individual or, as appropriate, the indi-
2 vidual’s representative;

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

9 “(iii) under an agency-provider model
10 or other model (as defined in paragraph
11 (2)(C)); and

12 “(iv) the furnishing of which is se-
13 lected, managed, and dismissed by the in-
14 dividual, or, as appropriate, with assistance
15 from the individual’s representative.

16 “(B) INCLUDED SERVICES AND SUP-
17 PORTS.—Such term includes—

18 “(i) tasks necessary to assist an indi-
19 vidual in accomplishing activities of daily
20 living, instrumental activities of daily liv-
21 ing, and health-related functions;

22 “(ii) acquisition, maintenance, and en-
23 hancement of skills necessary for the indi-
24 vidual to accomplish activities of daily liv-

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

3 “(iii) backup systems or mechanisms
4 (such as the use of beepers) to ensure con-
5 tinuity of services and supports; and

6 “(iv) voluntary training on how to se-
7 lect, manage, and dismiss attendants.

8 “(C) EXCLUDED SERVICES AND SUP-
9 PORTS.—Subject to subparagraph (D), such
10 term does not include—

11 “(i) provision of room and board for
12 the individual;

13 “(ii) special education and related
14 services provided under the Individuals
15 with Disabilities Education Act and voca-
16 tional rehabilitation services provided
17 under the Rehabilitation Act of 1973;

18 “(iii) assistive technology devices and
19 assistive technology services;

20 “(iv) durable medical equipment; or

21 “(v) home modifications.

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

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

7 “(2) ADDITIONAL DEFINITIONS.—

8 “(A) ACTIVITIES OF DAILY LIVING.—The
9 term ‘activities of daily living’ includes eating,
10 toileting, grooming, dressing, bathing, and
11 transferring.

12 “(B) CONSUMER DIRECTED.—The term
13 ‘consumer directed’ means a method of pro-
14 viding services and supports that allow the indi-
15 vidual, or where appropriate, the individual’s
16 representative, maximum control of the commu-
17 nity attendant services and supports, regardless
18 of who acts as the employer of record.

19 “(C) DELIVERY MODELS.—

20 “(i) AGENCY-PROVIDER MODEL.—The
21 term ‘agency-provider model’ means, with
22 respect to the provision of community at-
23 tendant services and supports for an indi-
24 vidual, a method of providing consumer-di-
25 rected services and supports under which

1 entities contract for the provision of such
2 services and supports.

3 “(ii) OTHER MODELS.—The term
4 ‘other models’ means methods, other than
5 an agency-provider model, for the provision
6 of consumer-directed services and supports.
7 Such models may include the provision of
8 vouchers, direct cash payments, or use of
9 a fiscal agent to assist in obtaining serv-
10 ices.

11 “(D) HEALTH-RELATED FUNCTIONS.—The
12 term ‘health-related functions’ means functions
13 that can be delegated or assigned by licensed
14 health-care professionals under State law to be
15 performed by an attendant.

16 “(E) INSTRUMENTAL ACTIVITIES OF DAILY
17 LIVING.—The term ‘instrumental activities of
18 daily living’ includes meal planning and prepa-
19 ration, managing finances, shopping for food,
20 clothing and other essential items, performing
21 essential household chores, communicating by
22 phone and other media, and getting around and
23 participating in the community.

24 “(F) INDIVIDUAL’S REPRESENTATIVE.—
25 The term ‘individual’s representative’ means a

1 parent, a family member, a guardian, an advo-
2 cate, or an authorized representative of an indi-
3 vidual.

4 “(b) LIMITATION ON AMOUNTS OF EXPENDITURES
5 UNDER THIS TITLE.—In carrying out section
6 1902(a)(10)(D)(ii), a State shall permit an individual who
7 has a level of severity of physical or mental impairment
8 that entitles such individual to medical assistance with re-
9 spect to nursing facility services or qualifies the individual
10 for intermediate care facility services for the mentally re-
11 tarded to choose to receive medical assistance for commu-
12 nity attendant services and supports (rather than medical
13 assistance for such institutional services and supports), in
14 the most integrated setting appropriate to the needs of
15 the individual, so long as the aggregate amount of the
16 Federal expenditures for community attendant services
17 and supports for all such individuals in a fiscal year does
18 not exceed the total that would have been expended for
19 such individuals to receive such institutional services and
20 supports in the year.

21 “(c) MAINTENANCE OF EFFORT.—With respect to a
22 fiscal year quarter, no Federal funds may be paid to a
23 State for medical assistance provided to individuals de-
24 scribed in section 1902(a)(10)(D)(ii) for such fiscal year
25 quarter if the Secretary determines that the total of the

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

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

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

17 “(A) minimum qualifications and training
18 requirements, as appropriate for agency-based
19 and other models;

20 “(B) financial operating standards; and

21 “(C) an appeals procedure for eligibility
22 denials and a procedure for resolving disagree-
23 ments over the terms of an individualized plan.

24 “(2) The State shall modify the quality assur-
25 ance program, where appropriate, to maximize con-

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

3 “(3) The State shall provide a system that al-
4 lows for the external monitoring of the quality of
5 services by entities consisting of consumers and their
6 representatives, disability organizations, providers,
7 family, members of the community, and others.

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

10 “(5) The State shall require that quality assur-
11 ance mechanisms appropriate for the individual
12 should be included in the individual’s written plan.

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

16 “(7) The State shall obtain meaningful con-
17 sumer input, including consumer surveys, that meas-
18 ure the extent to which a participant receives the
19 services and supports described in the individual’s
20 plan and the participant’s satisfaction with such
21 services and supports.

22 “(8) The State shall make available to the pub-
23 lic the findings of the quality assurance program.

1 “(9) The State shall establish an on-going pub-
2 lic process for the development, implementation, and
3 review of the State’s quality assurance program.

4 “(10) The State shall develop and implement a
5 program of sanctions.

6 “(e) FEDERAL ROLE IN QUALITY ASSURANCE.—The
7 Secretary shall conduct a periodic sample review of out-
8 comes for individuals based upon the individual’s plan of
9 support and based upon the quality assurance program of
10 the State. The Secretary may conduct targeted reviews
11 upon receipt of allegations of neglect, abuse, or exploi-
12 tation. The Secretary shall develop guidelines for States
13 to use in developing sanctions.

14 “(f) REQUIREMENT TO EXPAND ELIGIBILITY.—Ef-
15 fective October 1, 2002, a State may not exercise the op-
16 tion of coverage of individuals under section
17 1902(a)(10)(A)(ii)(V) without providing coverage under
18 section 1902(a)(10)(A)(ii)(VI).

19 “(g) REPORT ON IMPACT OF SECTION.—The Sec-
20 retary shall submit to Congress periodic reports on the
21 impact of this section on beneficiaries, States, and the
22 Federal Government.”.

23 (c) INCLUSION IN OPTIONAL ELIGIBILITY CLASSI-
24 FICATION.—Section 1902(a)(10)(A)(ii)(VI) of the Social
25 Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is

1 amended by inserting “or community attendant services
2 and supports described in section 1935” after “section
3 1915” each place such term appears.

4 (d) COVERAGE AS MEDICAL ASSISTANCE.—

5 (1) IN GENERAL.—Section 1905(a) of the So-
6 cial Security Act (42 U.S.C. 1396d) is amended—

7 (A) by striking “and” at the end of para-
8 graph (26);

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

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

13 “(27) community attendant services and sup-
14 ports (to the extent allowed and as defined in section
15 1935); and”.

16 (2) CONFORMING AMENDMENT.—Section
17 1902(a)(10)(C)(iv) of the Social Security Act (42
18 U.S.C. 1396a(a)(10)(C)(iv)) is amended by inserting
19 “and (27)” after “(24)”.

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

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

3 (a) ESTABLISHMENT.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (referred to in this section as the
6 “Secretary”) shall award grants described in sub-
7 section (b) to States for a fiscal year to support real
8 choice systems change initiatives that establish spe-
9 cific action steps and specific timetables to provide
10 consumer-responsive long term services and supports
11 to eligible individuals in the most integrated setting
12 appropriate based on the unique strengths and needs
13 of the individual and the priorities and concerns of
14 the individual (or, as appropriate, the individual’s
15 representative).

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

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

20 (B) submit an application at such time, in
21 such manner, and containing such information
22 as the Secretary may determine. The applica-
23 tion shall be jointly developed and signed by the
24 designated State official and the chairperson of
25 such Task Force, acting on behalf of and at the
26 direction of the Task Force.

1 (3) DEFINITION OF STATE.—In this section,
2 the term “State” means each of the 50 States, the
3 District of Columbia, Puerto Rico, Guam, the
4 United States Virgin Islands, American Samoa, and
5 the Commonwealth of the Northern Mariana Is-
6 lands.

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

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

12 (A) support the establishment, implemen-
13 tation, and operation of the State real choice
14 systems change initiatives described in sub-
15 section (a); and

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

18 (2) DETERMINATION OF AWARDS; STATE AL-
19 LOTMENTS.—The Secretary shall develop a formula
20 for the distribution of funds to States for each fiscal
21 year under subsection (a). Such formula shall give
22 preference to States that have a relatively higher
23 proportion of long-term services and supports fur-
24 nished to individuals in an institutional setting but

1 who have a plan described in an application sub-
2 mitted under subsection (a)(2).

3 (c) AUTHORIZED ACTIVITIES.—A State that receives
4 a grant under this section shall use the funds made avail-
5 able through the grant to accomplish the purposes de-
6 scribed in subsection (a) and, in accomplishing such pur-
7 poses, may carry out any of the following systems change
8 activities:

9 (1) NEEDS ASSESSMENT AND DATA GATH-
10 ERING.—The State may use funds to conduct a
11 statewide needs assessment that may be based on
12 data in existence on the date on which the assess-
13 ment is initiated and may include information about
14 the number of individuals within the State who are
15 receiving long-term services and supports in unnec-
16 essarily segregated settings, the nature and extent to
17 which current programs respond to the preferences
18 of individuals with disabilities to receive services in
19 home and community-based settings as well as in in-
20 stitutional settings, and the expected change in de-
21 mand for services provided in home and community
22 settings as well as institutional settings.

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

1 unnecessarily bias the provision of long-term services
2 and supports toward institutional settings and away
3 from home and community-based settings, including
4 policies, practices, and procedures governing
5 statewideness, comparability in amount, duration,
6 and scope of services, financial eligibility, individual-
7 ized functional assessments and screenings (includ-
8 ing individual and family involvement), and knowl-
9 edge about service options.

10 (3) OVER MEDICALIZATION OF SERVICES.—The
11 State may use funds to identify, develop, and imple-
12 ment strategies for modifying policies, practices, and
13 procedures that unnecessarily bias the provision of
14 long-term services and supports by health care pro-
15 fessionals to the extent that quality services and
16 supports can be provided by other qualified individ-
17 uals, including policies, practices, and procedures
18 governing service authorization, case management,
19 and service coordination, service delivery options,
20 quality controls, and supervision and training.

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

1 convening of interagency work groups and the enter-
2 ing into of interagency agreements that provide for
3 a single point of entry and the design and implemen-
4 tation of a coordinated screening and assessment
5 system for all persons eligible for long-term services
6 and supports.

7 (5) TRAINING AND TECHNICAL ASSISTANCE.—

8 The State may carry out directly, or may provide
9 support to a public or private entity to carry out
10 training and technical assistance activities that are
11 provided for individuals with disabilities, and, as ap-
12 propriate, their representatives, attendants, and
13 other personnel (including professionals, paraprofes-
14 sionals, volunteers, and other members of the com-
15 munity).

16 (6) PUBLIC AWARENESS.—The State may sup-

17 port a public awareness program that is designed to
18 provide information relating to the availability of
19 choices available to individuals with disabilities for
20 receiving long-term services and support in the most
21 integrated setting appropriate.

22 (7) DOWNSIZING OF LARGE INSTITUTIONS.—

23 The State may use funds to support the per capita
24 increased fixed costs in institutional settings directly
25 related to the movement of individuals with disabil-

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

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

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

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

15 (11) OTHER ACTIVITIES.—The State may use
16 funds for any systems change activities that are not
17 described in any of the preceding paragraphs of this
18 subsection and that are necessary for developing, im-
19 plementing, or evaluating the comprehensive state-
20 wide system of long term services and supports.

21 (d) CONSUMER TASK FORCE.—

22 (1) ESTABLISHMENT AND DUTIES.—To be eli-
23 gible to receive a grant under this section, each
24 State shall establish a Consumer Task Force (re-
25 ferred to in this section as the “Task Force”) to as-

1 sist the State in the development, implementation,
2 and evaluation of real choice systems change initia-
3 tives.

4 (2) APPOINTMENT.—Members of the Task
5 Force shall be appointed by the Chief Executive Of-
6 ficer of the State in accordance with the require-
7 ments of paragraph (3), after the solicitation of rec-
8 ommendations from representatives of organizations
9 representing a broad range of individuals with dis-
10 abilities and organizations interested in individuals
11 with disabilities.

12 (3) COMPOSITION.—

13 (A) IN GENERAL.—The Task Force shall
14 represent a broad range of individuals with dis-
15 abilities from diverse backgrounds and shall in-
16 clude representatives from Developmental Dis-
17 abilities Councils, State Independent Living
18 Councils, Commissions on Aging, organizations
19 that provide services to individuals with disabil-
20 ities and consumers of long-term services and
21 supports.

22 (B) INDIVIDUALS WITH DISABILITIES.—A
23 majority of the members of the Task Force
24 shall be individuals with disabilities or the rep-
25 resentatives of such individuals.

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

7 (e) AVAILABILITY OF FUNDS.—

8 (1) FUNDS ALLOTTED TO STATES.—Funds al-
9 lotted to a State under a grant made under this sec-
10 tion for a fiscal year shall remain available until ex-
11 pended.

12 (2) FUNDS NOT ALLOTTED TO STATES.—Funds
13 not allotted to States in the fiscal year for which
14 they are appropriated shall remain available in suc-
15 ceeding fiscal years for allotment by the Secretary
16 using the allotment formula established by the Sec-
17 retary under subsection (b)(2).

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

1 ant services and supports and other community-based set-
 2 tings.

3 (g) APPROPRIATION.—Out of any funds in the Treas-
 4 ury not otherwise appropriated, there is authorized to be
 5 appropriated and there is appropriated to make grants
 6 under this section for—

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

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

11 **SEC. 303. STATE OPTION FOR ELIGIBILITY FOR INDIVID-**
 12 **UALS.**

13 (a) IN GENERAL.—Section 1903(f) of the Social Se-
 14 curity Act (42 U.S.C. 1396b(f)) is amended—

15 (1) in paragraph (4)(C), by inserting “subject
 16 to paragraph (5),” after “does not exceed”, and

17 (2) by adding at the end the following:

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

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

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

4 (b) EFFECTIVE DATE.—The amendments made by
5 subsection (a) shall apply to medical assistance provided
6 for community attendant services and supports described
7 in section 1935 of the Social Security Act, as added by
8 section 301(b) of this Act, furnished on or after October
9 1, 2001.

10 **SEC. 304. STUDIES AND REPORTS.**

11 (a) REVIEW OF, AND REPORT ON, REGULATIONS.—
12 The National Council on Disability established under title
13 IV of the Rehabilitation Act of 1973 (29 U.S.C. 780 et
14 seq.) shall review regulations in existence under title XIX
15 of the Social Security Act (42 U.S.C. 1396 et seq.) on
16 the date of enactment of this Act insofar as such regula-
17 tions regulate the provision of home health services, per-
18 sonal care services, and other services in home and com-
19 munity-based settings and, not later than 1 year after
20 such date, submit a report to Congress on the results of
21 such study, together with any recommendations for legis-
22 lation that the Council determines to be appropriate as
23 a result of the study.

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

1 ment of this Act, the Secretary of Health and Human
 2 Services shall submit to Congress a report on how expendi-
 3 tures under the medicaid program under title XIX of the
 4 Social Security Act (42 U.S.C. 1396 et seq.) can be re-
 5 duced by the furnishing of community attendant services
 6 and supports in accordance with section 1935 of the Social
 7 Security Act (as added by section 301(b) of this Act).

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

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

16 **TITLE IV—HEALTH CARE**
 17 **INSURANCE COVERAGE**
 18 **Subtitle A—General Provisions**

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

21 (a) IN GENERAL.—Part 7 of subtitle B of title I of
 22 the Employee Retirement Income Security Act of 1974
 23 (29 U.S.C. 1181 et seq.) is amended—

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

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

2 “SUBPART C—GENERAL INSURANCE COVERAGE

3 REFORMS

4 **“CHAPTER 1—INCREASED AVAILABILITY AND**

5 **CONTINUITY OF HEALTH COVERAGE**

6 **“SEC. 721. DEFINITION.**

7 “As used in this subpart, the term ‘qualified group
8 health plan’ means a group health plan, and a health in-
9 surance issuer offering group health insurance coverage,
10 that is designed to provide standard coverage (consistent
11 with section 721A(b)).

12 **“SEC. 721A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**
13 **MITTED.**

14 “(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—

15 “(1) INITIAL DETERMINATION.—The NAIC is
16 requested to submit to the Secretary, within 6
17 months after the date of the enactment of this sub-
18 part, a set of rules which the NAIC determines is
19 sufficient for determining, in the case of any group
20 health plan, or a health insurance issuer offering
21 group health insurance coverage, and for purposes of
22 this section, the actuarial value of the coverage of-
23 fered by the plan or coverage.

24 “(2) CERTIFICATION.—If the Secretary deter-
25 mines that the NAIC has submitted a set of rules

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

8 “(b) STANDARD COVERAGE.—

9 “(1) IN GENERAL.—A group health plan, and a
10 health insurance issuer offering group health insur-
11 ance coverage, shall be considered to provide stand-
12 ard coverage consistent with this subsection if the
13 benefits are determined, in accordance with the set
14 of actuarial equivalence rules certified under sub-
15 section (a), to have a value that is within 5 percent-
16 age points of the target actuarial value for standard
17 coverage established under paragraph (2).

18 “(2) INITIAL DETERMINATION OF TARGET AC-
19 TUARIAL VALUE FOR STANDARD COVERAGE.—

20 “(A) INITIAL DETERMINATION.—

21 “(i) IN GENERAL.—The NAIC is re-
22 quested to submit to the Secretary, within
23 6 months after the date of the enactment
24 of this subpart, a target actuarial value for
25 standard coverage equal to the average ac-

1 tuarial value of the coverage described in
2 clause (ii). No specific procedure or treat-
3 ment, or classes thereof, is required to be
4 considered in such determination by this
5 subpart or through regulations. The deter-
6 mination of such value shall be based on a
7 representative distribution of the popu-
8 lation of eligible employees offered such
9 coverage and a single set of standardized
10 utilization and cost factors.

11 “(ii) COVERAGE DESCRIBED.—The
12 coverage described in this clause is cov-
13 erage for medically necessary and appro-
14 priate services consisting of medical and
15 surgical services, medical equipment, pre-
16 ventive services, and emergency transpor-
17 tation in frontier areas. No specific proce-
18 dure or treatment, or classes thereof, is re-
19 quired to be covered in such a plan, by this
20 subpart or through regulations.

21 “(B) CERTIFICATION.—If the Secretary
22 determines that the NAIC has submitted a tar-
23 get actuarial value for standard coverage that
24 complies with the requirements of subparagraph
25 (A), the Secretary shall certify such value for

1 use under this chapter. If the Secretary deter-
2 mines that a target actuarial value has not been
3 submitted or does not comply with the require-
4 ments of subparagraph (A), the Secretary shall
5 promptly determine a target actuarial value
6 that meets such requirements.

7 “(c) SUBSEQUENT REVISIONS.—

8 “(1) NAIC.—The NAIC may submit from time
9 to time to the Secretary revisions of the set of rules
10 of actuarial equivalence and target actuarial values
11 previously established or determined under this sec-
12 tion if the NAIC determines that revisions are nec-
13 essary to take into account changes in the relevant
14 types of health benefits provisions or in demographic
15 conditions which form the basis for the set of rules
16 of actuarial equivalence or the target actuarial val-
17 ues. The provisions of subsection (a)(2) shall apply
18 to such a revision in the same manner as they apply
19 to the initial determination of the set of rules.

20 “(2) SECRETARY.—The Secretary may by regu-
21 lation revise the set of rules of actuarial equivalence
22 and target actuarial values from time to time if the
23 Secretary determines such revisions are necessary to
24 take into account changes described in paragraph
25 (1).

1 **“SEC. 721B. ESTABLISHMENT OF PLAN STANDARDS.**

2 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

3 “(1) ROLE OF NAIC.—The NAIC is requested
4 to submit to the Secretary, within 9 months after
5 the date of the enactment of this subpart, model
6 regulations that specify standards for making quali-
7 fied group health plans available to small employers.
8 If the NAIC develops recommended regulations
9 specifying such standards within such period, the
10 Secretary shall review the standards. Such review
11 shall be completed within 60 days after the date the
12 regulations are developed. Such standards shall
13 serve as the standards under this section, with such
14 amendments as the Secretary deems necessary. Such
15 standards shall be nonbinding (except as provided in
16 chapter 4).

17 “(2) CONTINGENCY.—If the NAIC does not de-
18 velop such model regulations within the period de-
19 scribed in paragraph (1), the Secretary shall specify,
20 within 15 months after the date of the enactment of
21 this subpart, model regulations that specify stand-
22 ards for insurers with regard to making qualified
23 group health plans available to small employers.
24 Such standards shall be nonbinding (except as pro-
25 vided in chapter 4).

1 gible individuals for the standard coverage (as de-
2 fined under section 721A(b)).

3 “(2) ESTABLISHMENT OF COMMUNITY RATING
4 AREA.—

5 “(A) IN GENERAL.—Not later than Janu-
6 ary 1, 2002, each State shall, in accordance
7 with subparagraph (B), provide for the division
8 of the State into 1 or more community rating
9 areas. The State may revise the boundaries of
10 such areas from time to time consistent with
11 this paragraph.

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

14 “(i) may not identify an area that di-
15 vides a 3-digit zip code, a county, or all
16 portions of a metropolitan statistical area;

17 “(ii) shall not permit premium rates
18 for coverage offered in a portion of an
19 interstate metropolitan statistical area to
20 vary based on the State in which the cov-
21 erage is offered; and

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

1 “(3) ELIGIBLE INDIVIDUALS.—For purposes of
2 this section, the term ‘eligible individuals’ includes
3 certain uninsured individuals (as described in section
4 721G).

5 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
6 ING AREAS.—

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

15 “(2) APPLICATION TO ENROLLEES.—

16 “(A) IN GENERAL.—The premium charged
17 for coverage in a group health plan which cov-
18 ers eligible employees and eligible individuals
19 shall be the product of—

20 “(i) the standard premium (estab-
21 lished under paragraph (1));

22 “(ii) in the case of enrollment other
23 than individual enrollment, the family ad-
24 justment factor specified under subpara-
25 graph (B); and

1 “(iii) the age adjustment factor (spec-
2 fied under subparagraph (C)).

3 “(B) FAMILY ADJUSTMENT FACTOR.—

4 “(i) IN GENERAL.—The standards es-
5 tablished under section 721B shall specify
6 family adjustment factors that reflect the
7 relative actuarial costs of benefit packages
8 based on family classes of enrollment (as
9 compared with such costs for individual en-
10 rollment).

11 “(ii) CLASSES OF ENROLLMENT.—For
12 purposes of this subpart, there are 4 class-
13 es of enrollment:

14 “(I) Coverage only of an indi-
15 vidual (referred to in this subpart as
16 the ‘individual’ enrollment or class of
17 enrollment).

18 “(II) Coverage of a married cou-
19 ple without children (referred to in
20 this subpart as the ‘couple-only’ en-
21 rollment or class of enrollment).

22 “(III) Coverage of an individual
23 and one or more children (referred to
24 in this subpart as the ‘single parent’
25 enrollment or class of enrollment).

1 “(IV) Coverage of a married cou-
 2 ple and one or more children (referred
 3 to in this subpart as the ‘dual parent’
 4 enrollment or class of enrollment).

5 “(iii) REFERENCES TO FAMILY AND
 6 COUPLE CLASSES OF ENROLLMENT.—In
 7 this subpart:

8 “(I) FAMILY.—The terms ‘family
 9 enrollment’ and ‘family class of enroll-
 10 ment’ refer to enrollment in a class of
 11 enrollment described in any subclause
 12 of clause (ii) (other than subclause
 13 (I)).

14 “(II) COUPLE.—The term ‘couple
 15 class of enrollment’ refers to enroll-
 16 ment in a class of enrollment de-
 17 scribed in subclause (II) or (IV) of
 18 clause (ii).

19 “(iv) SPOUSE; MARRIED; COUPLE.—

20 “(I) IN GENERAL.—In this sub-
 21 part, the terms ‘spouse’ and ‘married’
 22 mean, with respect to an individual,
 23 another individual who is the spouse
 24 of, or is married to, the individual, as

1 determined under applicable State
2 law.

3 “(II) COUPLE.—The term ‘cou-
4 ple’ means an individual and the indi-
5 vidual’s spouse.

6 “(C) AGE ADJUSTMENT FACTOR.—The
7 Secretary, in consultation with the NAIC, shall
8 specify uniform age categories and maximum
9 rating increments for age adjustment factors
10 that reflect the relative actuarial costs of ben-
11 efit packages among enrollees. For individuals
12 who have attained age 18 but not age 65, the
13 highest age adjustment factor may not exceed 3
14 times the lowest age adjustment factor.

15 “(3) ADMINISTRATIVE CHARGES.—

16 “(A) IN GENERAL.—In accordance with
17 the standards established under section 721B, a
18 group health plan which covers eligible employ-
19 ees and eligible individuals may add a sepa-
20 rately-stated administrative charge which is
21 based on identifiable differences in legitimate
22 administrative costs and which is applied uni-
23 formly for individuals enrolling through the
24 same method of enrollment. Nothing in this
25 subparagraph may be construed as preventing a

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

4 “(B) ENROLLMENT THROUGH A QUALI-
5 FIED SMALL EMPLOYER PURCHASING GROUP.—
6 In the case of an administrative charge under
7 subparagraph (A) for enrollment through a
8 qualified small employer purchasing group, such
9 charge may not exceed the lowest charge of
10 such plan for enrollment other than through a
11 qualified small employer purchasing group in
12 such area.

13 “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-
14 NITY RATE.—Notwithstanding any other provision of this
15 section, a group health plan and a health insurance issuer
16 offering health insurance coverage that negotiates a pre-
17 mium rate (exclusive of any administrative charge de-
18 scribed in subsection (b)(3)) with a qualified small em-
19 ployer purchasing group in a community rating area shall
20 charge the same premium rate to all eligible employees
21 and eligible individuals.

22 **“SEC. 721D. RATING PRACTICES AND PAYMENT OF PRE-
23 MIUMS.**

24 “(a) FULL DISCLOSURE OF RATING PRACTICES.—

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

5 “(2) NOTICE ON EXPIRATION.—A group health
6 plan and a health insurance issuer offering health
7 insurance coverage shall provide for notice of the
8 terms for renewal of a plan at the time of the offer-
9 ing of the plan and at least 90 days before the date
10 of expiration of the plan.

11 “(3) ACTUARIAL CERTIFICATION.—Each group
12 health plan and health insurance issuer offering
13 health insurance coverage shall file annually with the
14 appropriate certifying authority a written statement
15 by a member of the American Academy of Actuaries
16 (or other individual acceptable to such authority)
17 who is not an employee of the group health plan or
18 issuer certifying that, based upon an examination by
19 the individual which includes a review of the appro-
20 priate records and of the actuarial assumptions of
21 such plan or insurer and methods used by the plan
22 or insurer in establishing premium rates and admin-
23 istrative charges for group health plans—

1 “(A) such plan or insurer is in compliance
2 with the applicable provisions of this subpart;
3 and

4 “(B) the rating methods are actuarially
5 sound.

6 Each plan and insurer shall retain a copy of such
7 statement at its principal place of business for exam-
8 ination by any individual.

9 “(b) PAYMENT OF PREMIUMS.—

10 “(1) IN GENERAL.—With respect to a new en-
11 rollee in a group health plan, the plan may require
12 advanced payment of an amount equal to the month-
13 ly applicable premium for the plan at the time such
14 individual is enrolled.

15 “(2) NOTIFICATION OF FAILURE TO RECEIVE
16 PREMIUM.—If a group health plan or a health insur-
17 ance issuer offering health insurance coverage fails
18 to receive payment on a premium due with respect
19 to an eligible employee or eligible individual covered
20 under the plan involved, the plan or issuer shall pro-
21 vide notice of such failure to the employee or indi-
22 vidual within the 20-day period after the date on
23 which such premium payment was due. A plan or
24 issuer may not terminate the enrollment of an eligi-
25 ble employee or eligible individual unless such em-

1 ployee or individual has been notified of any overdue
2 premiums and has been provided a reasonable op-
3 portunity to respond to such notice.

4 **“SEC. 721E. QUALIFIED SMALL EMPLOYER PURCHASING**
5 **GROUPS.**

6 “(a) QUALIFIED SMALL EMPLOYER PURCHASING
7 GROUPS DESCRIBED.—

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

10 “(A) is a nonprofit entity certified under
11 State law;

12 “(B) has a membership consisting solely of
13 small employers;

14 “(C) is administered solely under the au-
15 thority and control of its member employers;

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

20 “(E) offers a program under which quali-
21 fied group health plans are offered to eligible
22 employees and eligible individuals through its
23 member employers and to certain uninsured in-
24 dividuals in accordance with section 721D; and

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

4 “(i) does not form or underwrite; and
5 “(ii) does not hold or control any
6 right to vote with respect to.

7 “(2) STATE CERTIFICATION.—A qualified small
8 employer purchasing group formed under this sec-
9 tion shall submit an application to the State for cer-
10 tification. The State shall determine whether to
11 issue a certification and otherwise ensure compliance
12 with the requirements of this subpart.

13 “(3) SPECIAL RULE.—Notwithstanding para-
14 graph (1)(B), an employer member of a small em-
15 ployer purchasing group that has been certified by
16 the State as meeting the requirements of paragraph
17 (1) may retain its membership in the group if the
18 number of employees of the employer increases such
19 that the employer is no longer a small employer.

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

1 “(c) DOMICILIARY STATE.—For purposes of this sec-
2 tion, a qualified small employer purchasing group oper-
3 ating in more than one State shall be certified by the State
4 in which the group is domiciled.

5 “(d) MEMBERSHIP.—

6 “(1) IN GENERAL.—A qualified small employer
7 purchasing group shall accept all small employers
8 and certain uninsured individuals residing within the
9 area served by the group as members if such em-
10 ployers or individuals request such membership.

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

14 “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-
15 CHASING GROUPS.—Each qualified small employer pur-
16 chasing group shall—

17 “(1) enter into agreements with insurers offer-
18 ing qualified group health plans;

19 “(2) enter into agreements with small employ-
20 ers under section 721F;

21 “(3) enroll only eligible employees, eligible indi-
22 viduals, and certain uninsured individuals in quali-
23 fied group health plans, in accordance with section
24 721G;

25 “(4) provide enrollee information to the State;

1 “(5) meet the marketing requirements under
2 section 721I; and

3 “(6) carry out other functions provided for
4 under this subpart.

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

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

9 “(2) perform any activity (other than the re-
10 porting of noncompliance) relating to compliance of
11 qualified group health plans with the requirements
12 of this subpart;

13 “(3) assume financial risk in relation to any
14 such health plan; or

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

18 “(g) RULES OF CONSTRUCTION.—

19 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-
20 ing in this section shall be construed as requiring—

21 “(A) that a State organize, operate or oth-
22 erwise establish a qualified small employer pur-
23 chasing group, or otherwise require the estab-
24 lishment of purchasing groups; and

1 “(B) that there be only one qualified small
2 employer purchasing group established with re-
3 spect to a community rating area.

4 “(2) SINGLE ORGANIZATION SERVING MUL-
5 TIPLE AREAS AND STATES.—Nothing in this section
6 shall be construed as preventing a single entity from
7 being a qualified small employer purchasing group in
8 more than one community rating area or in more
9 than one State.

10 “(3) VOLUNTARY PARTICIPATION.—Nothing in
11 this section shall be construed as requiring any indi-
12 vidual or small employer to purchase a qualified
13 group health plan exclusively through a qualified
14 small employer purchasing group.

15 **“SEC. 721F. AGREEMENTS WITH SMALL EMPLOYERS.**

16 “(a) IN GENERAL.—A qualified small employer pur-
17 chasing group shall offer to enter into an agreement under
18 this section with each small employer that employs eligible
19 employees in the area served by the group.

20 “(b) PAYROLL DEDUCTION.—

21 “(1) IN GENERAL.—Under an agreement under
22 this section between a small employer and a quali-
23 fied small employer purchasing group, the small em-
24 ployer shall deduct premiums from an eligible em-
25 ployee’s wages.

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

8 **“SEC. 721G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**
9 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**
10 **DIVIDUALS IN QUALIFIED GROUP HEALTH**
11 **PLANS.**

12 “(a) IN GENERAL.—Each qualified small employer
13 purchasing group shall offer—

14 “(1) eligible employees,

15 “(2) eligible individuals, and

16 “(3) certain uninsured individuals,

17 the opportunity to enroll in any qualified group health
18 plan which has an agreement with the qualified small em-
19 ployer purchasing group for the community rating area
20 in which such employees and individuals reside.

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

1 of a qualified small employer purchasing group or a de-
2 pendent of such individual.

3 **“SEC. 721H. RECEIPT OF PREMIUMS.**

4 “(a) ENROLLMENT CHARGE.—The amount charged
5 by a qualified small employer purchasing group for cov-
6 erage under a qualified group health plan shall be equal
7 to the sum of—

8 “(1) the premium rate offered by such health
9 plan;

10 “(2) the administrative charge for such health
11 plan; and

12 “(3) the purchasing group administrative
13 charge for enrollment of eligible employees, eligible
14 individuals and certain uninsured individuals
15 through the group.

16 “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-
17 ISTRATIVE CHARGES.—Each qualified small employer
18 purchasing group shall, prior to the time of enrollment,
19 disclose to enrollees and other interested parties the pre-
20 mium rate for a qualified group health plan, the adminis-
21 trative charge for such plan, and the administrative charge
22 of the group, separately.

23 **“SEC. 721I. MARKETING ACTIVITIES.**

24 “Each qualified small employer purchasing group
25 shall market qualified group health plans to members

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

3 **“SEC. 721J. GRANTS TO STATES AND QUALIFIED SMALL EM-**
4 **PLOYER PURCHASING GROUPS.**

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

9 “(b) APPLICATION REQUIREMENTS.—To be eligible
10 to receive a grant under this section, a State or small em-
11 ployer purchasing group shall prepare and submit to the
12 Secretary an application in such form, at such time, and
13 containing such information, certifications, and assur-
14 ances as the Secretary shall reasonably require.

15 “(c) USE OF FUNDS.—Amounts awarded under this
16 section may be used to finance the costs associated with
17 planning, developing, and operating a qualified small em-
18 ployer purchasing group. Such costs may include the costs
19 associated with—

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

23 “(2) soliciting bids and negotiating with insur-
24 ers to make available group health plans;

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

4 “(4) such other activities determined appro-
5 priate by the Secretary.

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

9 **“SEC. 721K. QUALIFIED SMALL EMPLOYER PURCHASING**
10 **GROUPS ESTABLISHED BY A STATE.**

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

16 **“SEC. 721L. EFFECTIVE DATES.**

17 “(a) IN GENERAL.—Except as provided in this chap-
18 ter, the provisions of this chapter are effective on the date
19 of the enactment of this subpart.

20 “(b) EXCEPTION.—The provisions of section 721C(b)
21 shall apply to contracts which are issued, or renewed, after
22 the date which is 18 months after the date of the enact-
23 ment of this subpart.

1 **“CHAPTER 2—REQUIRED COVERAGE OPTIONS**
2 **FOR ELIGIBLE EMPLOYEES AND DEPEND-**
3 **ENTS OF SMALL EMPLOYERS**

4 **“SEC. 722. REQUIRING SMALL EMPLOYERS TO OFFER COV-**
5 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

6 “(a) REQUIREMENT TO OFFER.—Each small em-
7 ployer shall make available with respect to each eligible
8 employee a group health plan under which—

9 “(1) coverage of each eligible individual with re-
10 spect to such an eligible employee may be elected on
11 an annual basis for each plan year;

12 “(2) coverage is provided for at least the stand-
13 ard coverage specified in section 721A(b); and

14 “(3) each eligible employee electing such cov-
15 erage may elect to have any premiums owed by the
16 employee collected through payroll deduction.

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

21 “(c) SPECIAL RULES.—

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

1 “(A) such employer (including any prede-
2 cessor thereof) has been an employer for less
3 than 2 years;

4 “(B) such employer has no more than 2 el-
5 igible employees; or

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

8 “(2) EXCLUSION OF FAMILY MEMBERS.—Under
9 such procedures as the Secretary may prescribe, any
10 relative of a small employer may be, at the election
11 of the employer, excluded from consideration as an
12 eligible employee for purposes of applying the re-
13 quirements of subsection (a). In the case of a small
14 employer that is not an individual, an employee who
15 is a relative of a key employee (as defined in section
16 416(i)(1) of the Internal Revenue Code of 1986) of
17 the employer may, at the election of the key em-
18 ployee, be considered a relative excludable under this
19 paragraph.

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

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

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

7 **“SEC. 722A. COMPLIANCE WITH APPLICABLE REQUIRE-**
8 **MENTS THROUGH MULTIPLE EMPLOYER**
9 **HEALTH ARRANGEMENTS.**

10 “(a) IN GENERAL.—In any case in which an eligible
11 employee is, for any plan year, a participant in a group
12 health plan which is a multiemployer plan, the require-
13 ments of section 722(a) shall be deemed to be met with
14 respect to such employee for such plan year if the em-
15 ployer requirements of subsection (b) are met with respect
16 to the eligible employee, irrespective of whether, or to what
17 extent, the employer makes employer contributions on be-
18 half of the eligible employee.

19 “(b) EMPLOYER REQUIREMENTS.—The employer re-
20 quirements of this subsection are met under a group
21 health plan with respect to an eligible employee if—

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

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

3 “(2) coverage is provided for at least the stand-
 4 ard coverage specified in section 721A(b);

5 “(3) the employer facilitates collection of any
 6 employee contributions under the plan and permits
 7 the employee to elect to have employee contributions
 8 under the plan collected through payroll deduction;
 9 and

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

16 **“CHAPTER 3—REQUIRED COVERAGE OPTIONS**
 17 **FOR INDIVIDUALS INSURED THROUGH ASSO-**
 18 **CIATION PLANS**

19 **“Subchapter A—Qualified Association Plans**

20 **“SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION**
 21 **PLANS.**

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

24 “(1) except as otherwise provided in this sub-
 25 chapter, the plan shall meet all applicable require-

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

3 “(2) if such plan is certified as meeting such
4 requirements and the requirements of this sub-
5 chapter, such plan shall be treated as a plan estab-
6 lished and maintained by a small employer, and indi-
7 viduals enrolled in such plan shall be treated as eli-
8 gible employees; and

9 “(3) any individual who is a member of the as-
10 sociation not enrolling in the plan shall not be treat-
11 ed as an eligible employee solely by reason of mem-
12 bership in such association.

13 “(b) ELECTION TO BE TREATED AS PURCHASING
14 COOPERATIVE.—Subsection (a) shall not apply to a quali-
15 fied association plan if—

16 “(1) the health insurance issuer makes an irrev-
17 ocable election to be treated as a qualified small em-
18 ployer purchasing group for purposes of section
19 721D; and

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

22 **“SEC. 723A. QUALIFIED ASSOCIATION PLAN DEFINED.**

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

1 tiple employer welfare arrangement or similar
2 arrangement—

3 “(1) which is maintained by a qualified associa-
4 tion;

5 “(2) which has at least 500 participants in the
6 United States;

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

10 “(4) which may not condition participation in
11 the plan, or terminate coverage under the plan, on
12 the basis of the health status or health claims expe-
13 rience of any employee or member or dependent of
14 either;

15 “(5) which provides for bonding, in accordance
16 with regulations providing rules similar to the rules
17 under section 412, of all persons operating or ad-
18 ministering the plan or involved in the financial af-
19 fairs of the plan; and

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

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

1 514(b)(6)(D)), the plan shall be treated as a qualified as-
2 sociation plan only if—

3 “(1) the plan meets minimum financial solvency
4 and cash reserve requirements for claims which are
5 established by the Secretary and which shall be in
6 lieu of any other such requirements under this chap-
7 ter;

8 “(2) the plan provides an annual funding report
9 (certified by an independent actuary) and annual fi-
10 nancial statements to the Secretary and other inter-
11 ested parties; and

12 “(3) the plan appoints a plan sponsor who is
13 responsible for operating the plan and ensuring com-
14 pliance with applicable Federal and State laws.

15 “(c) CERTIFICATION.—

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

23 “(2) FEE.—The Secretary shall require a
24 \$5,000 fee for the original certification under para-
25 graph (1) and may charge a reasonable annual fee

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

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

6 “(4) AGREEMENTS.—The Secretary of Labor
7 may enter into agreements with the States to carry
8 out the Secretary’s responsibilities under this sub-
9 chapter.

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

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

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

20 “(2) no original certification shall be required
21 under this subchapter; and

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

1 **“SEC. 723B. DEFINITIONS AND SPECIAL RULES.**

2 “(a) QUALIFIED ASSOCIATION.—For purposes of this
3 subchapter, the term ‘qualified association’ means any or-
4 ganization which—

5 “(1) is organized and maintained in good faith
6 by a trade association, an industry association, a
7 professional association, a chamber of commerce, a
8 religious organization, a public entity association, or
9 other business association serving a common or simi-
10 lar industry;

11 “(2) is organized and maintained for substan-
12 tial purposes other than to provide a health plan;

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

15 “(4) receives a substantial portion of its finan-
16 cial support from its active, affiliated, or federation
17 members.

18 “(b) COORDINATION.—The term ‘qualified associa-
19 tion plan’ shall not include a plan to which subchapter
20 B applies.

1 **“Subchapter B—Special Rule for Church,**
2 **Multiemployer, and Cooperative Plans**

3 **“SEC. 723F. SPECIAL RULE FOR CHURCH, MULTIEM-**
4 **PLOYER, AND COOPERATIVE PLANS.**

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

8 “(1) except as otherwise provided in this sub-
9 chapter, the plan shall be required to meet all appli-
10 cable requirements of chapter 1 and chapter 2 for
11 group health plans offered to and by small employ-
12 ers;

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

18 “(3) any individual eligible to enroll in the plan
19 who does not enroll in the plan shall not be treated
20 as an eligible employee solely by reason of being eli-
21 gible to enroll in the plan.

22 “(b) MODIFIED STANDARDS.—

23 “(1) CERTIFYING AUTHORITY.—For purposes
24 of this chapter, the Secretary shall be the appro-
25 priate certifying authority with respect to a plan to
26 which this section applies.

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

4 “(3) ACCESS.—An employer which, pursuant to
5 a collective bargaining agreement, offers an em-
6 ployee the opportunity to enroll in a plan described
7 in subsection (c)(2) shall not be required to make
8 any other plan available to the employee.

9 “(4) TREATMENT UNDER STATE LAWS.—A
10 church plan described in subsection (c)(1) which is
11 certified as meeting the requirements of this section
12 shall not be deemed to be a multiple employer wel-
13 fare arrangement or an insurance company or other
14 insurer, or to be engaged in the business of insur-
15 ance, for purposes of any State law purporting to
16 regulate insurance companies or insurance contracts.

17 “(c) PLANS TO WHICH SECTION APPLIES.—This sec-
18 tion shall apply to a health plan which—

19 “(1) is a church plan (as defined in section
20 414(e) of the Internal Revenue Code of 1986) which
21 has at least 100 participants in the United States;

22 “(2) is a multiemployer plan which is main-
23 tained by a health plan sponsor described in section
24 3(16)(B)(iii) and which has at least 500 participants
25 in the United States; or

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

5 (b) CONFORMING AMENDMENTS.—Section 731(d) of
6 the Employee Retirement Income Security Act of 1974
7 (29 U.S.C. 1186(d)) is amended by adding at the end the
8 following:

9 “(3) ELIGIBLE EMPLOYEE.—The term ‘eligible
10 employee’ means, with respect to an employer, an
11 employee who normally performs on a monthly basis
12 at least 30 hours of service per week for that em-
13 ployer.

14 “(4) ELIGIBLE INDIVIDUAL.—The term ‘eligible
15 individual’ means, with respect to an eligible em-
16 ployee, such employee, and any dependent of such
17 employee.

18 “(5) NAIC.—The term ‘NAIC’ means the Na-
19 tional Association of Insurance Commissioners.

20 “(6) QUALIFIED GROUP HEALTH PLAN.—The
21 term ‘qualified group health plan’ shall have the
22 meaning given the term in section 721.”.

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

3 (a) IN GENERAL.—Subpart 2 of part A of title
 4 XXVII of the Public Health Service Act (42 U.S.C.
 5 300gg-4 et seq.) is amended—

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

8 **“CHAPTER 1—MISCELLANEOUS REQUIREMENTS”;**

9 and

10 (2) by adding at the end the following:

11 **“CHAPTER 2—GENERAL INSURANCE COVERAGE**
 12 **REFORMS**

13 **“Subchapter A—Increased Availability and**
 14 **Continuity of Health Coverage**

15 **“SEC. 2707. DEFINITION.**

16 “As used in this chapter, the term ‘qualified group
 17 health plan’ means a group health plan, and a health in-
 18 surance issuer offering group health insurance coverage,
 19 that is designed to provide standard coverage (consistent
 20 with section 2707A(b)).

21 **“SEC. 2707A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**
 22 **MITTED.**

23 **“(a) SET OF RULES OF ACTUARIAL EQUIVALENCE.—**

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

1 ter, a set of rules which the NAIC determines is suf-
2 ficient for determining, in the case of any group
3 health plan, or a health insurance issuer offering
4 group health insurance coverage, and for purposes of
5 this section, the actuarial value of the coverage of-
6 fered by the plan or coverage.

7 “(2) CERTIFICATION.—If the Secretary deter-
8 mines that the NAIC has submitted a set of rules
9 that comply with the requirements of paragraph (1),
10 the Secretary shall certify such set of rules for use
11 under this chapter. If the Secretary determines that
12 such a set of rules has not been submitted or does
13 not comply with such requirements, the Secretary
14 shall promptly establish a set of rules that meets
15 such requirements.

16 “(b) STANDARD COVERAGE.—

17 “(1) IN GENERAL.—A a group health plan, and
18 a health insurance issuer offering group health in-
19 surance coverage, shall be considered to provide
20 standard coverage consistent with this subsection if
21 the benefits are determined, in accordance with the
22 set of actuarial equivalence rules certified under sub-
23 section (a), to have a value that is within 5 percent-
24 age points of the target actuarial value for standard
25 coverage established under paragraph (2).

1 “(2) INITIAL DETERMINATION OF TARGET AC-
2 TUARIAL VALUE FOR STANDARD COVERAGE.—

3 “(A) INITIAL DETERMINATION.—

4 “(i) IN GENERAL.—The NAIC is re-
5 quested to submit to the Secretary, within
6 6 months after the date of the enactment
7 of this chapter, a target actuarial value for
8 standard coverage equal to the average ac-
9 tuarial value of the coverage described in
10 clause (ii). No specific procedure or treat-
11 ment, or classes thereof, is required to be
12 considered in such determination by this
13 chapter or through regulations. The deter-
14 mination of such value shall be based on a
15 representative distribution of the popu-
16 lation of eligible employees offered such
17 coverage and a single set of standardized
18 utilization and cost factors.

19 “(ii) COVERAGE DESCRIBED.—The
20 coverage described in this clause is cov-
21 erage for medically necessary and appro-
22 priate services consisting of medical and
23 surgical services, medical equipment, pre-
24 ventive services, and emergency transpor-
25 tation in frontier areas. No specific proce-

1 dure or treatment, or classes thereof, is re-
2 quired to be covered in such a plan, by this
3 chapter or through regulations.

4 “(B) CERTIFICATION.—If the Secretary
5 determines that the NAIC has submitted a tar-
6 get actuarial value for standard coverage that
7 complies with the requirements of subparagraph
8 (A), the Secretary shall certify such value for
9 use under this chapter. If the Secretary deter-
10 mines that a target actuarial value has not been
11 submitted or does not comply with the require-
12 ments of subparagraph (A), the Secretary shall
13 promptly determine a target actuarial value
14 that meets such requirements.

15 “(c) SUBSEQUENT REVISIONS.—

16 “(1) NAIC.—The NAIC may submit from time
17 to time to the Secretary revisions of the set of rules
18 of actuarial equivalence and target actuarial values
19 previously established or determined under this sec-
20 tion if the NAIC determines that revisions are nec-
21 essary to take into account changes in the relevant
22 types of health benefits provisions or in demographic
23 conditions which form the basis for the set of rules
24 of actuarial equivalence or the target actuarial val-
25 ues. The provisions of subsection (a)(2) shall apply

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

3 “(2) SECRETARY.—The Secretary may by regu-
4 lation revise the set of rules of actuarial equivalence
5 and target actuarial values from time to time if the
6 Secretary determines such revisions are necessary to
7 take into account changes described in paragraph
8 (1).

9 **“SEC. 2707B. ESTABLISHMENT OF PLAN STANDARDS.**

10 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

11 “(1) ROLE OF NAIC.—The NAIC is requested
12 to submit to the Secretary, within 9 months after
13 the date of the enactment of this chapter, model reg-
14 ulations that specify standards for making qualified
15 group health plans available to small employers. If
16 the NAIC develops recommended regulations speci-
17 fying such standards within such period, the Sec-
18 retary shall review the standards. Such review shall
19 be completed within 60 days after the date the regu-
20 lations are developed. Such standards shall serve as
21 the standards under this section, with such amend-
22 ments as the Secretary deems necessary. Such
23 standards shall be nonbinding (except as provided in
24 chapter 4).

1 “(2) CONTINGENCY.—If the NAIC does not de-
2 velop such model regulations within the period de-
3 scribed in paragraph (1), the Secretary shall specify,
4 within 15 months after the date of the enactment of
5 this chapter, model regulations that specify stand-
6 ards for insurers with regard to making qualified
7 group health plans available to small employers.
8 Such standards shall be nonbinding (except as pro-
9 vided in chapter 4).

10 “(3) EFFECTIVE DATE.—The standards speci-
11 fied in the model regulations shall apply to group
12 health plans and health insurance issuers offering
13 group health insurance coverage in a State on or
14 after the respective date the standards are imple-
15 mented in the State.

16 “(b) NO PREEMPTION OF STATE LAW.—A State may
17 implement standards for group health plans available, and
18 health insurance issuers offering group health insurance
19 coverage offered, to small employers that are more strin-
20 gent than the standards under this section, except that
21 a State may not implement standards that prevent the of-
22 fering of at least one group health plan that provides
23 standard coverage (as described in section 2707A(b)).

1 **“SEC. 2707C. RATING LIMITATIONS FOR COMMUNITY-**
2 **RATED MARKET.**

3 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-
4 MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-
5 DIVIDUALS.—

6 “(1) IN GENERAL.—Each group health plan of-
7 fered, and each health insurance issuer offering
8 group health insurance coverage, to a small em-
9 ployer shall establish within each community rating
10 area in which the plan is to be offered, a standard
11 premium for enrollment of eligible employees and eli-
12 gible individuals for the standard coverage (as de-
13 fined under section 2707A(b)).

14 “(2) ESTABLISHMENT OF COMMUNITY RATING
15 AREA.—

16 “(A) IN GENERAL.—Not later than Janu-
17 ary 1, 2002, each State shall, in accordance
18 with subparagraph (B), provide for the division
19 of the State into 1 or more community rating
20 areas. The State may revise the boundaries of
21 such areas from time to time consistent with
22 this paragraph.

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

1 “(i) may not identify an area that di-
2 vides a 3-digit zip code, a county, or all
3 portions of a metropolitan statistical area;

4 “(ii) shall not permit premium rates
5 for coverage offered in a portion of an
6 interstate metropolitan statistical area to
7 vary based on the State in which the cov-
8 erage is offered; and

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

13 “(3) ELIGIBLE INDIVIDUALS.—For purposes of
14 this section, the term ‘eligible individuals’ includes
15 certain uninsured individuals (as described in section
16 2707G).

17 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-
18 ING AREAS.—

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

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

3 “(2) APPLICATION TO ENROLLEES.—

4 “(A) IN GENERAL.—The premium charged
5 for coverage in a group health plan which cov-
6 ers eligible employees and eligible individuals
7 shall be the product of—

8 “(i) the standard premium (estab-
9 lished under paragraph (1));

10 “(ii) in the case of enrollment other
11 than individual enrollment, the family ad-
12 justment factor specified under subpara-
13 graph (B); and

14 “(iii) the age adjustment factor (spec-
15 ified under subparagraph (C)).

16 “(B) FAMILY ADJUSTMENT FACTOR.—

17 “(i) IN GENERAL.—The standards es-
18 tablished under section 2707B shall specify
19 family adjustment factors that reflect the
20 relative actuarial costs of benefit packages
21 based on family classes of enrollment (as
22 compared with such costs for individual en-
23 rollment).

1 “(ii) CLASSES OF ENROLLMENT.—For
2 purposes of this chapter, there are 4 class-
3 es of enrollment:

4 “(I) Coverage only of an indi-
5 vidual (referred to in this chapter as
6 the ‘individual’ enrollment or class of
7 enrollment).

8 “(II) Coverage of a married cou-
9 ple without children (referred to in
10 this chapter as the ‘couple-only’ en-
11 rollment or class of enrollment).

12 “(III) Coverage of an individual
13 and one or more children (referred to
14 in this chapter as the ‘single parent’
15 enrollment or class of enrollment).

16 “(IV) Coverage of a married cou-
17 ple and one or more children (referred
18 to in this chapter as the ‘dual parent’
19 enrollment or class of enrollment).

20 “(iii) REFERENCES TO FAMILY AND
21 COUPLE CLASSES OF ENROLLMENT.—In
22 this chapter:

23 “(I) FAMILY.—The terms ‘family
24 enrollment’ and ‘family class of enroll-
25 ment’ refer to enrollment in a class of

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

4 “(II) COUPLE.—The term ‘couple
5 class of enrollment’ refers to enroll-
6 ment in a class of enrollment de-
7 scribed in subclause (II) or (IV) of
8 clause (ii).

9 “(iv) SPOUSE; MARRIED; COUPLE.—

10 “(I) IN GENERAL.—In this chap-
11 ter, the terms ‘spouse’ and ‘married’
12 mean, with respect to an individual,
13 another individual who is the spouse
14 of, or is married to, the individual, as
15 determined under applicable State
16 law.

17 “(II) COUPLE.—The term ‘cou-
18 ple’ means an individual and the indi-
19 vidual’s spouse.

20 “(C) AGE ADJUSTMENT FACTOR.—The
21 Secretary, in consultation with the NAIC, shall
22 specify uniform age categories and maximum
23 rating increments for age adjustment factors
24 that reflect the relative actuarial costs of ben-
25 efit packages among enrollees. For individuals

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

4 “(3) ADMINISTRATIVE CHARGES.—

5 “(A) IN GENERAL.—In accordance with
6 the standards established under section 2707B,
7 a group health plan which covers eligible em-
8 ployees and eligible individuals may add a sepa-
9 rately-stated administrative charge which is
10 based on identifiable differences in legitimate
11 administrative costs and which is applied uni-
12 formly for individuals enrolling through the
13 same method of enrollment. Nothing in this
14 subparagraph may be construed as preventing a
15 qualified small employer purchasing group from
16 negotiating a unique administrative charge with
17 an insurer for a group health plan.

18 “(B) ENROLLMENT THROUGH A QUALI-
19 FIED SMALL EMPLOYER PURCHASING GROUP.—
20 In the case of an administrative charge under
21 subparagraph (A) for enrollment through a
22 qualified small employer purchasing group, such
23 charge may not exceed the lowest charge of
24 such plan for enrollment other than through a

1 qualified small employer purchasing group in
2 such area.

3 “(c) TREATMENT OF NEGOTIATED RATE AS COMMU-
4 NITY RATE.—Notwithstanding any other provision of this
5 section, a group health plan and a health insurance issuer
6 offering health insurance coverage that negotiates a pre-
7 mium rate (exclusive of any administrative charge de-
8 scribed in subsection (b)(3)) with a qualified small em-
9 ployer purchasing group in a community rating area shall
10 charge the same premium rate to all eligible employees
11 and eligible individuals.

12 **“SEC. 2707D. RATING PRACTICES AND PAYMENT OF PRE-
13 MIUMS.**

14 “(a) FULL DISCLOSURE OF RATING PRACTICES.—

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

19 “(2) NOTICE ON EXPIRATION.—A group health
20 plan and a health insurance issuer offering health
21 insurance coverage shall provide for notice of the
22 terms for renewal of a plan at the time of the offer-
23 ing of the plan and at least 90 days before the date
24 of expiration of the plan.

1 “(3) ACTUARIAL CERTIFICATION.—Each group
2 health plan and health insurance issuer offering
3 health insurance coverage shall file annually with the
4 appropriate certifying authority a written statement
5 by a member of the American Academy of Actuaries
6 (or other individual acceptable to such authority)
7 who is not an employee of the group health plan or
8 issuer certifying that, based upon an examination by
9 the individual which includes a review of the appro-
10 priate records and of the actuarial assumptions of
11 such plan or insurer and methods used by the plan
12 or insurer in establishing premium rates and admin-
13 istrative charges for group health plans—

14 “(A) such plan or insurer is in compliance
15 with the applicable provisions of this chapter;
16 and

17 “(B) the rating methods are actuarially
18 sound.

19 Each plan and insurer shall retain a copy of such
20 statement at its principal place of business for exam-
21 ination by any individual.

22 “(b) PAYMENT OF PREMIUMS.—

23 “(1) IN GENERAL.—With respect to a new en-
24 rollee in a group health plan, the plan may require
25 advanced payment of an amount equal to the month-

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

3 “(2) NOTIFICATION OF FAILURE TO RECEIVE
4 PREMIUM.—If a group health plan or a health insur-
5 ance issuer offering health insurance coverage fails
6 to receive payment on a premium due with respect
7 to an eligible employee or eligible individual covered
8 under the plan involved, the plan or issuer shall pro-
9 vide notice of such failure to the employee or indi-
10 vidual within the 20-day period after the date on
11 which such premium payment was due. A plan or
12 issuer may not terminate the enrollment of an eligi-
13 ble employee or eligible individual unless such em-
14 ployee or individual has been notified of any overdue
15 premiums and has been provided a reasonable op-
16 portunity to respond to such notice.

17 **“SEC. 2707E. QUALIFIED SMALL EMPLOYER PURCHASING**
18 **GROUPS.**

19 “(a) QUALIFIED SMALL EMPLOYER PURCHASING
20 GROUPS DESCRIBED.—

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

23 “(A) is a nonprofit entity certified under
24 State law;

1 “(B) has a membership consisting solely of
2 small employers;

3 “(C) is administered solely under the au-
4 thority and control of its member employers;

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

9 “(E) offers a program under which quali-
10 fied group health plans are offered to eligible
11 employees and eligible individuals through its
12 member employers and to certain uninsured in-
13 dividuals in accordance with section 2707D;
14 and

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

18 “(i) does not form or underwrite; and

19 “(ii) does not hold or control any
20 right to vote with respect to.

21 “(2) STATE CERTIFICATION.—A qualified small
22 employer purchasing group formed under this sec-
23 tion shall submit an application to the State for cer-
24 tification. The State shall determine whether to

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

3 “(3) SPECIAL RULE.—Notwithstanding para-
4 graph (1)(B), an employer member of a small em-
5 ployer purchasing group that has been certified by
6 the State as meeting the requirements of paragraph
7 (1) may retain its membership in the group if the
8 number of employees of the employer increases such
9 that the employer is no longer a small employer.

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

15 “(c) DOMICILIARY STATE.—For purposes of this sec-
16 tion, a qualified small employer purchasing group oper-
17 ating in more than one State shall be certified by the State
18 in which the group is domiciled.

19 “(d) MEMBERSHIP.—

20 “(1) IN GENERAL.—A qualified small employer
21 purchasing group shall accept all small employers
22 and certain uninsured individuals residing within the
23 area served by the group as members if such em-
24 ployers or individuals request such membership.

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

4 “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-
5 CHASING GROUPS.—Each qualified small employer pur-
6 chasing group shall—

7 “(1) enter into agreements with insurers offer-
8 ing qualified group health plans;

9 “(2) enter into agreements with small employ-
10 ers under section 2707F;

11 “(3) enroll only eligible employees, eligible indi-
12 viduals, and certain uninsured individuals in quali-
13 fied group health plans, in accordance with section
14 2707G;

15 “(4) provide enrollee information to the State;

16 “(5) meet the marketing requirements under
17 section 2707I; and

18 “(6) carry out other functions provided for
19 under this chapter.

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

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

24 “(2) perform any activity (other than the re-
25 porting of noncompliance) relating to compliance of

1 qualified group health plans with the requirements
2 of this chapter;

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

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

8 “(g) RULES OF CONSTRUCTION.—

9 “(1) ESTABLISHMENT NOT REQUIRED.—Noth-
10 ing in this section shall be construed as requiring—

11 “(A) that a State organize, operate or oth-
12 erwise establish a qualified small employer pur-
13 chasing group, or otherwise require the estab-
14 lishment of purchasing groups; and

15 “(B) that there be only one qualified small
16 employer purchasing group established with re-
17 spect to a community rating area.

18 “(2) SINGLE ORGANIZATION SERVING MUL-
19 TIPLE AREAS AND STATES.—Nothing in this section
20 shall be construed as preventing a single entity from
21 being a qualified small employer purchasing group in
22 more than one community rating area or in more
23 than one State.

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

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

4 **“SEC. 2707F. AGREEMENTS WITH SMALL EMPLOYERS.**

5 “(a) IN GENERAL.—A qualified small employer pur-
6 chasing group shall offer to enter into an agreement under
7 this section with each small employer that employs eligible
8 employees in the area served by the group.

9 “(b) PAYROLL DEDUCTION.—

10 “(1) IN GENERAL.—Under an agreement under
11 this section between a small employer and a quali-
12 fied small employer purchasing group, the small em-
13 ployer shall deduct premiums from an eligible em-
14 ployee’s wages.

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

1 **“SEC. 2707G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**
2 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**
3 **DIVIDUALS IN QUALIFIED GROUP HEALTH**
4 **PLANS.**

5 “(a) IN GENERAL.—Each qualified small employer
6 purchasing group shall offer—

7 “(1) eligible employees,

8 “(2) eligible individuals, and

9 “(3) certain uninsured individuals,

10 the opportunity to enroll in any qualified group health
11 plan which has an agreement with the qualified small em-
12 ployer purchasing group for the community rating area
13 in which such employees and individuals reside.

14 “(b) UNINSURED INDIVIDUALS.—For purposes of
15 this section, an individual is described in subsection (a)(3)
16 if such individual is an uninsured individual who is not
17 an eligible employee of a small employer that is a member
18 of a qualified small employer purchasing group or a de-
19 pendent of such individual.

20 **“SEC. 2707H. RECEIPT OF PREMIUMS.**

21 “(a) ENROLLMENT CHARGE.—The amount charged
22 by a qualified small employer purchasing group for cov-
23 erage under a qualified group health plan shall be equal
24 to the sum of—

25 “(1) the premium rate offered by such health
26 plan;

1 “(b) APPLICATION REQUIREMENTS.—To be eligible
2 to receive a grant under this section, a State or small em-
3 ployer purchasing group shall prepare and submit to the
4 Secretary an application in such form, at such time, and
5 containing such information, certifications, and assur-
6 ances as the Secretary shall reasonably require.

7 “(c) USE OF FUNDS.—Amounts awarded under this
8 section may be used to finance the costs associated with
9 planning, developing, and operating a qualified small em-
10 ployer purchasing group. Such costs may include the costs
11 associated with—

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

15 “(2) soliciting bids and negotiating with insur-
16 ers to make available group health plans;

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

20 “(4) such other activities determined appro-
21 priate by the Secretary.

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

1 **“SEC. 2707K. QUALIFIED SMALL EMPLOYER PURCHASING**
 2 **GROUPS ESTABLISHED BY A STATE.**

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

8 **“SEC. 2707L. EFFECTIVE DATES.**

9 “(a) IN GENERAL.—Except as provided in this chap-
 10 ter, the provisions of this chapter are effective on the date
 11 of the enactment of this chapter.

12 “(b) EXCEPTION.—The provisions of section
 13 2707C(b) shall apply to contracts which are issued, or re-
 14 newed, after the date which is 18 months after the date
 15 of the enactment of this chapter.

16 **“Subchapter B—Required Coverage Options for Eli-**
 17 **gible Employees and Dependents of Small Em-**
 18 **ployers**

19 **“SEC. 2708. REQUIRING SMALL EMPLOYERS TO OFFER COV-**
 20 **ERAGE FOR ELIGIBLE INDIVIDUALS.**

21 “(a) REQUIREMENT TO OFFER.—Each small em-
 22 ployer shall make available with respect to each eligible
 23 employee a group health plan under which—

24 “(1) coverage of each eligible individual with re-
 25 spect to such an eligible employee may be elected on
 26 an annual basis for each plan year;

1 “(2) coverage is provided for at least the stand-
2 ard coverage specified in section 2707A(b); and

3 “(3) each eligible employee electing such cov-
4 erage may elect to have any premiums owed by the
5 employee collected through payroll deduction.

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

10 “(c) SPECIAL RULES.—

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

15 “(A) such employer (including any prede-
16 cessor thereof) has been an employer for less
17 than 2 years;

18 “(B) such employer has no more than 2 el-
19 igible employees; or

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

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

1 eligible employee for purposes of applying the re-
2 quirements of subsection (a). In the case of a small
3 employer that is not an individual, an employee who
4 is a relative of a key employee (as defined in section
5 416(i)(1) of the Internal Revenue Code of 1986) of
6 the employer may, at the election of the key em-
7 ployee, be considered a relative excludable under this
8 paragraph.

9 “(3) OPTIONAL APPLICATION OF WAITING PE-
10 RIOD.—A group health plan and a health insurance
11 issuer offering group health insurance coverage shall
12 not be treated as failing to meet the requirements of
13 subsection (a) solely because a period of service by
14 an eligible employee of not more than 60 days is re-
15 quired under the plan for coverage under the plan
16 of eligible individuals with respect to such employee.

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

21 **“SEC. 2708A. COMPLIANCE WITH APPLICABLE REQUIRE-**
22 **MENTS THROUGH MULTIPLE EMPLOYER**
23 **HEALTH ARRANGEMENTS.**

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

1 health plan which is a multiemployer plan, the require-
2 ments of section 2722(a) shall be deemed to be met with
3 respect to such employee for such plan year if the em-
4 ployer requirements of subsection (b) are met with respect
5 to the eligible employee, irrespective of whether, or to what
6 extent, the employer makes employer contributions on be-
7 half of the eligible employee.

8 “(b) EMPLOYER REQUIREMENTS.—The employer re-
9 quirements of this subsection are met under a group
10 health plan with respect to an eligible employee if—

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

16 “(2) coverage is provided for at least the stand-
17 ard coverage specified in section 2707A(b);

18 “(3) the employer facilitates collection of any
19 employee contributions under the plan and permits
20 the employee to elect to have employee contributions
21 under the plan collected through payroll deduction;
22 and

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

1 in section 102(a)(1) of the Employee Retirement In-
2 come Security Act of 1974 in the form and manner
3 and at such times as are required under such sub-
4 chapter A with respect to employee welfare benefit
5 plans.

6 **“Subchapter C—Required Coverage Options for**
7 **Individuals Insured Through Association Plans**

8 **“SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION**
9 **PLANS.**

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

12 “(1) except as otherwise provided in this sub-
13 chapter, the plan shall meet all applicable require-
14 ments of chapter 1 and chapter 2 for group health
15 plans offered to and by small employers;

16 “(2) if such plan is certified as meeting such
17 requirements and the requirements of this sub-
18 chapter, such plan shall be treated as a plan estab-
19 lished and maintained by a small employer, and indi-
20 viduals enrolled in such plan shall be treated as eli-
21 gible employees; and

22 “(3) any individual who is a member of the as-
23 sociation not enrolling in the plan shall not be treat-
24 ed as an eligible employee solely by reason of mem-
25 bership in such association.

1 “(b) ELECTION TO BE TREATED AS PURCHASING
2 COOPERATIVE.—Subsection (a) shall not apply to a quali-
3 fied association plan if—

4 “(1) the health insurance issuer makes an irrev-
5 ovable election to be treated as a qualified small em-
6 ployer purchasing group for purposes of section
7 2707D; and

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

10 **“SEC. 2709A. QUALIFIED ASSOCIATION PLAN DEFINED.**

11 “(a) GENERAL RULE.—For purposes of this chapter,
12 a plan is a qualified association plan if the plan is a mul-
13 tiple employer welfare arrangement or similar
14 arrangement—

15 “(1) which is maintained by a qualified associa-
16 tion;

17 “(2) which has at least 500 participants in the
18 United States;

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

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

1 rience of any employee or member or dependent of
2 either;

3 “(5) which provides for bonding, in accordance
4 with regulations providing rules similar to the rules
5 under section 412, of all persons operating or ad-
6 ministering the plan or involved in the financial af-
7 fairs of the plan; and

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

11 “(b) SELF-INSURED PLANS.—In the case of a plan
12 which is not fully insured (within the meaning of section
13 514(b)(6)(D)), the plan shall be treated as a qualified as-
14 sociation plan only if—

15 “(1) the plan meets minimum financial solvency
16 and cash reserve requirements for claims which are
17 established by the Secretary and which shall be in
18 lieu of any other such requirements under this chap-
19 ter;

20 “(2) the plan provides an annual funding report
21 (certified by an independent actuary) and annual fi-
22 nancial statements to the Secretary and other inter-
23 ested parties; and

1 “(3) the plan appoints a plan sponsor who is
2 responsible for operating the plan and ensuring com-
3 pliance with applicable Federal and State laws.

4 “(c) CERTIFICATION.—

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

12 “(2) FEE.—The Secretary shall require a
13 \$5,000 fee for the original certification under para-
14 graph (1) and may charge a reasonable annual fee
15 to cover the costs of processing and reviewing the
16 annual statements of the plan.

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

20 “(4) AGREEMENTS.—The Secretary of Labor
21 may enter into agreements with the States to carry
22 out the Secretary’s responsibilities under this sub-
23 chapter.

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

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

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

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

9 “(2) no original certification shall be required
10 under this subchapter; and

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

15 **“SEC. 2709B. DEFINITIONS AND SPECIAL RULES.**

16 “(a) QUALIFIED ASSOCIATION.—For purposes of this
17 subchapter, the term ‘qualified association’ means any or-
18 ganization which—

19 “(1) is organized and maintained in good faith
20 by a trade association, an industry association, a
21 professional association, a chamber of commerce, a
22 religious organization, a public entity association, or
23 other business association serving a common or simi-
24 lar industry;

1 “(3) any individual eligible to enroll in the plan
2 who does not enroll in the plan shall not be treated
3 as an eligible employee solely by reason of being eli-
4 gible to enroll in the plan.

5 “(b) MODIFIED STANDARDS.—

6 “(1) CERTIFYING AUTHORITY.—For purposes
7 of this chapter, the Secretary shall be the appro-
8 priate certifying authority with respect to a plan to
9 which this section applies.

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

13 “(3) ACCESS.—An employer which, pursuant to
14 a collective bargaining agreement, offers an em-
15 ployee the opportunity to enroll in a plan described
16 in subsection (c)(2) shall not be required to make
17 any other plan available to the employee.

18 “(4) TREATMENT UNDER STATE LAWS.—A
19 church plan described in subsection (c)(1) which is
20 certified as meeting the requirements of this section
21 shall not be deemed to be a multiple employer wel-
22 fare arrangement or an insurance company or other
23 insurer, or to be engaged in the business of insur-
24 ance, for purposes of any State law purporting to
25 regulate insurance companies or insurance contracts.

1 “(c) PLANS TO WHICH SECTION APPLIES.—This sec-
2 tion shall apply to a health plan which—

3 “(1) is a church plan (as defined in section
4 414(e) of the Internal Revenue Code of 1986) which
5 has at least 100 participants in the United States;

6 “(2) is a multiemployer plan which is main-
7 tained by a health plan sponsor described in section
8 3(16)(B)(iii) of the Employee Retirement Income
9 Security Act of 1974 and which has at least 500
10 participants in the United States; or

11 “(3) is a plan which is maintained by a rural
12 electric cooperative or a rural telephone cooperative
13 association and which has at least 500 participants
14 in the United States.”.

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

18 “(15) ELIGIBLE EMPLOYEE.—The term ‘eligible
19 employee’ means, with respect to an employer, an
20 employee who normally performs on a monthly basis
21 at least 30 hours of service per week for that em-
22 ployer.

23 “(16) ELIGIBLE INDIVIDUAL.—The term ‘eligi-
24 ble individual’ means, with respect to an eligible em-

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

3 “(17) NAIC.—The term ‘NAIC’ means the Na-
4 tional Association of Insurance Commissioners.

5 “(18) QUALIFIED GROUP HEALTH PLAN.—The
6 term ‘qualified group health plan’ shall have the
7 meaning given the term in section 2707.”.

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

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

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

14 and

15 (2) by adding at the end the following:

16 **“SEC. 2753. APPLICABILITY OF GENERAL INSURANCE MAR-**
17 **KET REFORMS.**

18 “The provisions of chapter 2 of subpart 2 of part A
19 shall apply to health insurance coverage offered by a
20 health insurance issuer in the individual market in the
21 same manner as they apply to health insurance coverage
22 offered by a health insurance issuer in connection with a
23 group health plan in the small or large group market.”.

1 **SEC. 404. EFFECTIVE DATE.**

2 The amendments made by this subtitle shall apply
3 with respect to health insurance coverage offered, sold,
4 issued, renewed, in effect, or operated on or after January
5 1, 2002.

6 **Subtitle B—Tax Provisions**

7 **SEC. 411. ENFORCEMENT WITH RESPECT TO HEALTH IN-**
8 **SURANCE ISSUERS.**

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

12 **“SEC. 4980F. FAILURE OF INSURER TO COMPLY WITH CER-**
13 **TAIN STANDARDS FOR HEALTH INSURANCE**
14 **COVERAGE.**

15 “(a) IMPOSITION OF TAX.—

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

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

22 “(B) section 2753 of the Public Health
23 Service Act; and

24 “(C) subpart C of part 7 of subtitle B of
25 title I of the Employee Retirement Income Se-
26 curity Act of 1974.

1 “(2) EXCEPTION.—Paragraph (1) shall not
2 apply to a failure by a health insurance issuer in a
3 State if the Secretary of Health and Human Serv-
4 ices determines that the State has in effect a regu-
5 latory enforcement mechanism that provides ade-
6 quate sanctions with respect to such a failure by
7 such an issuer.

8 “(b) AMOUNT OF TAX.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
10 the amount of the tax imposed by subsection (a)
11 shall be \$100 for each day during which such failure
12 persists for each person to which such failure re-
13 lates. A rule similar to the rule of section
14 4980D(b)(3) shall apply for purposes of this section.

15 “(2) LIMITATION.—The amount of the tax im-
16 posed by subsection (a) for a health insurance issuer
17 with respect to health insurance coverage shall not
18 exceed 25 percent of the amounts received under the
19 coverage for coverage during the period such failure
20 persists.

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

23 “(d) LIMITATIONS ON AMOUNT OF TAX.—

1 “(1) TAX NOT TO APPLY TO FAILURES COR-
2 RECTED WITHIN 30 DAYS.—No tax shall be imposed
3 by subsection (a) on any failure if—

4 “(A) such failure was due to reasonable
5 cause and not to willful neglect, and

6 “(B) such failure is corrected during the
7 30-day period (or such period as the Secretary
8 may determine appropriate) beginning on the
9 first date the health insurance issuer knows, or
10 exercising reasonable diligence could have
11 known, that such failure existed.

12 “(2) WAIVER BY SECRETARY.—In the case of a
13 failure which is due to reasonable cause and not to
14 willful neglect, the Secretary may waive part or all
15 of the tax imposed by subsection (a) to the extent
16 that the payment of such tax would be excessive rel-
17 ative to the failure involved.

18 “(e) DEFINITIONS.—For purposes of this section, the
19 terms ‘health insurance coverage’ and ‘health insurance
20 issuer’ have the meanings given such terms in section
21 2791 of the Public Health Service Act and section 733
22 of the Employee Retirement Income Security Act of
23 1974.”.

1 (b) CONFORMING AMENDMENT.—The table of sec-
 2 tions for such chapter 43 is amended by adding at the
 3 end the following new item:

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

4 **SEC. 412. ENFORCEMENT WITH RESPECT TO SMALL EM-**
 5 **PLOYERS.**

6 (a) IN GENERAL.—Chapter 47 of the Internal Rev-
 7 enue Code of 1986 (relating to excise taxes on certain
 8 group health plans) is amended by inserting after section
 9 5000 the following new section:

10 **“SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.**

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

14 “(1) subchapter C of chapter 2 of subpart 2 of
 15 part A of title XXVII of the Public Health Service
 16 Act;

17 “(2) section 2753 of the Public Health Service
 18 Act; and

19 “(3) chapter 2 of subpart C of part 7 of sub-
 20 title B of title I of the Employee Retirement Income
 21 Security Act of 1974.

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

1 “(c) LIMITATION ON TAX.—

2 “(1) TAX NOT TO APPLY WHERE FAILURES
3 CORRECTED WITHIN 30 DAYS.—No tax shall be im-
4 posed by subsection (a) with respect to any failure
5 if—

6 “(A) such failure was due to reasonable
7 cause and not to willful neglect, and

8 “(B) such failure is corrected during the
9 30-day period (or such period as the Secretary
10 may determine appropriate) beginning on the
11 1st date any of the individuals on whom the tax
12 is imposed knew, or exercising reasonable dili-
13 gence would have known, that such failure ex-
14 isted.

15 “(2) WAIVER BY SECRETARY.—In the case of a
16 failure which is due to reasonable cause and not to
17 willful neglect, the Secretary may waive part or all
18 of the tax imposed by subsection (a) to the extent
19 that the payment of such tax would be excessive rel-
20 ative to the failure involved.”.

21 (b) CONFORMING AMENDMENT.—The table of sec-
22 tions for such chapter 47 is amended by adding at the
23 end the following new item:

“Sec. 5000A. Small employer requirements.”.

1 **SEC. 413. ENFORCEMENT BY EXCISE TAX ON QUALIFIED AS-**
 2 **SOCIATIONS.**

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

7 **“SEC. 4980G. FAILURE OF QUALIFIED ASSOCIATIONS, ETC.,**
 8 **TO COMPLY WITH CERTAIN STANDARDS FOR**
 9 **HEALTH INSURANCE COVERAGE.**

10 “(a) IMPOSITION OF TAX.—

11 “(1) IN GENERAL.—There is hereby imposed a
 12 tax on the failure of a qualified association (as de-
 13 fined in section 2709A of the Public Health Service
 14 Act and section 723A of the Employee Retirement
 15 Income Security Act of 1974), church plan (as de-
 16 fined in section 414(e)), multiemployer plan, or plan
 17 maintained by a rural electric cooperative or a rural
 18 telephone cooperative association (within the mean-
 19 ing of section 3(40) of the Employee Retirement In-
 20 come Security Act of 1974) to comply with the re-
 21 quirements applicable to such association or plans
 22 under—

23 “(A) subchapter C of chapter 2 of subpart
 24 2 of part A of title XXVII of the Public Health
 25 Service Act;

1 “(B) section 2753 of the Public Health
2 Service Act; and

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

6 “(2) EXCEPTION.—Paragraph (1) shall not
7 apply to a failure by a qualified association, church
8 plan, multiemployer plan, or plan maintained by a
9 rural electric cooperative or a rural telephone coop-
10 erative association in a State if the Secretary of
11 Health and Human Services determines that the
12 State has in effect a regulatory enforcement mecha-
13 nism that provides adequate sanctions with respect
14 to such a failure by such a qualified association or
15 plan.

16 “(b) AMOUNT OF TAX.—The amount of the tax im-
17 posed by subsection (a) shall be \$100 for each day during
18 which such failure persists for each person to which such
19 failure relates. A rule similar to the rule of section
20 4980D(b)(3) shall apply for purposes of this section.

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

23 “(d) LIMITATIONS ON AMOUNT OF TAX.—

1 “(1) TAX NOT TO APPLY TO FAILURES COR-
 2 RECTED WITHIN 30 DAYS.—No tax shall be imposed
 3 by subsection (a) on any failure if—

4 “(A) such failure was due to reasonable
 5 cause and not to willful neglect, and

6 “(B) such failure is corrected during the
 7 30-day period (or such period as the Secretary
 8 may determine appropriate) beginning on the
 9 first date the qualified association, church plan,
 10 multiemployer plan, or plan maintained by a
 11 rural electric cooperative or a rural telephone
 12 cooperative association knows, or exercising rea-
 13 sonable diligence could have known, that such
 14 failure existed.

15 “(2) WAIVER BY SECRETARY.—In the case of a
 16 failure which is due to reasonable cause and not to
 17 willful neglect, the Secretary may waive part or all
 18 of the tax imposed by subsection (a) to the extent
 19 that the payment of such tax would be excessive rel-
 20 ative to the failure involved.”.

21 (b) CONFORMING AMENDMENT.—The table of sec-
 22 tions for such chapter 43, as amended by section 411, is
 23 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.”.

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

3 (a) FULL DEDUCTION IN 2002.—The table contained
4 in section 162(l)(1)(B) of the Internal Revenue Code of
5 1986 (relating to special rules for health insurance costs
6 of self-employed individuals) is amended—

- 7 (1) by striking “2001” and inserting “2000”;
- 8 (2) by striking “2002” and all that follows; and
- 9 (3) by adding at the end the following:

“2001	70
“2002 and thereafter	100.”.

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

13 **SEC. 415. AMENDMENTS TO COBRA.**

14 (a) AMENDMENTS TO INTERNAL REVENUE CODE OF
15 1986.—

16 (1) LOWER COST COVERAGE OPTIONS.—Sub-
17 paragraph (A) of section 4980B(f)(2) of the Internal
18 Revenue Code of 1986 (relating to continuation cov-
19 erage requirements of group health plans) is amend-
20 ed to read as follows:

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

1 “(i) is identical to the coverage pro-
2 vided under the plan to similarly situated
3 beneficiaries under the plan with respect to
4 whom a qualifying event has not occurred,

5 “(ii) is so identical, except such cov-
6 erage is offered with an annual \$1,000 de-
7 ductible, and

8 “(iii) is so identical, except such cov-
9 erage is offered with an annual \$3,000 de-
10 ductible.

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

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

22 (A) by striking “or” at the end of sub-
23 clause (I);

24 (B) by redesignating subclause (II) as sub-
25 clause (III); and

1 (C) by inserting after subclause (I) the fol-
2 lowing:

3 “(II) eligible for such employer-
4 based coverage for more than 90 days,
5 or”.

6 (3) REDUCTION OF PERIOD OF COVERAGE.—
7 Clause (i) of section 4980B(f)(2)(B) of the Internal
8 Revenue Code of 1986 (relating to period of cov-
9 erage) is amended by striking “18 months” each
10 place it appears and inserting “24 months”.

11 (4) CONTINUATION COVERAGE FOR DEPENDENT
12 CHILD.—Clause (i) of section 4980B(f)(2)(B) of the
13 Internal Revenue Code of 1986 is amended by add-
14 ing at the end the following:

15 “(VI) SPECIAL RULE FOR DE-
16 PENDENT CHILD.—In the case of a
17 qualifying event described in para-
18 graph (3)(E), the date that is 36
19 months after the date on which the
20 dependent child of the covered em-
21 ployee ceases to be a dependent child
22 under the plan.”.

23 (b) AMENDMENTS TO EMPLOYEE RETIREMENT IN-
24 COME SECURITY ACT OF 1974.—

1 (1) LOWER COST COVERAGE OPTIONS.—Para-
2 graph (1) of section 602 of the Employee Retire-
3 ment Income Security Act of 1974 (29 U.S.C.
4 1162(1)) (relating to continuation coverage require-
5 ments of group health plans) is amended to read as
6 follows:

7 “(1) TYPE OF BENEFIT COVERAGE.—The cov-
8 erage must consist of coverage which, as of the time
9 the coverage is being provided—

10 “(A) is identical to the coverage provided
11 under the plan to similarly situated bene-
12 ficiaries under the plan with respect to whom a
13 qualifying event has not occurred,

14 “(B) is so identical, except such coverage
15 is offered with an annual \$1,000 deductible,
16 and

17 “(C) is so identical, except such coverage is
18 offered with an annual \$3,000 deductible.

19 If coverage under the plan is modified for any group
20 of similarly situated beneficiaries, the coverage shall
21 also be modified in the same manner for all individ-
22 uals who are qualified beneficiaries under the plan
23 pursuant to this subsection in connection with such
24 group.”.

1 (2) TERMINATION OF COBRA COVERAGE AFTER
2 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
3 DAYS.—Subparagraph (D) of section 602(2) of the
4 Employee Retirement Income Security Act of 1974
5 (29 U.S.C. 1162(2)(D)) (relating to period of cov-
6 erage) is amended—

7 (A) by striking “or” at the end of clause

8 (i);

9 (B) by redesignating clause (ii) as clause

10 (iii); and

11 (C) by inserting after clause (i) the fol-

12 lowing:

13 “(ii) eligible for such employer-based

14 coverage for more than 90 days, or”.

15 (3) REDUCTION OF PERIOD OF COVERAGE.—

16 Subparagraph (A) of section 602(2) of the Employee
17 Retirement Income Security Act of 1974 (29 U.S.C.
18 1162(2)(A)) (relating to period of coverage) is
19 amended by striking “18 months” each place it ap-
20 pears and inserting “24 months”.

21 (4) CONTINUATION COVERAGE FOR DEPENDENT

22 CHILD.—Subparagraph (A) of section 602(2) of the
23 Employee Retirement Income Security Act of 1974
24 (29 U.S.C. 1162(2)(A)) is amended by adding at the
25 end the following:

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

8 (c) AMENDMENTS TO PUBLIC HEALTH SERVICE
9 ACT.—

10 (1) LOWER COST COVERAGE OPTIONS.—Para-
11 graph (1) of section 2202 of the Public Health Serv-
12 ice Act (42 U.S.C. 300bb-2(1)) (relating to continu-
13 ation coverage requirements of group health plans)
14 is amended to read as follows:

15 “(1) TYPE OF BENEFIT COVERAGE.—The cov-
16 erage must consist of coverage which, as of the time
17 the coverage is being provided—

18 “(A) is identical to the coverage provided
19 under the plan to similarly situated bene-
20 ficiaries under the plan with respect to whom a
21 qualifying event has not occurred,

22 “(B) is so identical, except such coverage
23 is offered with an annual \$1,000 deductible,
24 and

1 “(C) is so identical, except such coverage is
2 offered with an annual \$3,000 deductible.

3 If coverage under the plan is modified for any group
4 of similarly situated beneficiaries, the coverage shall
5 also be modified in the same manner for all individ-
6 uals who are qualified beneficiaries under the plan
7 pursuant to this subsection in connection with such
8 group.”.

9 (2) TERMINATION OF COBRA COVERAGE AFTER
10 ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90
11 DAYS.—Subparagraph (D) of section 2202(2) of the
12 Public Health Service Act (42 U.S.C. 300bb-
13 2(2)(D)) (relating to period of coverage) is
14 amended—

15 (A) by striking “or” at the end of clause
16 (i);

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

19 (C) by inserting after clause (i) the fol-
20 lowing:

21 “(ii) eligible for such employer-based
22 coverage for more than 90 days, or”.

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

1 lating to period of coverage) is amended by striking
 2 “18 months” each place it appears and inserting
 3 “24 months”.

4 (4) CONTINUATION COVERAGE FOR DEPENDENT
 5 CHILD.—Subparagraph (A) of section 2202(2) of the
 6 Public Health Service Act (42 U.S.C. 300bb-
 7 2(2)(A)) is amended by adding at the end the fol-
 8 lowing:

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

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

19 **TITLE V—PRIMARY AND**
 20 **PREVENTIVE CARE SERVICES**

21 **SEC. 501. IMPROVEMENT OF MEDICARE PREVENTIVE CARE**
 22 **SERVICES.**

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

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

7 (A) by striking “and (U)” and inserting
8 “(U)”; and

9 (B) by striking the semicolon at the end
10 and inserting the following: “, and (V) with re-
11 spect to screening mammography (as defined in
12 section 1861(jj)) and diagnostic mammography,
13 100 percent of the payment basis determined
14 under section 1848;”.

15 (2) WAIVER OF COINSURANCE IN OUTPATIENT
16 HOSPITAL SETTINGS.—The third sentence of section
17 1866(a)(2)(A) of the Social Security Act (42 U.S.C.
18 1395cc(a)(2)(A)) is amended by inserting after
19 “1861(s)(10)(A)” the following: “, with respect to
20 screening mammography (as defined in section
21 1861(jj)) and diagnostic mammography,”.

22 (b) COVERAGE OF INSULIN PUMPS.—

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

1 ing before the semicolon the following: “, and in-
 2 cludes insulin infusion pumps (as defined in sub-
 3 section (ww)) prescribed by the physician of an indi-
 4 vidual with Type I diabetes who is experiencing se-
 5 vere swings of high and low blood glucose levels and
 6 has successfully completed a training program that
 7 meets standards established by the Secretary or who
 8 has used such a pump without interruption for at
 9 least 18 months immediately before enrollment
 10 under part B”.

11 (2) DEFINITION OF INSULIN INFUSION PUMP.—
 12 Section 1861 of the Social Security Act (42 U.S.C.
 13 1395x), as amended by section 105(b) of the Medi-
 14 care, Medicaid, and SCHIP Benefits Improvement
 15 and Protection Act of 2000 (as enacted into law by
 16 section 1(a)(6) of Public Law 106–554), is amended
 17 by adding at the end the following:

18 “Insulin Infusion Pump
 19 “(ww) The term ‘insulin infusion pump’ means an in-
 20 fusion pump, approved by the Federal Food and Drug Ad-
 21 ministration, that provides for the computerized delivery
 22 of insulin for individuals with diabetes in lieu of multiple
 23 daily manual insulin injections.”.

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

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

3 (A) in clause (ii), by striking “or” at the
4 end;

5 (B) in clause (iii), by inserting “or” at the
6 end; and

7 (C) by inserting after clause (iii) the fol-
8 lowing:

9 “(iv) which is an accessory used in
10 conjunction with an insulin infusion pump
11 (as defined in section 1861(wv)),”.

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

14 (1) IN GENERAL.—Section 1861(nn) of the So-
15 cial Security Act (42 U.S.C. 1395x(nn)), as amended
16 by section 101(a) of the Medicare, Medicaid, and
17 SCHIP Benefits Improvement and Protection Act of
18 2000 (as enacted into law by section 1(a)(6) of Pub-
19 lic Law 106–554), is amended to read as follows:

20 “Screening Pap Smear; Screening Pelvic Exam

21 “(nn)(1) The term ‘screening pap smear’ means a di-
22 agnostic laboratory test consisting of a routine exfoliative
23 cytology test (Papanicolaou test) provided to a woman for
24 the purpose of early detection of cervical or vaginal cancer
25 and includes a physician’s interpretation of the results of

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

3 “(2) The term ‘screening pelvic exam’ means a pelvic
4 examination provided to a woman if the woman involved
5 has not had such an examination during the preceding
6 year, and includes a clinical breast examination, relevant
7 history-taking, medical decision-making, and patient coun-
8 seling.”.

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

16 (A) by striking “and (V)” and inserting
17 “(V)”; and

18 (B) by striking the semicolon at the end
19 and inserting the following: “, and (W) with re-
20 spect to services described in section
21 1861(m)(2), 100 percent of the payment basis
22 determined under section 1848;”.

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

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

3 **SEC. 502. AUTHORIZATION OF APPROPRIATIONS FOR**
4 **HEALTHY START PROGRAM.**

5 (a) AUTHORIZATION OF APPROPRIATIONS.—To en-
6 able the Secretary of Health and Human Services to carry
7 out the healthy start program established under the au-
8 thority of section 301 of the Public Health Service Act
9 (42 U.S.C. 241), there are authorized to be appropriated
10 \$115,000,000 for fiscal year 2002, \$150,000,000 for fis-
11 cal year 2003, \$250,000,000 for fiscal year 2004, and
12 \$300,000,000 for each of the fiscal years 2005 through
13 2007.

14 (b) MODEL PROJECTS.—

15 (1) IN GENERAL.—Of the amount appropriated
16 under subsection (a) for a fiscal year, the Secretary
17 of Health and Human Services shall reserve
18 \$50,000,000 for such fiscal year to be distributed to
19 model projects determined to be eligible under para-
20 graph (2).

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

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

1 (B) be determined by Secretary of Health
2 and Human Services to have been successful in
3 serving needy areas and reducing infant mor-
4 tality.

5 (3) USE OF PROJECTS.—A model project that
6 receives funding under paragraph (1) shall be uti-
7 lized as a resource center to assist in the training
8 of those individuals to be involved in projects estab-
9 lished under subsection (c). It shall be the goal of
10 such projects to become self-sustaining within the
11 project area.

12 (4) PROVISION OF MATCHING FUNDS.—In pro-
13 viding assistance to a project under this subsection,
14 the Secretary of Health and Human Services shall
15 ensure that—

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

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

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

6 (D) with respect to each of the fiscal years
7 2005 through 2007, the project shall make non-
8 Federal contributions (in cash or in-kind) to-
9 wards the costs of such project in an amount
10 equal to not less than 50 percent of such costs
11 for each such fiscal year.

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

1 **SEC. 503. REAUTHORIZATION OF CERTAIN PROGRAMS PRO-**
2 **VIDING PRIMARY AND PREVENTIVE CARE.**

3 (a) TUBERCULOSIS PREVENTION GRANTS.—Section
4 317(j)(1) of the Public Health Service Act (42 U.S.C.
5 247b(j)(1)), as amended by section 1711 of the Children’s
6 Health Act of 2000 (Public Law 106-310), is amended
7 by striking “2005” and inserting “2007”.

8 (b) SEXUALLY TRANSMITTED DISEASES.—Section
9 318(e)(1) of the Public Health Service Act (42 U.S.C.
10 247c(e)(1)) is amended—

11 (1) by striking “and such sums” and inserting
12 “such sums”;

13 (2) by striking “1998” and inserting “2001”;
14 and

15 (3) by inserting before the period the following:
16 “, \$130,000,000 for each of the fiscal years 2002
17 and 2003, and such sums as may be necessary for
18 each of the fiscal years 2004 through 2006”.

19 (c) FAMILY PLANNING PROJECT GRANTS.—Section
20 1001(d) of the Public Health Service Act (42 U.S.C.
21 300(d)) is amended—

22 (1) by striking “and \$158,400,000” and insert-
23 ing “\$158,400,000”; and

24 (2) by inserting before the period the following:
25 “; \$430,000,000 for fiscal year 2002; and such sums

1 as may be necessary for each of the fiscal years
2 2003 through 2005”.

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

6 (1) by striking “and such sums” and inserting
7 “such sums”; and

8 (2) by inserting before the period the following:
9 “, \$200,000,000 for fiscal year 2002, and such sums
10 as may be necessary for each of the fiscal years
11 2003 through 2005”.

12 (e) PREVENTIVE HEALTH AND HEALTH SERVICES
13 BLOCK GRANT.—Section 1901(a) of the Public Health
14 Service Act (42 U.S.C. 300w(a)) is amended by striking
15 “\$205,000,000” and inserting “\$235,000,000”.

16 (f) MATERNAL AND CHILD HEALTH SERVICES
17 BLOCK GRANT.—Section 501(a) of the Social Security
18 Act (42 U.S.C. 701(a)) is amended by striking “fiscal year
19 2001 and each fiscal year thereafter” and inserting “each
20 of fiscal years 2001 and 2002, and such sums as may be
21 necessary for each of the fiscal years 2003 through 2005”.

22 **SEC. 504. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
23 **PROGRAM.**

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

1 vention program for elementary and secondary school stu-
2 dents.

3 (b) PROGRAM AUTHORIZED.—The Secretary of Edu-
4 cation (referred to in this section as the “Secretary”),
5 through the Office of Comprehensive School Health Edu-
6 cation established in subsection (e), shall award grants to
7 States from allotments under subsection (c) to enable such
8 States to—

9 (1) award grants to local or intermediate edu-
10 cational agencies, and consortia thereof, to enable
11 such agencies or consortia to establish, operate, and
12 improve local programs of comprehensive health edu-
13 cation and prevention, early health intervention, and
14 health education, in elementary and secondary
15 schools (including preschool, kindergarten, inter-
16 mediate, and junior high schools); and

17 (2) develop training, technical assistance, and
18 coordination activities for the programs assisted pur-
19 suant to paragraph (1).

20 (c) RESERVATIONS AND STATE ALLOTMENTS.—

21 (1) RESERVATIONS.—From the sums appro-
22 priated pursuant to the authority of subsection (f)
23 for any fiscal year, the Secretary shall reserve—

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

1 public of the Marshall Islands, the Federated
2 States of Micronesia, the Northern Mariana Is-
3 lands, and the Republic of Palau, to be allotted
4 in accordance with their respective needs; and

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

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

15 (3) REALLOTMENT.—The Secretary may reallocate
16 any amount of any allotment to a State to the extent
17 that the Secretary determines that the State will not
18 be able to obligate such amount within 2 years of al-
19 lotment. Any such reallocation shall be made on the
20 same basis as an allotment under paragraph (2).

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

25 (1) personal health and fitness;

- 1 (2) prevention of chronic diseases;
- 2 (3) prevention and control of communicable dis-
- 3 eases;
- 4 (4) nutrition;
- 5 (5) substance use and abuse;
- 6 (6) accident prevention and safety;
- 7 (7) community and environmental health;
- 8 (8) mental and emotional health;
- 9 (9) parenting and the challenges of raising chil-
- 10 dren; and
- 11 (10) the effective use of the health services de-
- 12 livery system.

13 (e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH
14 EDUCATION.—The Secretary shall establish within the Of-
15 fice of the Secretary an Office of Comprehensive School
16 Health Education which shall have the following respon-
17 sibilities:

- 18 (1) To recommend mechanisms for the coordi-
19 nation of school health education programs con-
20 ducted by the various departments and agencies of
21 the Federal Government.
- 22 (2) To advise the Secretary on formulation of
23 school health education policy within the Depart-
24 ment of Education.

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

4 (f) AUTHORIZATION OF APPROPRIATIONS.—

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

9 (2) AVAILABILITY.—Funds appropriated pursu-
10 ant to the authority of paragraph (1) in any fiscal
11 year shall remain available for obligation and ex-
12 penditure until the end of the fiscal year succeeding
13 the fiscal year for which such funds were appro-
14 priated.

15 **SEC. 505. COMPREHENSIVE EARLY CHILDHOOD HEALTH**
16 **EDUCATION PROGRAM.**

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

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

1 teachers and other child care providers. Such program
2 shall—

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

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

12 (3) provide technical support for health edu-
13 cation programs and curricula; and

14 (4) provide cooperation with other early child-
15 hood providers to ensure coordination of such pro-
16 grams and the transition of students into the public
17 school environment.

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

21 (1) personal health and fitness;

22 (2) prevention of chronic diseases;

23 (3) prevention and control of communicable dis-
24 eases;

25 (4) dental health;

- 1 (5) nutrition;
- 2 (6) substance use and abuse;
- 3 (7) accident prevention and safety;
- 4 (8) community and environmental health;
- 5 (9) mental and emotional health; and
- 6 (10) strengthening the role of parent involve-
- 7 ment.

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

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

17 **SEC. 506. ADOLESCENT FAMILY LIFE AND ABSTINENCE.**

18 (a) DEFINITIONS.—Section 2002(a)(4)(G)(i) of the
19 Public Health Service Act (42 U.S.C. 300z-1(a)(4)(G)(i))
20 is amended by inserting “and abstinence” after “adop-
21 tion”.

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

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

3 (2) by inserting after subsection (a) the fol-
4 lowing:

5 “(b) In approving applications for grants for dem-
6 onstration projects for services under this title, the Sec-
7 retary shall, to the maximum extent practicable, ensure
8 adequate representation of both urban and rural areas.”.

9 (c) SIMPLIFIED APPLICATION PROCESS.—Section
10 2006 of the Public Health Service Act (42 U.S.C. 300z-
11 5) is amended by adding at the end following:

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

16 (d) AUTHORIZATION OF APPROPRIATIONS.—Section
17 2010(a) of the Public Health Service Act (42 U.S.C.
18 300z-9) is amended to read as follows:

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

1 **TITLE VI—PATIENT’S RIGHT TO**
2 **DECLINE MEDICAL TREATMENT**

3 **SEC. 601. PATIENT’S RIGHT TO DECLINE MEDICAL TREAT-**
4 **MENT.**

5 (a) RIGHT TO DECLINE MEDICAL TREATMENT.—

6 (1) RIGHTS OF COMPETENT ADULTS.—

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

11 (B) LIMITATIONS.—

12 (i) AFFECT ON THIRD PARTIES.—A
13 State may impose limitations on the right
14 of a competent adult to decline treatment
15 if such limitations protect third parties (in-
16 cluding minor children) from harm.

17 (ii) TREATMENT WHICH IS NOT MEDI-
18 CALLY INDICATED.—Nothing in this sub-
19 section shall be construed to require that
20 any individual be offered, or to state that
21 any individual may demand, medical treat-
22 ment which the health care provider does
23 not have available, or which is, under pre-
24 vailing medical standards, either futile or
25 otherwise not medically indicated.

1 (2) RIGHTS OF INCAPACITATED ADULTS.—

2 (A) IN GENERAL.—Except as provided in
3 subparagraph (B)(i) of paragraph (1), States
4 may not restrict the right of an incapacitated
5 adult to consent to, or to decline, medical treat-
6 ment as exercised through the documents speci-
7 fied in this paragraph, or through similar docu-
8 ments or other written methods of directive
9 which evidence the adult’s treatment choices.

10 (B) ADVANCE DIRECTIVES AND POWERS
11 OF ATTORNEY.—

12 (i) IN GENERAL.—In order to facili-
13 tate the communication, despite incapacity,
14 of an adult’s treatment choices, the Sec-
15 retary of Health and Human Services (re-
16 ferred to in this section as the “Sec-
17 retary”), in consultation with the Attorney
18 General, shall develop a national advance
19 directive form that—

20 (I) shall not limit or otherwise
21 restrict, except as provided in sub-
22 paragraph (B)(i) of paragraph (1), an
23 adult’s right to consent to, or to de-
24 cline, medical treatment; and

25 (II) shall, at minimum—

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

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

12 (cc) provide the means by
13 which an adult may, at such
14 adult's option, declare such
15 adult's wishes with respect to all
16 forms of medical treatment, in-
17 cluding forms of medical treat-
18 ment such as the provision of nu-
19 trition and hydration by artificial
20 means which may be, in some cir-
21 cumstances, relatively nonburden-
22 some.

23 (ii) NATIONAL DURABLE POWER OF
24 ATTORNEY FORM.—The Secretary, in con-
25 sultation with the Attorney General, shall

1 develop a national durable power of attor-
2 ney form for health care decisionmaking.
3 The form shall provide a means for any
4 adult to designate another adult or adults
5 to exercise the same decisionmaking pow-
6 ers which would otherwise be exercised by
7 the patient if the patient were competent.

8 (iii) HONORED BY ALL HEALTH CARE
9 PROVIDERS.—The national advance direc-
10 tive and durable power of attorney forms
11 developed by the Secretary shall be hon-
12 ored by all health care providers.

13 (iv) LIMITATIONS.—No individual
14 shall be required to execute an advance di-
15 rective. This section makes no presumption
16 concerning the intention of an individual
17 who has not executed an advance directive.
18 An advance directive shall be sufficient,
19 but not necessary, proof of an adult’s
20 treatment choices with respect to the cir-
21 cumstances addressed in the advance direc-
22 tive.

23 (C) DEFINITION.—For purposes of this
24 paragraph, the term “incapacity” means the in-
25 ability to understand or to communicate con-

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

6 (3) HEALTH CARE PROVIDERS.—

7 (A) IN GENERAL.—No health care provider
8 may provide treatment to an adult contrary to
9 the adult's wishes as expressed personally, by
10 an advance directive as provided for in para-
11 graph (2)(B), or by a similar written advance
12 directive form or another written method of di-
13 rective which clearly and convincingly evidence
14 the adult's treatment choices. A health care
15 provider who acts in good faith pursuant to the
16 preceding sentence shall be immune from crimi-
17 nal or civil liability or discipline for professional
18 misconduct.

19 (B) HEALTH CARE PROVIDERS UNDER
20 THE MEDICARE AND MEDICAID PROGRAMS.—

21 Any health care provider who knowingly pro-
22 vides services to an adult contrary to the adult's
23 wishes as expressed personally, by an advance
24 directive as provided for in paragraph (2)(B),
25 or by a similar written advance directive form

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

6 (C) TRANSFERS.—Health care providers
7 who object to the provision of medical care in
8 accordance with an adult's wishes shall transfer
9 the adult to the care of another health care pro-
10 vider.

11 (4) DEFINITION.—For purposes of this sub-
12 section, the term “adult” means—

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

15 (B) an emancipated minor.

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

20 (c) SUICIDE AND HOMICIDE.—Nothing in this section
21 shall be construed to permit, condone, authorize, or ap-
22 prove suicide or mercy killing, or any affirmative act to
23 end a human life.

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

4 (e) EFFECT ON OTHER LAWS.—

5 (1) IN GENERAL.—Except as specified in para-
6 graph (2), written policies and written information
7 adopted by health care providers pursuant to sec-
8 tions 4206 and 4751 of the Omnibus Budget Rec-
9 onciliation Act of 1990 (Public Law 101–508), shall
10 be modified within 6 months after the enactment of
11 this section to conform to the provisions of this sec-
12 tion.

13 (2) DELAY PERIOD FOR UNIFORM FORMS.—
14 Health care providers shall modify any written forms
15 distributed as written information under sections
16 4206 and 4751 of the Omnibus Budget Reconcili-
17 ation Act of 1990 (Public Law 101–508) not later
18 than 6 months after promulgation of the forms re-
19 ferred to in clauses (i) and (ii) of subsection
20 (a)(2)(B) by the Secretary.

21 (f) INFORMATION PROVIDED TO CERTAIN INDIVID-
22 UALS.—The Secretary shall provide on a periodic basis
23 written information regarding an individual’s right to con-
24 sent to, or to decline, medical treatment as provided in

1 this section to individuals who are beneficiaries under ti-
2 tles II, XVI, XVIII, and XIX of the Social Security Act.

3 (g) RECOMMENDATIONS TO CONGRESS ON ISSUES
4 RELATING TO A PATIENT'S RIGHT OF SELF-DETERMINA-
5 TION.—Not later than 180 days after the date of the en-
6 actment of this Act, and annually thereafter for a period
7 of 3 years, the Secretary shall provide recommendations
8 to Congress concerning the medical, legal, ethical, social,
9 and educational issues related to in this section. In devel-
10 oping recommendations under this subsection the Sec-
11 retary shall address the following issues:

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

14 (2) Issues pertaining to the education and
15 training of health care professionals concerning pa-
16 tients' self-determination rights.

17 (3) Issues pertaining to health care profes-
18 sionals' duties with respect to patients' rights, and
19 health care professionals' roles in identifying, assess-
20 ing, and presenting for patient consideration medi-
21 cally indicated treatment options.

22 (4) Issues pertaining to the education of pa-
23 tients concerning their rights to consent to, and de-
24 cline, treatment, including how individuals might
25 best be informed of such rights prior to hospitaliza-

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

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

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

10 (h) EFFECTIVE DATE.—

11 (1) IN GENERAL.—Except as provided in para-
 12 graph (2), this section shall take effect on the date
 13 that is 6 months after the date of enactment of this
 14 Act.

15 (2) SUBSECTION (g).—The provisions of sub-
 16 section (g) shall take effect on the date of enactment
 17 of this Act.

18 **TITLE VII—PRIMARY AND** 19 **PREVENTIVE CARE PROVIDERS**

20 **SEC. 701. INCREASED MEDICARE REIMBURSEMENT FOR** 21 **PHYSICIAN ASSISTANTS, NURSE PRACTI-** 22 **TIONERS, AND CLINICAL NURSE SPECIAL-** 23 **ISTS.**

24 (a) FEE SCHEDULE AMOUNT.—Section
 25 1833(a)(1)(O) of the Social Security Act (42 U.S.C.

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

3 (b) TECHNICAL AMENDMENT.—Section
 4 1833(a)(1)(O) of the Social Security Act (42 U.S.C.
 5 1395l(a)(1)(O)) is amended by striking “clinic” and in-
 6 serting “clinical”.

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

10 **SEC. 702. REQUIRING COVERAGE OF CERTAIN NONPHYSI-**
 11 **CIAN PROVIDERS UNDER THE MEDICAID**
 12 **PROGRAM.**

13 (a) IN GENERAL.—Section 1905(a) of the Social Se-
 14 curity Act (42 U.S.C. 1396d(a)), as amended by section
 15 301(e)(1), is amended—

16 (1) in paragraph (27), by striking “and” at the
 17 end;

18 (2) by redesignating paragraph (28) as para-
 19 graph (29); and

20 (3) by inserting after paragraph (27) the fol-
 21 lowing:

22 “(28) services furnished by a physician assist-
 23 ant, nurse practitioner, clinical nurse specialist (as
 24 defined in section 1861(aa)(5)), or certified reg-

1 “(b) APPLICATION.—To be eligible to receive a grant
2 under this section, a school of medicine or osteopathic
3 medicine shall prepare and submit to the Secretary an ap-
4 plication at such time, in such manner, and containing
5 such information as the Secretary may require, including
6 assurances that the school will use amounts received under
7 the grant in accordance with subsection (c).

8 “(c) USE OF FUNDS.—

9 “(1) IN GENERAL.—Amounts received under a
10 grant awarded under this section shall be used to—

11 “(A) fund programs under which students
12 of the grantee are provided as tutors for high
13 school and college students in the areas of
14 mathematics, science, health promotion and
15 prevention, first aid, nutrition and prenatal
16 care;

17 “(B) fund programs under which students
18 of the grantee are provided as participants in
19 clinics and seminars in the areas described in
20 paragraph (1); and

21 “(C) conduct summer institutes for high
22 school and college students to promote careers
23 in medicine.

1 “(2) DESIGN OF PROGRAMS.—The programs,
2 institutes, and other activities conducted by grantees
3 under paragraph (1) shall be designed to—

4 “(A) give medical students desiring to
5 practice general medicine access to the local
6 community;

7 “(B) provide information to high school
8 and college students concerning medical school
9 and the general practice of medicine; and

10 “(C) promote careers in general medicine.

11 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section,
13 \$5,000,000 for fiscal year 2002, and such sums as may
14 be necessary for fiscal year 2003.”.

15 **SEC. 704. GENERAL MEDICAL PRACTICE GRANTS.**

16 Part C of title VII of the Public Health Service Act
17 (as amended by section 703) is further amended by adding
18 at the end thereof the following:

19 **“SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.**

20 “(a) ESTABLISHMENT.—The Secretary shall estab-
21 lish a program to award grants to eligible public or private
22 nonprofit schools of medicine or osteopathic medicine, hos-
23 pitals, residency programs in family medicine or pediat-
24 rics, or to a consortium of such entities, to enable such
25 entities to develop effective strategies for recruiting med-

1 ical students interested in the practice of general medicine
2 and placing such students into general practice positions
3 upon graduation.

4 “(b) APPLICATION.—To be eligible to receive a grant
5 under this section, an entity of the type described in sub-
6 section (a) shall prepare and submit to the Secretary an
7 application at such time, in such manner, and containing
8 such information as the Secretary may require, including
9 assurances that the entity will use amounts received under
10 the grant in accordance with subsection (c).

11 “(c) USE OF FUNDS.—Amounts received under a
12 grant awarded under this section shall be used to fund
13 programs under which effective strategies are developed
14 and implemented for recruiting medical students inter-
15 ested in the practice of general medicine and placing such
16 students into general practice positions upon graduation.

17 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this section,
19 \$25,000,000 for each of the fiscal years 2002 through
20 2004, and such sums as may be necessary for fiscal years
21 thereafter.”.

1 **TITLE VIII—SAFE AND COST-EF-**
 2 **FECTIVE MEDICAL TREAT-**
 3 **MENT**

4 **SEC. 801. ENHANCING INVESTMENT IN COST-EFFECTIVE**
 5 **METHODS OF HEALTH CARE.**

6 (a) ESTABLISHMENT OF TRUST FUND FOR MEDICAL
 7 TREATMENT OUTCOMES RESEARCH.—

8 (1) IN GENERAL.—Subchapter A of chapter 98
 9 of the Internal Revenue Code of 1986 (relating to
 10 trust fund code) is amended by adding at the end
 11 the following:

12 **“SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUT-**
 13 **COMES RESEARCH.**

14 “(a) CREATION OF TRUST FUND.—There is estab-
 15 lished in the Treasury of the United States a trust fund
 16 to be known as the ‘Trust Fund for Medical Treatment
 17 Outcomes Research’ (referred to in this section as the
 18 ‘Trust Fund’), consisting of such amounts as may be ap-
 19 propriated or credited to the Trust Fund as provided in
 20 this section or section 9602(b).

21 “(b) TRANSFERS TO TRUST FUND.—There is hereby
 22 appropriated to the Trust Fund an amount equivalent to
 23 the taxes received in the Treasury under section 4491 (re-
 24 lating to tax on health insurance policies).

1 thereof, of the premium paid on a policy of health insur-
2 ance.

3 “(b) DEFINITION.—For purposes of subsection (a),
4 the term ‘policy of health insurance’ means any policy or
5 other instrument by whatever name called whereby a con-
6 tract of insurance is made, continued, or renewed with re-
7 spect to the health of an individual or group of individuals.

8 **“SEC. 4492. LIABILITY FOR TAX.**

9 “The tax imposed by this subchapter shall be paid,
10 on the basis of a return, by any person who makes, signs,
11 issues, or sells any of the documents and instruments sub-
12 ject to the tax, or for whose use or benefit the same are
13 made, signed, issued, or sold. The United States or any
14 agency or instrumentality thereof shall not be liable for
15 the tax.”.

16 (2) CONFORMING AMENDMENT.—The table of
17 subchapters for chapter 36 of such Code is amended
18 by adding at the end the following:

“SUBCHAPTER F. Tax on health insurance policies.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to policies issued after December
21 31, 2001.

22 **SEC. 802. MEDICAL ERRORS REDUCTION.**

23 Title IX of the Public Health Service Act (42 U.S.C.
24 299 et seq.) is amended—

25 (1) by redesignating part C as part D;

1 (2) by redesignating sections 921 through 928,
2 as sections 931 through 938, respectively;

3 (3) in section 938(1) (as so redesignated), by
4 striking “921” and inserting “931”; and

5 (4) by inserting after part B the following:

6 **“PART C—REDUCING ERRORS IN HEALTH CARE**

7 **“SEC. 921. DEFINITIONS.**

8 “In this part:

9 “(1) ADVERSE EVENT.—The term ‘adverse
10 event’ means an injury resulting from medical man-
11 agement rather than the underlying condition of the
12 patient.

13 “(2) ERROR.—The term ‘error’ means the fail-
14 ure of a planned action to be completed as intended
15 or the use of a wrong plan to achieve the desired
16 outcome.

17 “(3) HEALTH CARE PROVIDER.—The term
18 ‘health care provider’ means an individual or entity
19 that provides medical services and is a participant in
20 a demonstration program under this part.

21 “(4) HEALTH CARE-RELATED ERROR.—The
22 term “health care-related error” means a prevent-
23 able adverse event related to a health care interven-
24 tion or a failure to intervene appropriately.

1 “(5) MEDICATION-RELATED ERROR.—The term
2 ‘medication-related error’ means a preventable ad-
3 verse event related to the administration of a medi-
4 cation.

5 “(6) SAFETY.—The term ‘safety’ with respect
6 to an individual means that such individual has a
7 right to be free from preventable serious injury.

8 “(7) SENTINEL EVENT.—The term ‘sentinel
9 event’ means an unexpected occurrence involving an
10 individual that results in death or serious physical
11 injury that is unrelated to the natural course of the
12 individual’s illness or underlying condition.

13 **“SEC. 922. ESTABLISHMENT OF STATE-BASED MEDICAL**
14 **ERROR REPORTING SYSTEMS.**

15 “(a) IN GENERAL.—The Secretary shall make grants
16 available to States to enable such States to establish re-
17 porting systems designed to reduce medical errors and im-
18 prove health care quality.

19 “(b) REQUIREMENT.—

20 “(1) IN GENERAL.—To be eligible to receive a
21 grant under subsection (a), the State involved shall
22 provide assurances to the Secretary that amounts re-
23 ceived under the grant will be used to establish and
24 implement a medical error reporting system using
25 guidelines (including guidelines relating to the con-

1 confidentiality of the reporting system) developed by the
2 Agency for Healthcare Research and Quality with
3 input from interested, non-governmental parties in-
4 cluding patient, consumer and health care provider
5 groups.

6 “(2) GUIDELINES.—Not later than 90 days
7 after the date of enactment of this part, the Agency
8 for Healthcare Research and Quality shall develop
9 and publish the guidelines described in paragraph
10 (1).

11 “(c) DATA.—

12 “(1) AVAILABILITY.—A State that receives a
13 grant under subsection (a) shall make the data pro-
14 vided to the medical error reporting system involved
15 available only to the Agency for Healthcare Research
16 and Quality and may not otherwise disclose such in-
17 formation.

18 “(2) CONFIDENTIALITY.—Nothing in this part
19 shall be construed to supersede any State law that
20 is inconsistent with this part.

21 “(d) APPLICATION.—To be eligible for a grant under
22 this section, a State shall prepare and submit to the Sec-
23 retary an application at such time, in such manner and
24 containing, such information as the Secretary shall re-
25 quire.

1 **“SEC. 923. DEMONSTRATION PROJECTS TO REDUCE MED-**
2 **ICAL ERRORS, IMPROVE PATIENT SAFETY,**
3 **AND EVALUATE REPORTING.**

4 “(a) ESTABLISHMENT.—The Secretary, acting
5 through the Director of the Agency for Healthcare Re-
6 search and Quality and in conjunction with the Adminis-
7 trator of the Health Care Financing Administration, may
8 establish a program under which funding will be provided
9 for not less than 15 demonstration projects, to be competi-
10 tively awarded, in health care facilities and organizations
11 in geographically diverse locations, including rural and
12 urban areas (as determined by the Secretary), to deter-
13 mine the causes of medical errors and to—

14 “(1) use technology, staff training, and other
15 methods to reduce such errors;

16 “(2) develop replicable models that minimize
17 the frequency and severity of medical errors;

18 “(3) develop mechanisms that encourage report-
19 ing, prompt review, and corrective action with re-
20 spect to medical errors; and

21 “(4) develop methods to minimize any addi-
22 tional paperwork burden on health care profes-
23 sionals.

24 “(b) ACTIVITIES.—

1 “(1) IN GENERAL.—A health care provider par-
2 ticipating in a demonstration project under sub-
3 section (a) shall—

4 “(A) utilize all available and appropriate
5 technologies to reduce the probability of future
6 medical errors; and

7 “(B) carry out other activities consistent
8 with subsection (a).

9 “(2) REPORTING TO PATIENTS.—In carrying
10 out this section, the Secretary shall ensure that—

11 “(A) 5 of the demonstration projects per-
12 mit the voluntary reporting by participating
13 health care providers of any adverse events,
14 sentinel events, health care-related errors, or
15 medication-related errors to the Secretary;

16 “(B) 5 of the demonstration projects re-
17 quire participating health care providers to re-
18 port any adverse events, sentinel events, health
19 care-related errors, or medication-related errors
20 to the Secretary; and

21 “(C) 5 of the demonstration projects re-
22 quire participating health care providers to re-
23 port any adverse events, sentinel events, health
24 care-related errors, or medication-related errors

1 to the Secretary and to the patient involved and
2 a family member or guardian of the patient.

3 “(3) CONFIDENTIALITY.—

4 “(A) IN GENERAL.—The Secretary and the
5 participating grantee organization shall ensure
6 that information reported under this section re-
7 mains confidential.

8 “(B) USE.—The Secretary may use the in-
9 formation reported under this section only for
10 the purpose of evaluating the ability to reduce
11 errors in the delivery of care. Such information
12 shall not be used for enforcement purposes.

13 “(C) DISCLOSURE.—The Secretary may
14 not disclose the information reported under this
15 section.

16 “(D) NONADMISSIBILITY.—Information re-
17 ported under this section shall be privileged,
18 confidential, shall not be admissible as evidence
19 or discoverable in any civil or criminal action or
20 proceeding or subject to disclosure, and shall
21 not be subject to the Freedom of Information
22 Act (5 U.S.C. App). This paragraph shall apply
23 to all information maintained by the reporting
24 entity and the entities who receive such reports.

1 “(c) USE OF TECHNOLOGIES.—The Secretary shall
2 encourage, as part of the demonstration projects con-
3 ducted under subsection (a), the use of appropriate tech-
4 nologies to reduce medical errors, such as hand-held elec-
5 tronic prescription pads, training simulators for medical
6 education, and bar-coding of prescription drugs and pa-
7 tient bracelets.

8 “(d) DATABASE.—The Secretary shall provide for the
9 establishment and operation of a national database of
10 medical errors to be used as provided for by the Secretary.
11 The information provided to the Secretary under sub-
12 section (b)(2) shall be contained in the database.

13 “(e) EVALUATION.—The Secretary shall evaluate the
14 progress of each demonstration project established under
15 this section in reducing the incidence of medical errors and
16 submit the results of such evaluations as part of the re-
17 ports under section 926(b).

18 “(f) REPORTING.—Prior to October 1, of the third
19 fiscal year for which funds are made available under this
20 section, the Secretary shall prepare and submit to the ap-
21 propriate committees of Congress an interim report con-
22 cerning the results of such demonstration projects.

23 **“SEC. 924. PATIENT SAFETY IMPROVEMENT.**

24 “(a) IN GENERAL.—The Secretary shall provide in-
25 formation to educate patients and family members about

1 their role in reducing medical errors. Such information
2 shall be provided to all individuals who participate in Fed-
3 erally-funded health care programs.

4 “(b) DEVELOPMENT OF PROGRAMS.—The Secretary
5 shall develop programs that encourage patients to take a
6 more active role in their medical treatment, including en-
7 couraging patients to provide information to health care
8 providers concerning pre-existing conditions and medica-
9 tions.

10 **“SEC. 925. PRIVATE, NONPROFIT EFFORTS TO REDUCE**
11 **MEDICAL ERRORS.**

12 “(a) IN GENERAL.—The Secretary shall make grants
13 to health professional associations and other organizations
14 to provide training in ways to reduce medical errors, in-
15 cluding curriculum development, technology training, and
16 continuing medical education.

17 “(b) APPLICATION.—To be eligible for a grant under
18 this section, an entity shall prepare and submit to the Sec-
19 retary an application at such time, in such manner and
20 containing, such information as the Secretary shall re-
21 quire.

22 **“SEC. 926. REPORT TO CONGRESS.**

23 “(a) INITIAL REPORT.—Not later than 180 days
24 after the date of enactment of this part, the Secretary
25 shall prepare and submit to the appropriate committees

1 of Congress a report concerning the costs associated with
2 implementing a program that identifies factors that con-
3 tribute to errors and which includes upgrading the health
4 care computer systems and other technologies in the
5 United States in order to reduce medical errors, including
6 computerizing hospital systems for the coordination of
7 prescription drugs and handling of laboratory specimens,
8 and contains recommendation on ways in which to reduce
9 those factors.

10 “(b) OTHER REPORTS.—Not later than 180 days
11 after the completion of all demonstration projects under
12 section 923, the Secretary shall prepare and submit to the
13 appropriate committees of Congress a report concerning—

14 “(1) how successful each demonstration project
15 was in reducing medical errors;

16 “(2) the data submitted by States under section
17 922(c);

18 “(3) the best methods for reducing medical er-
19 rors;

20 “(4) the costs associated with applying such
21 best methods on a nationwide basis; and

22 “(5) the manner in which other Federal agen-
23 cies can share information on best practices in order
24 to reduce medical errors in all Federal health care
25 programs.

1 **“SEC. 927. AUTHORIZATION OF APPROPRIATIONS.**

2 “There is authorized to be appropriated such sums
3 as may be necessary to carry out this part.”.

4 **TITLE IX—TAX INCENTIVES FOR**
5 **PURCHASE OF QUALIFIED**
6 **LONG-TERM CARE INSUR-**
7 **ANCE**

8 **SEC. 901. CREDIT FOR QUALIFIED LONG-TERM CARE PRE-**
9 **MIUMS.**

10 (a) **GENERAL RULE.**—Subpart C of part IV of sub-
11 chapter A of chapter 1 of the Internal Revenue Code of
12 1986 (relating to refundable credits) is amended by redес-
13 ignating section 35 as section 36 and by inserting after
14 section 34 the following:

15 **“SEC. 35. LONG-TERM CARE INSURANCE CREDIT.**

16 “(a) **GENERAL RULE.**—In the case of an individual,
17 there shall be allowed as a credit against the tax imposed
18 by this subtitle for the taxable year an amount equal to
19 the applicable percentage of the premiums for a qualified
20 long-term care insurance contract (as defined in section
21 7702B(b)) paid during such taxable year for such indi-
22 vidual or the spouse of such individual.

23 “(b) **APPLICABLE PERCENTAGE.**—

24 “(1) **IN GENERAL.**—For purposes of this sec-
25 tion, the term ‘applicable percentage’ means 28 per-
26 cent reduced (but not below zero) by 1 percentage

1 point for each \$1,000 (or fraction thereof) by which
2 the taxpayer's adjusted gross income for the taxable
3 year exceeds the base amount.

4 “(2) BASE AMOUNT.—For purposes of para-
5 graph (1) the term ‘base amount’ means—

6 “(A) except as otherwise provided in this
7 paragraph, \$25,000,

8 “(B) \$40,000 in the case of a joint return,
9 and

10 “(C) zero in the case of a taxpayer who—

11 “(i) is married at the close of the tax-
12 able year (within the meaning of section
13 7703) but does not file a joint return for
14 such taxable year, and

15 “(ii) does not live apart from the tax-
16 payer's spouse at all times during the tax-
17 able year.

18 “(c) COORDINATION WITH MEDICAL EXPENSE DE-
19 DUCTION.—Any amount allowed as a credit under this
20 section shall not be taken into account under section
21 213.”.

22 (b) CONFORMING AMENDMENT.—The table of sec-
23 tions for such subpart C is amended by striking the item
24 relating to section 35 and inserting the following:

“Sec. 35. Long-term care insurance credit.

“Sec. 36. Overpayments of tax.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2001.

4 **SEC. 902. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**
5 **SURANCE IN CAFETERIA PLANS AND FLEXI-**
6 **BLE SPENDING ARRANGEMENTS.**

7 (a) CAFETERIA PLANS.—The last sentence of section
8 125(f) of the Internal Revenue Code of 1986 (defining
9 qualified benefits) is amended by striking “shall not” and
10 inserting “shall”.

11 (b) FLEXIBLE SPENDING ARRANGEMENTS.—Section
12 106(e) of the Internal Revenue Code of 1986 (relating to
13 contributions by employer to accident and health plans)
14 is amended—

15 (1) in paragraph (1), by striking “include” and
16 inserting “shall not”; and

17 (2) in the heading, by striking “INCLUSION”
18 and inserting “EXCLUSION”.

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

1 **SEC. 903. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
 2 **RECEIVED ON CANCELLATION OF LIFE IN-**
 3 **SURANCE POLICIES AND USED FOR QUALI-**
 4 **FIED LONG-TERM CARE INSURANCE CON-**
 5 **TRACTS.**

6 (a) IN GENERAL.—

7 (1) EXCLUSION FROM GROSS INCOME.—

8 (A) IN GENERAL.—Part III of subchapter
 9 B of chapter 1 of the Internal Revenue Code of
 10 1986 (relating to items specifically excluded
 11 from gross income) is amended by redesign-
 12 ating section 139 as section 140 and by insert-
 13 ing after section 138 the following new section:

14 **“SEC. 139. AMOUNTS RECEIVED ON CANCELLATION, ETC.**
 15 **OF LIFE INSURANCE CONTRACTS AND USED**
 16 **TO PAY PREMIUMS FOR QUALIFIED LONG-**
 17 **TERM CARE INSURANCE.**

18 “No amount (which but for this section would be in-
 19 cludible in the gross income of an individual) shall be in-
 20 cluded in gross income on the whole or partial surrender,
 21 cancellation, or exchange of any life insurance contract
 22 during the taxable year if—

23 “(1) such individual has attained age 59½ on
 24 or before the date of the transaction, and

25 “(2) the amount otherwise includible in gross
 26 income is used during such year to pay for any

1 qualified long-term care insurance contract (as de-
 2 fined in section 7702B(b)) which—

3 “(A) is for the benefit of such individual or
 4 the spouse of such individual if such spouse has
 5 attained age 59½ on or before the date of the
 6 transaction, and

7 “(B) may not be surrendered for cash.”.

8 (B) CONFORMING AMENDMENT.—The
 9 table of sections for such part III is amended
 10 by striking the item relating to section 139 and
 11 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.”.

12 (2) CERTAIN EXCHANGES NOT TAXABLE.—Sec-
 13 tion 1035(a) of such Code (relating to certain ex-
 14 changes of insurance contracts) is amended by strik-
 15 ing the period at the end of paragraph (3) and in-
 16 serting “; or”, and by adding at the end the fol-
 17 lowing:

18 “(4) in the case of an individual who has at-
 19 tained age 59½, a contract of life insurance or an
 20 endowment or annuity contract for a qualified long-
 21 term care insurance contract (as defined in section
 22 7702B(b)), if the qualified long-term care insurance
 23 contract may not be surrendered for cash.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 2001.

4 **SEC. 904. USE OF GAIN FROM SALE OF PRINCIPAL RESI-**
 5 **DENCE FOR PURCHASE OF QUALIFIED LONG-**
 6 **TERM HEALTH CARE INSURANCE.**

7 (a) IN GENERAL.—Subsection (d) of section 121 of
 8 the Internal Revenue Code of 1986 (relating to exclusion
 9 of gain from sale of principal) is amended by adding at
 10 the end the following:

11 “(9) ELIGIBILITY OF HOME EQUITY CONVER-
 12 SION SALE-LEASEBACK TRANSACTION FOR EXCLU-
 13 SION.—

14 “(A) IN GENERAL.—For purposes of this
 15 section, the term ‘sale or exchange’ includes a
 16 home equity conversion sale-leaseback trans-
 17 action.

18 “(B) HOME EQUITY CONVERSION SALE-
 19 LEASEBACK TRANSACTION.—For purposes of
 20 subparagraph (A), the term ‘home equity con-
 21 version sale-leaseback’ means a transaction in
 22 which—

23 “(i) the seller-lessee—

24 “(I) sells property which during
 25 the 5-year period ending on the date

1 of the transaction has been owned and
2 used as a principal residence by such
3 seller-lessee for periods aggregating 2
4 years or more,

5 “(II) uses a portion of the pro-
6 ceeds from such sale to purchase a
7 qualified long-term care insurance
8 contract (as defined in section
9 7702B(b)), which contract may not be
10 surrendered for cash,

11 “(III) obtains occupancy rights
12 in such property pursuant to a written
13 lease requiring a fair rental, and

14 “(IV) receives no option to repur-
15 chase the property at a price less than
16 the fair market price of the property
17 unencumbered by any leaseback at the
18 time such option is exercised, and

19 “(ii) the purchaser-lessor—

20 “(I) is a person,

21 “(II) is contractually responsible
22 for the risks and burdens of owner-
23 ship and receives the benefits of own-
24 ership (other than the seller-lessee’s

1 occupancy rights) after the date of
2 such transaction, and

3 “(III) pays a purchase price for
4 the property that is not less than the
5 fair market price of such property en-
6 cumbered by a leaseback, and taking
7 into account the terms of the lease.

8 “(C) ADDITIONAL DEFINITIONS.—For pur-
9 poses of subparagraph (B)—

10 “(i) OCCUPANCY RIGHTS.—The term
11 ‘occupancy rights’ means the right to oc-
12 cupy the property for any period of time,
13 including a period of time measured by the
14 life of the seller-lessee on the date of the
15 sale-leaseback transaction (or the life of
16 the surviving seller-lessee, in the case of
17 jointly held occupancy rights), or a periodic
18 term subject to a continuing right of re-
19 newal by the seller-lessee (or by the sur-
20 viving seller-lessee, in the case of jointly
21 held occupancy rights).

22 “(ii) FAIR RENTAL.—The term ‘fair
23 rental’ means a rental for any subsequent
24 year which equals or exceeds the rental for

1 the 1st year of a sale-leaseback trans-
2 action.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 this section shall apply to sales after December 31, 2001,
5 in taxable years beginning after such date.

6 **TITLE X—NATIONAL FUND FOR**
7 **HEALTH RESEARCH**

8 **SEC. 1001. ESTABLISHMENT OF FUND.**

9 (a) ESTABLISHMENT.—There is established in the
10 Treasury of the United States a fund, to be known as the
11 “National Fund for Health Research” (in this section re-
12 ferred to as the “Fund”), consisting of such amounts as
13 are transferred to the Fund under subsection (b) and any
14 interest earned on investment of amounts in the Fund.

15 (b) TRANSFERS TO FUND.—

16 (1) IN GENERAL.—The Secretary of the Treas-
17 ury shall transfer to the Fund amounts equivalent to
18 amounts designated under paragraph (2) and re-
19 ceived in the Treasury.

20 (2) AMOUNTS.—

21 (A) HEALTH PLAN SET ASIDE.—With re-
22 spect to each calendar year beginning with the
23 first full calendar year after the date of enact-
24 ment of this Act, each health plan shall set

1 aside and transfer to the Treasury of the
2 United States an amount equal to—

3 (i) for the first full calendar year,
4 0.25 percent of all health premiums re-
5 ceived with respect to the plan for such
6 year;

7 (ii) for the second full calendar year,
8 0.5 percent of all health premiums received
9 with respect to the plan for such year;

10 (iii) for the third full calendar year,
11 0.75 percent of all health premiums re-
12 ceived with respect to the plan for such
13 year; and

14 (iv) for the fourth and each suc-
15 ceeding full calendar year, 1 percent of all
16 health premiums received with respect to
17 the plan for such year.

18 (3) TRANSFERS BASED ON ESTIMATES.—The
19 amounts transferred by paragraph (1) shall annually
20 be transferred to the Fund within 30 days after the
21 President signs an appropriations Act for the De-
22 partments of Labor, Health and Human Services,
23 and Education, and related agencies, or by the end
24 of the first quarter of the fiscal year. Proper adjust-
25 ment shall be made in amounts subsequently trans-

1 ferred to the extent prior estimates were in excess
2 of or less than the amounts required to be trans-
3 ferred.

4 (4) DEFINITION.—As used in this subsection,
5 the term “health plan” means a group health plan
6 (as defined in section 2791(a) of the Public Health
7 Service Act and any individual health insurance (as
8 defined in section 2791(b)(5) of such Act) operated
9 by a health insurance issuer.

10 (c) OBLIGATIONS FROM FUND.—

11 (1) IN GENERAL.—Subject to the provisions of
12 paragraph (4), with respect to the amounts made
13 available in the Fund in a fiscal year, the Secretary
14 of Health and Human Services shall distribute—

15 (A) 2 percent of such amounts during any
16 fiscal year to the Office of the Director of the
17 National Institutes of Health to be allocated at
18 the Director’s discretion for the following activi-
19 ties:

20 (i) for carrying out the responsibilities
21 of the Office of the Director, including the
22 Office of Research on Women’s Health and
23 the Office of Research on Minority Health,
24 the Office of Rare Disease Research, the
25 Office of Behavioral and Social Sciences

1 Research (for use for efforts to reduce to-
2 bacco use), the Office of Dietary Supple-
3 ments, and the Office for Disease Preven-
4 tion; and

5 (ii) for construction and acquisition of
6 equipment for or facilities of or used by
7 the National Institutes of Health;

8 (B) 2 percent of such amounts for transfer
9 to the National Center for Research Resources
10 to carry out section 1502 of the National Insti-
11 tutes of Health Revitalization Act of 1993 con-
12 cerning Biomedical and Behavioral Research
13 Facilities;

14 (C) 1 percent of such amounts during any
15 fiscal year for carrying out section 301 and
16 part D of title IV of the Public Health Service
17 Act with respect to health information commu-
18 nications; and

19 (D) the remainder of such amounts during
20 any fiscal year to member institutes and cen-
21 ters, including the Office of AIDS Research, of
22 the National Institutes of Health in the same
23 proportion to the total amount received under
24 this section, as the amount of annual appro-
25 priations under appropriations Acts for each

1 member institute and Centers for the fiscal year
2 bears to the total amount of appropriations
3 under appropriations Acts for all member insti-
4 tutes and Centers of the National Institutes of
5 Health for the fiscal year.

6 (2) PLANS OF ALLOCATION.—The amounts
7 transferred under paragraph (1)(D) shall be allo-
8 cated by the Director of the National Institutes of
9 Health or the various directors of the institutes and
10 centers, as the case may be, pursuant to allocation
11 plans developed by the various advisory councils to
12 such directors, after consultation with such direc-
13 tors.

14 (3) GRANTS AND CONTRACTS FULLY FUNDED
15 IN FIRST YEAR.—With respect to any grant or con-
16 tract funded by amounts distributed under para-
17 graph (1), the full amount of the total obligation of
18 such grant or contract shall be funded in the first
19 year of such grant or contract, and shall remain
20 available until expended.

21 (4) TRIGGER AND RELEASE OF MONIES AND
22 PHASE-IN.—

23 (A) TRIGGER AND RELEASE.—No expendi-
24 ture shall be made under paragraph (1) during
25 any fiscal year in which the annual amount ap-

1 appropriated for the National Institutes of Health
2 is less than the amount so appropriated for the
3 prior fiscal year.

4 (B) PHASE-IN.—The Secretary of Health
5 and Human Services shall phase-in the distribu-
6 tions required under paragraph (1) so that—

7 (i) 25 percent of the amount in the
8 Fund is distributed in the first fiscal year
9 for which funds are available;

10 (ii) 50 percent of the amount in the
11 Fund is distributed in the second fiscal
12 year for which funds are available;

13 (iii) 75 percent of the amount in the
14 Fund is distributed in the third fiscal year
15 for which funds are available; and

16 (iv) 100 percent of the amount in the
17 Fund is distributed in the fourth and each
18 succeeding fiscal year for which funds are
19 available.

20 (d) BUDGET TREATMENT OF AMOUNTS IN FUND.—

21 The amounts in the Fund shall be excluded from, and
22 shall not be taken into account, for purposes of any budget
23 enforcement procedure under the Congressional Budget

- 1 Act of 1974 or the Balanced Budget and Emergency Def-
- 2 icit Control Act of 1985.

○