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105TH CONGRESS
1ST SESSION

H. R. 561

To amend the Internal Revenue Code of 1986 to require that group health plans and insurers offer access to coverage for children and to assist families in the purchase of such coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 4, 1997

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

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A BILL

To amend the Internal Revenue Code of 1986 to require that group health plans and insurers offer access to coverage for children and to assist families in the purchase of such coverage, and for other purposes.

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

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

(a) SHORT TITLE.—This Act may be cited as the ''Children Health Insurance Act of 1997''.

(b) FINDINGS.—Congress finds that—

(1) it is in the national interest to ensure that every American child has access to affordable health care;

(2) no family should be forced to choose between health care for its children and other essential needs;

(3) 10,500,000 children in the United States under the age of 19 have no health insurance coverage, and 90 percent of these children have parents who work, and too many of these children go without needed health care;

(4) families have an obligation to contribute to the cost of health insurance coverage for their children, consistent with their ability to pay; and

(5) the Federal Government has an obligation to help families provide health insurance coverage for children.

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

SEC. 2. HEALTH INSURANCE AVAILABILITY FOR CHILDREN.

(a) IN GENERAL.—The Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996) is amended by adding at the end the following:

"Subtitle L—Health Insurance Availability for Children

"CHAPTER 101—HEALTH INSURANCE AVAILABILITY FOR CHILDREN

"SEC. 9901. EXCISE TAX ON FAILURE TO MEET REQUIREMENT OF ACCESS TO COVERAGE.

"(a) IMPOSITION OF TAX.—There is hereby imposed a tax on the failure of—

"(1) a group health plan to meet the coverage requirements of section 9902(a); and

"(2) an insurer that offers health insurance coverage in the individual market to meet the requirements of section 9902(b).

"(b) AMOUNT OF TAX.—

"(1) GROUP HEALTH PLAN.—

"(A) IN GENERAL.—The amount of tax imposed by subsection (a)(1) on any failure with respect to a participant or beneficiary of a

group health plan shall be 25 percent of each premium received by the group health plan for the plan year in which such failure occurs.

''(B) SELF-INSURED PLANS.—In the case that the group health plan is self-insured, the cost to the plan of the coverage of participants and beneficiaries shall be treated as the premium received for the purposes of subparagraph (A).

''(2) INSURER OFFERING INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amount of tax imposed by subsection (a)(2) on any failure of an insurer with respect to an individual described in paragraph (1) or (2) of section 9902(b) shall be 25 percent of the total amount of the premiums paid to the insurer for such coverage for the plan year in which such failure occurs.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (e)

knew, or exercising reasonable diligence would have known, that such failure existed.

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

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

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons referred to in subsection (e) knew, or exercising reasonable diligence would have known, that such failure existed.

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

''(d) TAX NOT TO APPLY TO CERTAIN PLANS.—This section shall not apply to—

''(1) any governmental plan (within the meaning of section 414(d)), or

''(2) any church plan (within the meaning of section 414(e)).

''(e) LIABILITY FOR TAX.—The following shall be responsible for the tax imposed by subsection (a):

''(1) In the case of the tax imposed by subsection (a)(1) on a group health plan, the plan.

''(2) In the case of the tax imposed by subsection (a)(2) on an insurer offering health insurance coverage, the insurer.

''SEC. 9902. REQUIREMENT OF ACCESS TO COVERAGE.

''(a) GROUP HEALTH PLANS.—

''(1) IN GENERAL.—Each group health plan that provides coverage to any participant (or beneficiary) must make available qualifying coverage for each qualifying young dependent of an individual who is a participant or beneficiary under the plan.

''(2) TIMING OF OFFER.—The offer under paragraph (1) shall be made at the time a person first becomes a qualifying young dependent and at least annually thereafter.

''(b) HEALTH INSURANCE COVERAGE.—Each insurer that offers health insurance coverage in the individual market must offer qualifying coverage for each individual who is under 21 years of age, residing in the United States, and a citizen or national of the United States (or alien permanently residing in the United States under color of law).

''(c) QUALIFYING COVERAGE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualifying coverage' means coverage of health care benefits that the Secretary of Health and Human Services determines approximates the following benefits, without any limitation based on a pre-existing condition with respect to such benefits and without any waiting period for coverage with respect to such benefits at a premium or other charge that is reasonably priced (within the meaning of paragraph (3)):

''(A) MEDICARE BENEFITS.—Benefits provided under parts A and B of title XVIII of the Social Security Act, or benefits determined to be actuarially equivalent to (or greater than) such benefits; except that, subject to subparagraph (D), in no case shall the coinsurance attributable to benefits under part B of such title exceed (with respect to provision of an item or service) the lesser of $10 or 10 percent of the recognized payment amount with respect to such item or service (determined without regard to cost-sharing).

''(B) WELL CHILD CARE BENEFITS.—

"(i) IN GENERAL.—Payment for the following items and services, without the application of deductibles, coinsurance, and copayments:

"(I) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

"(II) Well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care.

"(III) Early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act) for individuals under the age of 21.

"(ii) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American Academy of Pediatrics, shall establish a schedule of periodicity for services described in clauses (I) and (II) of clause (i)

which reflects the general, appropriate frequency with which such services should be provided to healthy children.

''(C) PRESCRIPTION DRUG BENEFIT.—A benefit for prescription drugs and biologicals necessary to meet catastrophic costs for such drugs and biologicals, as determined by the Secretary.

''(D) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no deductibles, coinsurance, or other cost sharing imposed with respect to benefits for preventive services, as defined by the Secretary.

''(2) MANAGED CARE PERMITTED.—Nothing in this section shall be construed as limiting the providers through whom the benefits described in paragraph (1) may be provided so long as there is reasonable access to such benefits.

''(3) REASONABLY PRICED.—For purposes of this subsection, coverage is considered to be 'reasonably priced' only if the premium or other charge for the coverage does not exceed 150 percent of the average price for similar coverage offered in the same

State (as determined based upon information provided by the Secretary of Health and Human Services).

''(d) QUALIFYING YOUNG DEPENDENT.—For purposes of this section, the term 'qualifying young dependent' means an individual who is under 21 years of age, residing in the United States, is a citizen or national of the United States (or alien permanently residing in the United States under color of law), and a dependent (as defined in section 152).

''SEC. 9903. DEFINITIONS.

''In this chapter—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 5000(b)(1), but does not include such a plan that has medical benefits that only consist of coverage described in paragraph (2)(B).

''(2) HEALTH INSURANCE COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health

maintenance organization group contract offered by an insurer or a health maintenance organization.

"(B) EXCEPTION.—Such term does not include coverage under any separate policy, certificate, or contract only for one or more of any of the following:

"(i) Coverage for accident, credit-only, vision, disability income, long-term care, nursing home care, community-based care dental, on-site medical clinics, or employee assistance programs, or any combination thereof.

"(ii) Medicare supplemental health insurance (within the meaning of section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1))) and similar supplemental coverage provided under a group health plan.

"(iii) Coverage issued as a supplement to liability insurance.

"(iv) Liability insurance, including general liability insurance and automobile liability insurance.

"(v) Workers' compensation or similar insurance.

"(vi) Automobile medical-payment insurance.

"(vii) Coverage for a specified disease or illness.

"(viii) Hospital or fixed indemnity insurance.

"(ix) Short-term limited duration insurance.

"(x) Such other coverage, comparable to that described in previous clauses, as may be specified in regulations prescribed under this title.

"(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

"(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

"(B) an organization recognized under State law as a health maintenance organization, or

"(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization,

if it is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

"(4) INSURER.—The term 'insurer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974).

"(5) INDIVIDUAL MARKET.—The term 'individual market' means the market for health insurance coverage offered to individuals and not to employers or in connection with a group health plan and does not include the market for such coverage issued only by an insurer that makes such coverage available only on the basis of affiliation with an association.

"(6) INCORPORATION OF CERTAIN DEFINITIONS.—The terms 'beneficiary' and 'participant' have the meanings given such terms in section 3 of

the Employee Retirement Income Security Act of 1974.''.

(b) CLERICAL AMENDMENT.—The table of contents for the Internal Revenue Code of 1986 is amended by adding after the item relating to subtitle K the following new item:

''Subtitle L. Health Insurance Availability for Children.''

(c) EFFECTIVE DATE.—The requirement of section 9902 of the Internal Revenue Code of 1986 (as added by subsection (a) of this section) shall take effect on January 1, 1998, and shall apply to coverage offered on or after such date regardless of whether the plan year began before such date.

SEC. 3. REFUNDABLE CREDIT FOR PURCHASE OF HEALTH INSURANCE COVERAGE FOR CHILDREN.

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. PURCHASE OF HEALTH INSURANCE COVERAGE FOR CHILDREN.

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to 95 percent of the amount paid by the taxpayer during the

taxable year for insurance which constitutes medical care (as defined in section 213) for a qualifying child of the taxpayer.

''(b) LIMITATIONS BASED ON ADJUSTED GROSS INCOME AND EMPLOYER CONTRIBUTIONS.—

''(1) LIMITATION BASED ON AGI.—

''(A) IN GENERAL.—No credit shall be allowed under subsection (a) for any taxable year for which the taxpayer's adjusted gross income exceeds the applicable dollar amount by $10,000 or more.

''(B) PHASEOUT.—If the taxpayer's adjusted gross income for the taxable year exceeds the applicable dollar amount by less than $10,000, the credit which would (but for this paragraph) be allowed under subsection (a) shall be reduced (but not below zero) by an amount which bears the same ratio to such credit as such excess bears to $10,000. Any reduction under the preceding sentence which is not a multiple of $10 shall be rounded to the next lowest $10.

''(C) APPLICABLE DOLLAR AMOUNT.—The term 'applicable dollar amount' means the sum of—

"(i) $15,000, plus

"(ii) $5,000 for each qualifying child of the taxpayer who is covered by the insurance referred to in subsection (a).

"(2) REDUCTION BASED ON EMPLOYER CONTRIBUTION.—The amount of any credit allowed under subsection (a) for any taxable year shall be reduced by the amount (if any) of an employer contribution that is made (or offered to be made) on behalf of the individual toward the premium for the insurance for periods during such year.

"(c) QUALIFYING CHILD.—

"(1) IN GENERAL.—Subject to paragraph (2), for the purposes of this section, the term 'qualifying child' has the meaning given such term by section 32(c)(3).

"(2) EXCEPTIONS.—Such term does not include—

"(A) an individual who has applied and been determined eligible for medical assistance under title XIX of the Social Security Act, until such time as the individual is no longer eligible for such assistance; and

"(B) an individual who is residing in a State (as defined for purposes of such title)

that the Secretary of Health and Human Services determines has reduced eligibility requirements for children under a State plan under such title below that in effect as of January 1, 1997, until such time as such Secretary determines the State no longer has reduced such requirements.

''(d) SPECIAL RULES.—

''(1) ONLY QUALIFYING CHILDREN MAY BE COVERED BY INSURANCE.—No amount shall be treated as paid for insurance under subsection (a) if any individual other than a qualifying child of the taxpayer is covered under such insurance. The principles of section 213(d)(6) shall apply for purposes of the preceding sentence.

''(2) ONLY REASONABLY PRICED COVERAGE QUALIFIES.—No amount shall be treated as paid for insurance under subsection (a) if the premium or other charge for the insurance is not reasonably priced (within the meaning of section 9902(c)(3)).

''(3) CERTAIN PLANS TREATED AS INSURANCE.—For purposes of this section, the term 'insurance' includes coverage under a State high risk pool plan or under a governmental plan (within the meaning of section 414(d)).

''(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (d), (e), and (h) of section 32, and section 213(d)(6), shall apply for purposes of this section.

''(5) SECTION NOT TO APPLY TO LONG-TERM CARE INSURANCE.—This section shall not apply to insurance which constitutes medical care by reason of section 213(d)(1)(C).

''(6) DISQUALIFICATION OF CERTAIN INSURANCE.—If the Secretary of Health and Human Services determines, based on information provided by a State or otherwise, that an issuer of insurance under this section has engaged in a pattern of abuse or misrepresentation of such insurance, this section shall not apply to insurance issued by such issuer until such Secretary is satisfied that such pattern has been remedied and will not recur.

''(e) COORDINATION WITH OTHER PROVISIONS.—

''(1) DEDUCTION FOR MEDICAL EXPENSES.—The amount taken into account in computing the credit under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—No

amount taken into account under section 162(l) may be taken into account under this section.''

(b) ADVANCE PAYMENT OF CREDIT.—

(1) IN GENERAL.—Chapter 25 of such Code (relating to general provisions relating to employment taxes) is amended by inserting after section 3507 the following new section:

''SEC. 3507A. ADVANCE PAYMENT OF CHILDREN'S HEALTH INSURANCE CREDIT.

''(a) GENERAL RULE.—Except as otherwise provided in this section, every employer making payment of wages to an employee with respect to whom a children's health insurance credit eligibility certificate is in effect shall, at the time of paying such wages, make an additional payment equal to the children's health insurance credit advance amount of such employee.

''(b) CHILDREN'S HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this title, a children's health insurance credit eligibility certificate is a statement furnished by an employee to the employer which—

''(1) certifies that the employee will be eligible to receive the credit provided by section 35 for the taxable year,

''(2) certifies that the employee does not have a children's health insurance credit eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer,

''(3) states whether or not the employee's spouse has such a certificate in effect, and

''(4) estimates the amount of children's health insurance credit of the employee for the calendar year.

For purposes of this section, a certificate shall be treated as being in effect with respect to a spouse if such a certificate will be in effect on the first status determination date following the date on which the employee furnishes the statement in question.

''(c) CHILDREN'S HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—

''(1) IN GENERAL.—For purposes of this title, the term 'children's health insurance credit advance amount' means, with respect to any payroll period, the amount determined—

''(A) on the basis of the employee's wages from the employer for such period,

''(B) on the basis of the employee's estimated amount of children's health insurance

credit included in the children's health insurance credit eligibility certificate, and

"(C) in accordance with tables prescribed by the Secretary.

"(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(C)—

"(A) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordinated with such tables and the tables prescribed under section 3507(c), and

"(B) shall be structured to carry out the principles of subparagraphs (B) and (C) of section 3507(c)(2).

"(d) CHILDREN'S HEALTH INSURANCE CREDIT.—For purposes of this section, the term 'children's health insurance credit' means the credit allowable by section 35.

"(e) OTHER RULES.—For purposes of this section, rules similar to the rules of subsections (d) and (e) of section 3507 shall apply.

"(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.".

(2) CLERICAL AMENDMENT.—The table of sections for chapter 25 of such Code is amended by inserting after the item relating to section 3507 the following new item:

"Sec. 3507A. Advance payment of children's health insurance credit.".

(c) REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new section:

"SEC. 6050S. RETURNS RELATING TO PREMIUMS RECEIVED FOR HEALTH INSURANCE COVERAGE FOR CHILDREN.

"(a) REQUIREMENT OF REPORTING.—Any person who, in connection with a trade or business, receives from any individual any premium for coverage to which section 35 applies shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

"(1) the aggregate amount of such premiums received from such individual during any calendar year,

"(2) the name, address, and TIN of such individual, and

"(3) such other information as the Secretary may prescribe.

''(b) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name, address, and phone number of the information contact of the person required to make such return, and

''(2) the aggregate amount of premiums described in subsection (a) received by such person from such individual.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.''

(2) PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code is amended by redesignating clauses (x) through (xv) as clauses (xi) through (xvi), respectively, and by inserting after clause (ix) the following new clause:

''(x) section 6050S (relating to reporting of premiums received for health insurance coverage for children),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by redesignating subparagraph (R) and the succeeding subparagraphs as subparagraphs (S) and following, respectively, and by inserting after subparagraph (Q) the following new subparagraph:

''(R) section 6050S(b) (relating to reporting of premiums received for health insurance coverage for children),''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Sec. 6050S. Returns relating to premiums received for health insurance coverage for children.''

(d) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ''or from section 35 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following new items:

''Sec. 35. Purchase of health insurance coverage for children.
''Sec. 36. Overpayments of tax.''

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 1997.

(2) ADVANCE PAYMENTS.—The amendment made by subsection (b) shall apply to remuneration paid after December 31, 1997.

(3) REPORTING.—The amendment made by subsection (c) shall apply to payments received after December 31, 1997.

SEC. 4. EMPLOYER MAY NOT DISCRIMINATE AGAINST SUBSIDY ELIGIBLE INDIVIDUALS.

(a) GENERAL RULE.—Any employer which elects to make employer contributions on behalf of an individual who is an employee of such employer, or who is a dependent of such employee, for health insurance coverage shall not condition, or vary, such contributions with respect to any such individual by reason of such individual's status as an individual eligible for a tax credit under section 35 of the Internal Revenue Code of 1986 (as added by section 3 of this Act).

(b) ELIMINATION OF CONTRIBUTIONS.—An employer shall not be treated as failing to meet the requirements of subsection (a) if the employer ceases to make employer

contributions for health insurance coverage for all its employees.

SEC. 5. MEDICAID COST-SHARING ASSISTANCE FOR QUALIFYING CHILDREN WITH FAMILY INCOME BELOW 150 PERCENT OF THE POVERTY LINE.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(E)—

(A) by striking ''and'' at the end of clause (ii), and

(B) by inserting at the end the following new clause:

''(iv) for making medical assistance available for cost-sharing assistance described in subsection (aa)(2) for qualifying children described in subsection (aa)(1); and''; and

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

''(aa)(1) For purposes of subsection (a)(10)(E)(iv), individuals described in this paragraph are qualifying children (as defined in section 35(c) of the Internal Revenue Code of 1986) whose family income has been determined under paragraph (3) to be less than 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with

section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(2) For purposes of subsection (a)(10)(E)(iv), the cost-sharing assistance described in this paragraph consists of a reduction in the amount of copayment applied with respect to an item or service for insurance under section 35 of the Internal Revenue Code of 1986 to an amount equal to 20 percent of the copayment amount otherwise applicable under the insurance, rounded to the nearest dollar.

''(3)(A) The Secretary shall promulgate regulations specifying requirements for State plans under this title with respect to determining eligibility of qualifying children for cost-sharing assistance under this subsection.

''(B) The regulations promulgated by the Secretary under subparagraph (A) shall include the following requirements:

''(i) A State plan shall provide that an individual may file an application for assistance with an agency designated by the State at any time, in person or by mail.

''(ii) A State plan shall provide for the use of an application form developed by the Secretary. Such form shall—

''(I) be simple in form and understandable to the average individual;

''(II) in the case of a State with a significant number of residents with limited English-speaking proficiency, be in languages other than English, as appropriate for the State;

''(III) require the provision of information necessary to make a determination as to whether an individual is eligible for assistance, including a declaration of estimated income by the individual; and

''(IV) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(iii) A State plan shall make applications accessible at locations where individuals are most likely to obtain the applications.

''(iv) A State plan shall require individuals to submit revised applications to reflect changes in estimated family incomes, including changes in employment status of family members, during the year. The State shall revise the amount of any cost-sharing assistance based on such a revised application.

''(C) A determination by a State that an individual is eligible for cost-sharing assistance shall be effective for the calendar year for which such determination is made unless a revised application submitted under subparagraph (B)(iv) indicates that an individual is no longer eligible for assistance.

''(D) Determinations made pursuant to this paragraph may be coordinated with determinations of eligibility for state-administered health programs to the extent that such coordination brings about administrative efficiencies.

''(4) If a State determines that a qualifying child is eligible for cost-sharing assistance under this section the State shall notify the health plan in which such individual is enrolled in a timely manner.''.

(b) 100 PERCENT FEDERAL FINANCING.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for cost-sharing assistance described in the last sentence of section 1905(a).''.

(c) COVERAGE OF COST-SHARING ASSISTANCE AS MEDICAL ASSISTANCE.—Section 1905(a) of such Act (42

U.S.C. 1396d(a)) is amended by adding at the end the following: ''Such term also includes payment of the cost-sharing assistance under section 1902(a)(10)(E)(iv).''.

(d) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1998, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6. GRANTS TO STATES FOR HEALTH INSURANCE OUTREACH AND INFORMATION PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide financial assistance to States in order to operate outreach and information programs that meet the requirements specified in subsection (b).

(b) REQUIREMENTS FOR OUTREACH AND INFORMATION PROGRAMS.—Each outreach and information program shall—

(1) target individuals eligible for access to health coverage under section 9902 of the Internal Revenue Code of 1986, tax credits under section 35 of such Code, or cost-sharing assistance under section 1902(aa) of the Social Security Act;

(2) provide comparative information on the policies offered by issuers in the State under sections 35 and 9902 of such Code;

(3) assist individuals in purchasing policies under section 9902 of such Code; and

(4) forward to the Secretary any findings by the State of a pattern of abuse or misrepresentation by the issuer of insurance for which a tax credit is available under section 35 of such Code.

The Secretary shall consider findings forwarded under paragraph (4) in determining whether a insurance continues to qualify for purposes of obtaining a tax credit under section 35 of such Code.

(c) AMOUNT OF ASSISTANCE.—The Secretary shall determine the amount of financial assistance provided to a State under this section. In determining such amount, the Secretary shall take into account the number of qualifying children (as defined in section 35(c) of such Code) in the State.

(d) APPLICATION REQUIRED.—No State is eligible for assistance under this section unless the State submits to the Secretary an application that is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each fiscal year (beginning with fiscal year 1998) such sums as may be necessary to carry out this section.

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