108TH CONGRESS
2D SESSION

S. 2570

Entitled the ''Health Care Assurance Act of 2004''.

IN THE SENATE OF THE UNITED STATES

JUNE 23 (legislative day, JUNE 22), 2004

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

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A BILL

Entitled the ''Health Care Assurance Act of 2004''.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Assurance Act of 2004''.

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

TITLE I—HEALTH CARE INSURANCE COVERAGE FOR THE UNINSURED

Subtitle A—Small Employer and Individual Purchasing Groups

CHAPTER 1—GENERAL PROVISIONS

SEC. 101. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

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

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

''SUBPART C—GENERAL INSURANCE COVERAGE REFORMS

"CHAPTER 1—INCREASED AVAILABILITY AND CONTINUITY OF HEALTH COVERAGE

"SEC. 721. DEFINITION.

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

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

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

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

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

''(b) STANDARD COVERAGE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall be considered to provide standard coverage consistent with this subsection if the

benefits are determined, in accordance with the set of actuarial equivalence rules certified under subsection (a), to have a value that is within 5 percentage points of the target actuarial value for standard coverage established under paragraph (2).

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

''(A) INITIAL DETERMINATION.—

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

''(ii) COVERAGE DESCRIBED.—The coverage described in this clause is cov-

erage for medically necessary and appropriate services consisting of medical and surgical services, medical equipment, preventive services, and emergency transportation in frontier areas. No specific procedure or treatment, or classes thereof, is required to be covered in such a plan, by this subpart or through regulations.

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

''(c) SUBSEQUENT REVISIONS.—

''(1) NAIC.—The NAIC may submit from time to time to the Secretary revisions of the set of rules of actuarial equivalence and target actuarial values previously established or determined under this section if the NAIC determines that revisions are nec-

essary to take into account changes in the relevant types of health benefits provisions or in demographic conditions which form the basis for the set of rules of actuarial equivalence or the target actuarial values. The provisions of subsection (a)(2) shall apply to such a revision in the same manner as they apply to the initial determination of the set of rules.

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

''SEC. 721B. ESTABLISHMENT OF PLAN STANDARDS.

''(a) ESTABLISHMENT OF GENERAL STANDARDS.—

''(1) ROLE OF NAIC.—The NAIC is requested to submit to the Secretary, within 9 months after the date of the enactment of this subpart, model regulations that specify standards for making qualified group health plans available to small employers. If the NAIC develops recommended regulations specifying such standards within such period, the Secretary shall review the standards. Such review shall be completed within 60 days after the date the regulations are developed. Such standards shall

serve as the standards under this section, with such amendments as the Secretary deems necessary. Such standards shall be nonbinding (except as provided in chapter 4).

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

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

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

fering of at least one group health plan that provides standard coverage (as described in section 721A(b)).

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

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

"(1) IN GENERAL.—Each group health plan offered, and each health insurance issuer offering group health insurance coverage, to a small employer shall establish within each community rating area in which the plan is to be offered, a standard premium for enrollment of eligible employees and eligible individuals for the standard coverage (as defined under section 721A(b)).

"(2) ESTABLISHMENT OF COMMUNITY RATING AREA.—

"(A) IN GENERAL.—Not later than January 1, 2005, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

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

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

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

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

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

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

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

on whether the method of enrollment is through a qualified small employer purchasing group, through a small employer, or through a broker.

''(2) APPLICATION TO ENROLLEES.—

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

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

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

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

''(B) FAMILY ADJUSTMENT FACTOR.—

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

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

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

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

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

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

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

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

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

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

''(iv) SPOUSE; MARRIED; COUPLE.—

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

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

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

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

''(3) ADMINISTRATIVE CHARGES.—

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

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

qualified small employer purchasing group in such area.

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

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

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

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

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

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

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

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

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

''(b) PAYMENT OF PREMIUMS.—

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

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

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

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

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

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

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

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

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

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

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

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

''(i) does not form or underwrite; and

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

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

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

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

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

''(d) MEMBERSHIP.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(g) RULES OF CONSTRUCTION.—

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

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

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

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

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

group health plan exclusively through a qualified small employer purchasing group.

"SEC. 721F. AGREEMENTS WITH SMALL EMPLOYERS.

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

"(b) PAYROLL DEDUCTION.—

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

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

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

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

''(1) eligible employees,

''(2) eligible individuals, and

''(3) certain uninsured individuals,

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

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

"SEC. 721H. RECEIPT OF PREMIUMS.

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

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

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

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

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

''SEC. 721I. MARKETING ACTIVITIES.

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 721L. EFFECTIVE DATES.

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

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

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

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

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

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

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

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

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

''(c) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

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

health plan which is a multiemployer plan, the requirements of section 722(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (b) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

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

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

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

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

''(4) in the case of a plan to which part 1 does not otherwise apply, the employer provides to the employee a summary plan description described in

section 102(a)(1) in the form and manner and at such times as are required under such part 1 with respect to employee welfare benefit plans.

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

"Subchapter A—Qualified Association Plans

"SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

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

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

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

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

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

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

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

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

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

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

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

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

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

rience of any employee or member or dependent of either;

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

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

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

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

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

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

''(c) CERTIFICATION.—

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

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

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

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

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

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

''(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 2005—

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

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

''(3) no annual report or funding statement shall be required before January 1, 2006, but the plan shall file with the Secretary a description of the plan and the name of the health insurance issuer.

''SEC. 723B. DEFINITIONS AND SPECIAL RULES.

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

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

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

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

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

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

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

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

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

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

''(2) if such plan is certified as meeting such requirements, such plan shall be treated as a plan established and maintained by a small employer and

individuals enrolled in such plan shall be treated as eligible employees; and

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

''(b) MODIFIED STANDARDS.—

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

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

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

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

ance, for purposes of any State law purporting to regulate insurance companies or insurance contracts.

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

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

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

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

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

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

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

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

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

SEC. 102. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

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

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

"CHAPTER 1—MISCELLANEOUS REQUIREMENTS"; and

(2) by adding at the end the following:

"CHAPTER 2—GENERAL INSURANCE COVERAGE REFORMS

"Subchapter A—Increased Availability and Continuity of Health Coverage

"SEC. 2707. DEFINITION.

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

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

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

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

''(2) CERTIFICATION.—If the Secretary determines that the NAIC has submitted a set of rules that comply with the requirements of paragraph (1), the Secretary shall certify such set of rules for use

under this chapter. If the Secretary determines that such a set of rules has not been submitted or does not comply with such requirements, the Secretary shall promptly establish a set of rules that meets such requirements.

''(b) STANDARD COVERAGE.—

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

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

''(A) INITIAL DETERMINATION.—

''(i) IN GENERAL.—The NAIC is requested to submit to the Secretary, within 6 months after the date of the enactment of this chapter, a target actuarial value for standard coverage equal to the average actuarial value of the coverage described in clause (ii). No specific procedure or treat-

ment, or classes thereof, is required to be considered in such determination by this chapter or through regulations. The determination of such value shall be based on a representative distribution of the population of eligible employees offered such coverage and a single set of standardized utilization and cost factors.

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

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

submitted or does not comply with the requirements of subparagraph (A), the Secretary shall promptly determine a target actuarial value that meets such requirements.

''(c) SUBSEQUENT REVISIONS.—

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

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

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

''(a) ESTABLISHMENT OF GENERAL STANDARDS.—

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

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

''(3) EFFECTIVE DATE.—The standards specified in the model regulations shall apply to group

health plans and health insurance issuers offering group health insurance coverage in a State on or after the respective date the standards are implemented in the State.

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

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

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

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

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

''(A) IN GENERAL.—Not later than January 1, 2005, each State shall, in accordance with subparagraph (B), provide for the division of the State into 1 or more community rating areas. The State may revise the boundaries of such areas from time to time consistent with this paragraph.

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

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

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

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

''(3) ELIGIBLE INDIVIDUALS.—For purposes of this section, the term 'eligible individuals' includes

certain uninsured individuals (as described in section 2707G).

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

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

''(2) APPLICATION TO ENROLLEES.—

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

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

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

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

''(B) FAMILY ADJUSTMENT FACTOR.—

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

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

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

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

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

''(IV) Coverage of a married couple and one or more children (referred

to in this chapter as the 'dual parent' enrollment or class of enrollment).

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

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

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

''(iv) SPOUSE; MARRIED; COUPLE.—

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

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

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

"(3) ADMINISTRATIVE CHARGES.—

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

negotiating a unique administrative charge with an insurer for a group health plan.

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

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

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

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

''(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance

coverage shall fully disclose rating practices for the plan to the appropriate certifying authority.

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

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

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

"(B) the rating methods are actuarially sound.

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

"(b) PAYMENT OF PREMIUMS.—

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

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

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

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

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

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

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

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

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

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

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

"(i) does not form or underwrite; and

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

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

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

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

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

''(d) MEMBERSHIP.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(g) RULES OF CONSTRUCTION.—

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

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

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

''(2) SINGLE ORGANIZATION SERVING MULTIPLE AREAS AND STATES.—Nothing in this section

shall be construed as preventing a single entity from being a qualified small employer purchasing group in more than one community rating area or in more than one State.

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

''SEC. 2707F. AGREEMENTS WITH SMALL EMPLOYERS.

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

''(b) PAYROLL DEDUCTION.—

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

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

difference between the amount of such premiums and the amount withheld.

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

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

''(1) eligible employees,

''(2) eligible individuals, and

''(3) certain uninsured individuals,

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

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

"SEC. 2707H. RECEIPT OF PREMIUMS.

''(a) ENROLLMENT CHARGE.—The amount charged by a qualified small employer purchasing group for cov-

erage under a qualified group health plan shall be equal to the sum of—

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

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

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

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

''SEC. 2707I. MARKETING ACTIVITIES.

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

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

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

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

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

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

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

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

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

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

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

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

"SEC. 2707L. EFFECTIVE DATES.

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

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

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

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

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

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

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

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

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

''(c) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

''(a) IN GENERAL.—In any case in which an eligible employee is, for any plan year, a participant in a group health plan which is a multiemployer plan, the requirements of section 2722(a) shall be deemed to be met with respect to such employee for such plan year if the employer requirements of subsection (b) are met with respect to the eligible employee, irrespective of whether, or to what extent, the employer makes employer contributions on behalf of the eligible employee.

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

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

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

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

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

''(4) in the case of a plan to which subchapter A does not otherwise apply, the employer provides to the employee a summary plan description described in section 102(a)(1) of the Employee Retirement Income Security Act of 1974 in the form and manner and at such times as are required under such subchapter A with respect to employee welfare benefit plans.

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

''SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

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

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

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

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

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

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

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

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

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

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

tiple employer welfare arrangement or similar arrangement—

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

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

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

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

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

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

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

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

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

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

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

''(c) CERTIFICATION.—

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

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

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

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

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

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

''(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 2005—

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

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

''(3) no annual report or funding statement shall be required before January 1, 2006, but the plan shall file with the Secretary a description of the plan and the name of the health insurance issuer.

"SEC. 2709B. DEFINITIONS AND SPECIAL RULES.

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

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

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

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

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

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

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

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

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

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

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

''(b) MODIFIED STANDARDS.—

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

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

''(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described

in subsection (c)(2) shall not be required to make any other plan available to the employee.

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

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

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

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

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

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

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

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

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

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

SEC. 103. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

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

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

(2) by adding at the end the following:

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

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

SEC. 104. EFFECTIVE DATE.

The amendments made by this subtitle shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated on or after January 1, 2005.

CHAPTER 2—TAX PROVISIONS

SEC. 111. ENFORCEMENT WITH RESPECT TO HEALTH INSURANCE ISSUERS.

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

''SEC. 4980H. FAILURE OF INSURER TO COMPLY WITH CERTAIN STANDARDS FOR HEALTH INSURANCE COVERAGE.

''(a) IMPOSITION OF TAX.—

''(1) IN GENERAL.—There is hereby imposed a tax on the failure of a health insurance issuer to

comply with the requirements applicable to such issuer under—

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

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

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

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

"(b) AMOUNT OF TAX.—

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

"(2) LIMITATION.—The amount of the tax imposed by subsection (a) for a health insurance issuer

with respect to health insurance coverage shall not exceed 25 percent of the amounts received under the coverage for coverage during the period such failure persists.

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

''(d) LIMITATIONS ON AMOUNT OF TAX.—

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

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

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

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

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

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

''Sec. 4980H. Failure of insurer to comply with certain standards for health insurance coverage.''.

SEC. 112. ENFORCEMENT WITH RESPECT TO SMALL EMPLOYERS.

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

''SEC. 5000A. SMALL EMPLOYER REQUIREMENTS.

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

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

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

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

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

''(c) LIMITATION ON TAX.—

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

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

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

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

that the payment of such tax would be excessive relative to the failure involved.''.

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

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

SEC. 113. ENFORCEMENT BY EXCISE TAX ON QUALIFIED ASSOCIATIONS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans), as amended by section 111, is amended by adding at the end the following new section:

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

''(a) IMPOSITION OF TAX.—

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

quirements applicable to such association or plans under—

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

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

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

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

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

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

''(d) LIMITATIONS ON AMOUNT OF TAX.—

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

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

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

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

(b) CONFORMING AMENDMENT.—The table of sections for such chapter 43, as amended by section 111, is amended by adding at the end the following new item:

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

Subtitle B—COBRA Portability Reform

SEC. 121. AMENDMENTS TO COBRA.

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

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

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

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

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

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

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

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

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

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

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

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

(3) INCREASE IN PERIOD OF COVERAGE.—Clause (i) of section 4980B(f)(2)(B) of the Internal

Revenue Code of 1986 (relating to period of coverage) is amended by striking ''18 months'' each place it appears and inserting ''24 months''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ceases to be a dependent child under the plan.''.

(c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—

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

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

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

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

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

If coverage under the plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan

pursuant to this subsection in connection with such group.''.

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

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

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

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

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

(3) INCREASE OF PERIOD OF COVERAGE.—Subparagraph (A) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-2(2)(A)) (relating to period of coverage) is amended by striking ''18 months'' each place it appears and inserting ''24 months''.

(4) CONTINUATION COVERAGE FOR DEPENDENT CHILD.—Subparagraph (A) of section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb-

2(2)(A)) is amended by adding at the end the following:

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

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

Subtitle C—Providing Coverage for Young Adults

SEC. 131. GRANTS FOR YOUNG ADULTS HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to State for the establishment and demonstration of programs to provide incentives to eligible young adults for the acquisition of health insurance coverage.

(b) APPLICATION.—To be eligible to receive a grant under subsection (a) a State shall prepare and submit to the Secretary an application at such time, in such manner,

and containing such information as the Secretary may require, including a description of the program to be carried out by the State with amounts received under the grant.

(c) USE OF FUNDS.—A State shall use amounts received under a grant under this section to carry out program to provide financial incentives to full-time or part-time college students, recent college graduates, and other young adults (as defined by the State program) without health insurance coverage to enable such individuals to purchase such coverage.

(d) REQUIREMENT.—A State shall carry out a program under this section through an existing State program such as a State high risk pool.

(e) TERMINATION OF INCENTIVE.—A State shall ensure that under the program established by the State under this section, the incentive provided to an individual shall terminate upon the individual being provided with the opportunity to purchase health insurance coverage through an employer.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $4,000,000,000 for fiscal year 2005, and such sums as may be necessary for each fiscal year thereafter.

Subtitle D—Low Income Coverage Outreach Program

SEC. 141. LOW INCOME COVERAGE OUTREACH PROGRAM.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, in conjunction with the Secretary of Agriculture, the Administrator of the Social Security Administration, and other appropriate Federal officials, shall establish a program to provide outreach to improve the public's knowledge concerning—

(1) health insurance coverage and health services available through Federal programs; and

(2) the public health benefits of health insurance coverage, including the advantages of receiving preventive and wellness items and services.

(b) TARGET POPULATIONS.—Outreach efforts under the program under subsection (a) shall be targeted at populations who may be eligible for assistance under programs described in subsection (a), as determined by the Federal officials involved in administering the outreach program, including recent immigrants and migrant and seasonal farmworkers.

(c) CULTURALLY APPROPRIATE MESSAGE.—Informational and other materials provided through the program established under subsection (a), shall be designed in a culturally appropriate manner.

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

SEC. 201. INCREASE IN INCOME ELIGIBILITY.

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

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on October 1, 2004.

SEC. 202. STATE OPTION TO EXPAND COVERAGE TO PARENTS AND PREGNANT WOMEN.

(a) IN GENERAL.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. OPTIONAL COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN AND PREGNANT WOMEN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of parent health assistance for targeted low-income parents, health care assistance for

targeted low-income pregnant women, or both, in accordance with this section.

''(b) DEFINITIONS.—For purposes of this title:

''(1) PARENT HEALTH ASSISTANCE.—The term 'parent health assistance' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income parents.

''(2) PARENT.—The term 'parent' has the meaning given the term 'caretaker relative' for purposes of carrying out section 1931.

''(3) HEALTH CARE ASSISTANCE FOR PREGNANT WOMEN.—The term 'health care assistance for pregnant women' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

''(4) TARGETED LOW-INCOME PARENT.—The term 'targeted low-income parent' has the meaning given the term targeted low-income child in section 2110(b) as if the reference to a child were deemed a reference to a parent (as defined in paragraph (3)) of the child; except that in applying such section—

''(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I)

the applicable income level in effect for a targeted low-income child;

"(B) in paragraph (3), January 1, 2005, shall be substituted for July 1, 1997; and

"(C) in paragraph (4), January 1, 2005, shall be substituted for March 31, 1997.

"(5) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' has the meaning given the term targeted low-income child in section 2110(b) as if any reference to a child were a reference to a woman during pregnancy and through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends; except that in applying such section—

"(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I) the applicable income level in effect for a targeted low-income child;

"(B) in paragraph (3), January 1, 2005, shall be substituted for July 1, 1997; and

"(C) in paragraph (4), January 1, 2005, shall be substituted for March 31, 1997.

"(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State pro-

viding for coverage of parent health assistance to targeted low-income parents or health care assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

''(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income parent or a targeted low-income pregnant woman (as applicable).

''(2) Any such reference to child health assistance—

''(A) with respect to such parents is deemed a reference to parent health assistance; and

''(B) with respect to such pregnant women, is deemed a reference to health care assistance for pregnant women.

''(3) In applying section 2103(e)(3)(B) in the case of a family (consisting of a parent and one or more children) provided coverage under this section or a pregnant woman provided coverage under this section without covering other family members, the limitation on total annual aggregate cost-sharing shall be applied to such entire family or such pregnant woman, respectively.

''(4) In applying section 2110(b)(4), any reference to 'section 1902(l)(2) or 1905(n)(2) (as selected by a State)' is deemed a reference to the effective income level applicable to parents under section 1931 or under a waiver approved under section 1115, or, in the case of a pregnant woman, the income level established under section 1902(l)(2)(A).

''(5) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to parents and pregnant women.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection apply to items and services furnished on or after October 1, 2004, whether or not regulations implementing such amendments have been issued.

TITLE III—MEDICARE PROGRAM INTEGRITY ACTIVITIES

SEC. 301. INCREASED FUNDING FOR THE MEDICARE INTEGRITY PROGRAM.

Section 1817(k)(4)(B) of the Social Security Act (42 U.S.C. 1395i(k)(4)(B)) is amended by striking clause (vii) and inserting the following:

''(vi) For each of fiscal years 2002, 2003, and 2004, such amount shall be not

less than $710,000,000 and not more than $720,000,000.

"(vii) For fiscal year 2005, such amount shall be not less than $760,000,000 and not more than $770,000,000.

"(viii) For fiscal year 2006, such amount shall be not less than $810,000,000 and not more than $820,000,000.

"(ix) For fiscal year 2007, such amount shall be not less than $860,000,000 and not more than $870,000,000.

"(x) For fiscal year 2008, such amount shall be not less than $920,000,000 and not more than $930,000,000.

"(xi) For each fiscal year after fiscal year 2008, such amount shall be not less than $990,000,000 and not more than $1,000,000,000.".

TITLE IV—REDUCING MEDICAL ERRORS AND INCREASING THE USE OF MEDICAL TECHNOLOGY

SEC. 401. MEDICAL ERRORS REDUCTION.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part C as part D;

(2) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(3) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(4) by inserting after part B the following:

''PART C—REDUCING ERRORS IN HEALTH CARE

''SEC. 921. DEFINITIONS.

''In this part:

''(1) ADVERSE EVENT.—The term 'adverse event' means an injury resulting from medical management rather than the underlying condition of the patient.

''(2) ERROR.—The term 'error' means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve the desired outcome.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means an individual or entity that provides medical services and is a participant in a demonstration program under this part.

''(4) HEALTH CARE-RELATED ERROR.—The term ''health care-related error'' means a preventable adverse event related to a health care intervention or a failure to intervene appropriately.

''(5) MEDICATION-RELATED ERROR.—The term 'medication-related error' means a preventable adverse event related to the administration of a medication.

''(6) SAFETY.—The term 'safety' with respect to an individual means that such individual has a right to be free from preventable serious injury.

''(7) SENTINEL EVENT.—The term 'sentinel event' means an unexpected occurrence involving an individual that results in death or serious physical injury that is unrelated to the natural course of the individual's illness or underlying condition.

''SEC. 922. ESTABLISHMENT OF STATE-BASED MEDICAL ERROR REPORTING SYSTEMS.

''(a) IN GENERAL.—The Secretary shall make grants available to States to enable such States to establish re-

porting systems designed to reduce medical errors and improve health care quality.

''(b) REQUIREMENT.—

''(1) IN GENERAL.—To be eligible to receive a grant under subsection (a), the State involved shall provide assurances to the Secretary that amounts received under the grant will be used to establish and implement a medical error reporting system using guidelines (including guidelines relating to the confidentiality of the reporting system) developed by the Agency for Healthcare Research and Quality with input from interested, non-governmental parties including patient, consumer and health care provider groups.

''(2) GUIDELINES.—Not later than 90 days after the date of enactment of this part, the Agency for Healthcare Research and Quality shall develop and publish the guidelines described in paragraph (1).

''(c) DATA.—

''(1) AVAILABILITY.—A State that receives a grant under subsection (a) shall make the data provided to the medical error reporting system involved available only to the Agency for Healthcare Research

and Quality and may not otherwise disclose such information.

''(2) CONFIDENTIALITY.—Nothing in this part shall be construed to supersede any State law that is inconsistent with this part.

''(d) APPLICATION.—To be eligible for a grant under this section, a State shall prepare and submit to the Secretary an application at such time, in such manner and containing, such information as the Secretary shall require.

''SEC. 923. DEMONSTRATION PROJECTS TO REDUCE MEDICAL ERRORS, IMPROVE PATIENT SAFETY, AND EVALUATE REPORTING.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in conjunction with the Administrator of the Health Care Financing Administration, may establish a program under which funding will be provided for not less than 15 demonstration projects, to be competitively awarded, in health care facilities and organizations in geographically diverse locations, including rural and urban areas (as determined by the Secretary), to determine the causes of medical errors and to—

''(1) use technology, staff training, and other methods to reduce such errors;

''(2) develop replicable models that minimize the frequency and severity of medical errors;

''(3) develop mechanisms that encourage reporting, prompt review, and corrective action with respect to medical errors; and

''(4) develop methods to minimize any additional paperwork burden on health care professionals.

''(b) ACTIVITIES.—

''(1) IN GENERAL.—A health care provider participating in a demonstration project under subsection (a) shall—

''(A) utilize all available and appropriate technologies to reduce the probability of future medical errors; and

''(B) carry out other activities consistent with subsection (a).

''(2) REPORTING TO PATIENTS.—In carrying out this section, the Secretary shall ensure that—

''(A) 5 of the demonstration projects permit the voluntary reporting by participating health care providers of any adverse events, sentinel events, health care-related errors, or medication-related errors to the Secretary;

''(B) 5 of the demonstration projects require participating health care providers to report any adverse events, sentinel events, health care-related errors, or medication-related errors to the Secretary; and

''(C) 5 of the demonstration projects require participating health care providers to report any adverse events, sentinel events, health care-related errors, or medication-related errors to the Secretary and to the patient involved and a family member or guardian of the patient.

''(3) CONFIDENTIALITY.—

''(A) IN GENERAL.—The Secretary and the participating grantee organization shall ensure that information reported under this section remains confidential.

''(B) USE.—The Secretary may use the information reported under this section only for the purpose of evaluating the ability to reduce errors in the delivery of care. Such information shall not be used for enforcement purposes.

''(C) DISCLOSURE.—The Secretary may not disclose the information reported under this section.

''(D) NONADMISSIBILITY.—Information reported under this section shall be privileged, confidential, shall not be admissible as evidence or discoverable in any civil or criminal action or proceeding or subject to disclosure, and shall not be subject to the Freedom of Information Act (5 U.S.C. App). This paragraph shall apply to all information maintained by the reporting entity and the entities who receive such reports.

''(c) USE OF TECHNOLOGIES.—The Secretary shall encourage, as part of the demonstration projects conducted under subsection (a), the use of appropriate technologies to reduce medical errors, such as hand-held electronic prescription pads, training simulators for medical education, and bar-coding of prescription drugs and patient bracelets.

''(d) DATABASE.—The Secretary shall provide for the establishment and operation of a national database of medical errors to be used as provided for by the Secretary. The information provided to the Secretary under subsection (b)(2) shall be contained in the database.

''(e) EVALUATION.—The Secretary shall evaluate the progress of each demonstration project established under this section in reducing the incidence of medical errors and

submit the results of such evaluations as part of the reports under section 926(b).

''(f) REPORTING.—Prior to October 1, of the third fiscal year for which funds are made available under this section, the Secretary shall prepare and submit to the appropriate committees of Congress an interim report concerning the results of such demonstration projects.

''SEC. 924. PATIENT SAFETY IMPROVEMENT.

''(a) IN GENERAL.—The Secretary shall provide information to educate patients and family members about their role in reducing medical errors. Such information shall be provided to all individuals who participate in Federally-funded health care programs.

''(b) DEVELOPMENT OF PROGRAMS.—The Secretary shall develop programs that encourage patients to take a more active role in their medical treatment, including encouraging patients to provide information to health care providers concerning pre-existing conditions and medications.

''SEC. 925. PRIVATE, NONPROFIT EFFORTS TO REDUCE MEDICAL ERRORS.

''(a) IN GENERAL.—The Secretary shall make grants to health professional associations and other organizations to provide training in ways to reduce medical errors, in-

cluding curriculum development, technology training, and continuing medical education.

''(b) APPLICATION.—To be eligible for a grant under this section, an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing, such information as the Secretary shall require.

''SEC. 926. REPORT TO CONGRESS.

''(a) INITIAL REPORT.—Not later than 180 days after the date of enactment of this part, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the costs associated with implementing a program that identifies factors that contribute to errors and which includes upgrading the health care computer systems and other technologies in the United States in order to reduce medical errors, including computerizing hospital systems for the coordination of prescription drugs and handling of laboratory specimens, and contains recommendations on ways in which to reduce those factors.

''(b) OTHER REPORTS.—Not later than 180 days after the completion of all demonstration projects under section 923, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning—

''(1) how successful each demonstration project was in reducing medical errors;

''(2) the data submitted by States under section 922(c);

''(3) the best methods for reducing medical errors;

''(4) the costs associated with applying such best methods on a nationwide basis; and

''(5) the manner in which other Federal agencies can share information on best practices in order to reduce medical errors in all Federal health care programs.

''SEC. 927. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary to carry out this part.''.

SEC. 402. ENHANCING INVESTMENT IN COST-EFFECTIVE METHODS OF HEALTH CARE.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following:

''SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUTCOMES RESEARCH.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Trust Fund for Medical Treatment

Outcomes Research' (referred to in this section as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Trust Fund an amount equivalent to the taxes received in the Treasury under section 4491 (relating to tax on health insurance policies).

''(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—On an annual basis and without further appropriation the Secretary shall distribute the amounts in the Trust Fund to the Secretary of Health and Human Services for use by the Agency for Healthcare Research and Quality. Such amounts shall be available to pay for research activities related to medical treatment outcomes and shall be in addition to any other amounts appropriated for such purposes.''.

(b) CONFORMING AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following:

''Sec. 9511. Trust Fund for Medical Treatment Outcomes Research.''.

SEC. 403. INCREASING THE USE OF MEDICAL TECHNOLOGY

The Secretary of Health and Human Services shall—

(1) provide grants and contracts to enhance the development of information technology standards by the private sector;

(2) carry out activities to examine how the use of information technology can be encouraged; and

(3) coordinate information technology-related activities taken by the Federal Government and ensure that such activities will further national health information and infrastructure.

TITLE V—IMPROVING HEALTH CARE QUALITY, EFFICIENCY, AND CONSUMER EDUCATION

SEC. 501. GRANTS FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to eligible entities for the establishment of demonstration projects to educate the public concerning their health care choices.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall be a public or nonprofit private entity and prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF FUNDS.—An entity shall use amounts received under a grant under this section to conduct activi-

ties to provide educational materials to individuals to inform such individuals about—

(1) health care choices;

(2) health care costs;

(3) health care quality control; and

(4) other matter determined appropriate by the Secretary.

(d) PUBLIC SERVICE ANNOUNCEMENTS.— the Secretary shall provide for the development of public service announcements to educate the public about their health care choices.

(e) ADVANCE DIRECTIVES.—In carrying out this section, the Secretary shall develop ways to improve the effectiveness and portability of advance directives and living wills.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.

TITLE VI—PRIMARY AND PREVENTIVE CARE PROVIDERS

SEC. 601. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS, AND CLINICAL NURSE SPECIALISTS.

(a) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395l(a)(1)(O)) is amended by striking ''85 percent'' and inserting ''90 percent'' each place it appears.

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on and after January 1, 2005.

SEC. 602. REQUIRING COVERAGE OF CERTAIN NONPHYSICIAN PROVIDERS UNDER THE MEDICAID PROGRAM.

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

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

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

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

''(28) services furnished by a physician assistant, nurse practitioner, clinical nurse specialist (as defined in section 1861(aa)(5)), or certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and''.

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

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

SEC. 603. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

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

"SEC. 749. MEDICAL STUDENT TUTORIAL PROGRAM GRANTS.

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

''(b) APPLICATION.—To be eligible to receive a grant under this section, a school of medicine or osteopathic medicine shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the school will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be used to—

''(A) fund programs under which students of the grantee are provided as tutors for high school and college students in the areas of mathematics, science, health promotion and prevention, first aid, nutrition and prenatal care;

''(B) fund programs under which students of the grantee are provided as participants in

clinics and seminars in the areas described in paragraph (1); and

''(C) conduct summer institutes for high school and college students to promote careers in medicine.

''(2) DESIGN OF PROGRAMS.—The programs, institutes, and other activities conducted by grantees under paragraph (1) shall be designed to—

''(A) give medical students desiring to practice general medicine access to the local community;

''(B) provide information to high school and college students concerning medical school and the general practice of medicine; and

''(C) promote careers in general medicine.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for fiscal year 2005, and such sums as may be necessary for fiscal year 2006.''.

SEC. 604. GENERAL MEDICAL PRACTICE GRANTS.

Part C of title VII of the Public Health Service Act (as amended by section 703) is further amended by adding at the end the following:

"SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.

''(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible public or private nonprofit schools of medicine or osteopathic medicine, hospitals, residency programs in family medicine or pediatrics, or to a consortium of such entities, to enable such entities to develop effective strategies for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(b) APPLICATION.—To be eligible to receive a grant under this section, an entity of the type described in subsection (a) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including assurances that the entity will use amounts received under the grant in accordance with subsection (c).

''(c) USE OF FUNDS.—Amounts received under a grant awarded under this section shall be used to fund programs under which effective strategies are developed and implemented for recruiting medical students interested in the practice of general medicine and placing such students into general practice positions upon graduation.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $25,000,000 for each of the fiscal years 2005 through

2007, and such sums as may be necessary for fiscal years thereafter.''.

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