

108TH CONGRESS  
2D SESSION

# S. 2570

Entitled the “Health Care Assurance Act of 2004”.

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## 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”.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Health Care Assurance Act of 2004”.

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

Sec. 1. Short title; table of contents.

#### TITLE I—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.

- Sec. 102. Amendments to the Public Health Service Act relating to the group market.
- Sec. 103. Amendment to the Public Health Service Act relating to the individual market.
- Sec. 104. Effective date.

#### CHAPTER 2—TAX PROVISIONS

- Sec. 111. Enforcement with respect to health insurance issuers.
- Sec. 112. Enforcement with respect to small employers.
- Sec. 113. Enforcement by excise tax on qualified associations.

#### Subtitle B—COBRA Portability Reform

- Sec. 121. Amendments to COBRA.

#### Subtitle C—Providing Coverage for Young Adults

- Sec. 131. Grants for young adults health insurance coverage.

#### Subtitle D—Low Income Coverage Outreach Program

- Sec. 141. Low income coverage outreach program.

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

- Sec. 201. Increase in income eligibility.
- Sec. 202. State option to expand coverage to parents and pregnant women.

### TITLE III—MEDICARE PROGRAM INTEGRITY ACTIVITIES

- Sec. 301. Increased funding for the medicare integrity program.

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

- Sec. 401. Medical errors reduction.
- Sec. 402. Enhancing investment in cost-effective methods of health care.
- Sec. 403. Increasing the use of medical technology

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

- Sec. 501. Grants for demonstration projects.

### TITLE VI—PRIMARY AND PREVENTIVE CARE PROVIDERS

- Sec. 601. Increased medicare reimbursement for physician assistants, nurse practitioners, and clinical nurse specialists.
- Sec. 602. Requiring coverage of certain nonphysician providers under the medicaid program.
- Sec. 603. Medical student tutorial program grants.
- Sec. 604. General medical practice grants.

1 **TITLE I—HEALTH CARE INSUR-**  
 2 **ANCE COVERAGE FOR THE**  
 3 **UNINSURED**

4 **Subtitle A—Small Employer and**  
 5 **Individual Purchasing Groups**

6 **CHAPTER 1—GENERAL PROVISIONS**

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

9 (a) IN GENERAL.—Part 7 of subtitle B of title I of  
 10 the Employee Retirement Income Security Act of 1974  
 11 (29 U.S.C. 1181 et seq.) is amended—

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

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

15 “SUBPART C—GENERAL INSURANCE COVERAGE  
 16 REFORMS

17 **“CHAPTER 1—INCREASED AVAILABILITY AND**  
 18 **CONTINUITY OF HEALTH COVERAGE**

19 **“SEC. 721. DEFINITION.**

20 “As used in this subpart, the term ‘qualified group  
 21 health plan’ means a group health plan, and a health in-  
 22 surance issuer offering group health insurance coverage,  
 23 that is designed to provide standard coverage (consistent  
 24 with section 721A(b)).

1 **“SEC. 721A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**  
 2 **MITTED.**

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

4 “(1) INITIAL DETERMINATION.—The NAIC is  
 5 requested to submit to the Secretary, within 6  
 6 months after the date of the enactment of this sub-  
 7 part, a set of rules which the NAIC determines is  
 8 sufficient for determining, in the case of any group  
 9 health plan, or a health insurance issuer offering  
 10 group health insurance coverage, and for purposes of  
 11 this section, the actuarial value of the coverage of-  
 12 fered by the plan or coverage.

13 “(2) CERTIFICATION.—If the Secretary deter-  
 14 mines that the NAIC has submitted a set of rules  
 15 that comply with the requirements of paragraph (1),  
 16 the Secretary shall certify such set of rules for use  
 17 under this subpart. If the Secretary determines that  
 18 such a set of rules has not been submitted or does  
 19 not comply with such requirements, the Secretary  
 20 shall promptly establish a set of rules that meets  
 21 such requirements.

22 “(b) STANDARD COVERAGE.—

23 “(1) IN GENERAL.—A group health plan, and a  
 24 health insurance issuer offering group health insur-  
 25 ance coverage, shall be considered to provide stand-  
 26 ard 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-

1 erage for medically necessary and appro-  
 2 priate services consisting of medical and  
 3 surgical services, medical equipment, pre-  
 4 ventive services, and emergency transpor-  
 5 tation in frontier areas. No specific proce-  
 6 dure or treatment, or classes thereof, is re-  
 7 quired to be covered in such a plan, by this  
 8 subpart or through regulations.

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

20 “(c) SUBSEQUENT REVISIONS.—

21 “(1) NAIC.—The NAIC may submit from time  
 22 to time to the Secretary revisions of the set of rules  
 23 of actuarial equivalence and target actuarial values  
 24 previously established or determined under this sec-  
 25 tion if the NAIC determines that revisions are nec-

1        necessary to take into account changes in the relevant  
 2        types of health benefits provisions or in demographic  
 3        conditions which form the basis for the set of rules  
 4        of actuarial equivalence or the target actuarial val-  
 5        ues. The provisions of subsection (a)(2) shall apply  
 6        to such a revision in the same manner as they apply  
 7        to the initial determination of the set of rules.

8                “(2) SECRETARY.—The Secretary may by regu-  
 9        lation revise the set of rules of actuarial equivalence  
 10       and target actuarial values from time to time if the  
 11       Secretary determines such revisions are necessary to  
 12       take into account changes described in paragraph  
 13       (1).

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

15        “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

16                “(1) ROLE OF NAIC.—The NAIC is requested  
 17       to submit to the Secretary, within 9 months after  
 18       the date of the enactment of this subpart, model  
 19       regulations that specify standards for making quali-  
 20       fied group health plans available to small employers.  
 21       If the NAIC develops recommended regulations  
 22       specifying such standards within such period, the  
 23       Secretary shall review the standards. Such review  
 24       shall be completed within 60 days after the date the  
 25       regulations are developed. Such standards shall

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

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

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

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

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

3   **“SEC. 721C. RATING LIMITATIONS FOR COMMUNITY-RATED**  
 4                   **MARKET.**

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

8           “(1) IN GENERAL.—Each group health plan of-  
 9   fered, and each health insurance issuer offering  
 10   group health insurance coverage, to a small em-  
 11   ployer shall establish within each community rating  
 12   area in which the plan is to be offered, a standard  
 13   premium for enrollment of eligible employees and eli-  
 14   gible individuals for the standard coverage (as de-  
 15   fined under section 721A(b)).

16           “(2) ESTABLISHMENT OF COMMUNITY RATING  
 17   AREA.—

18           “(A) IN GENERAL.—Not later than Janu-  
 19   ary 1, 2005, each State shall, in accordance  
 20   with subparagraph (B), provide for the division  
 21   of the State into 1 or more community rating  
 22   areas. The State may revise the boundaries of  
 23   such areas from time to time consistent with  
 24   this paragraph.

1 “(B) GEOGRAPHIC AREA VARIATIONS.—

2 For purposes of subparagraph (A), a State—

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

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

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

15 “(3) ELIGIBLE INDIVIDUALS.—For purposes of  
16 this section, the term ‘eligible individuals’ includes  
17 certain uninsured individuals (as described in section  
18 721G).

19 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
20 ING AREAS.—

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

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

4 “(2) APPLICATION TO ENROLLEES.—

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

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

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

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

17 “(B) FAMILY ADJUSTMENT FACTOR.—

18 “(i) IN GENERAL.—The standards es-  
 19 tablished under section 721B shall specify  
 20 family adjustment factors that reflect the  
 21 relative actuarial costs of benefit packages  
 22 based on family classes of enrollment (as  
 23 compared with such costs for individual en-  
 24 rollment).

“(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

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

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

9 “(iv) SPOUSE; MARRIED; COUPLE.—

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

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

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

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

4 “(3) ADMINISTRATIVE CHARGES.—

5 “(A) IN GENERAL.—In accordance with  
6 the standards established under section 721B, a  
7 group health plan which covers eligible employ-  
8 ees and eligible individuals may add a sepa-  
9 rately-stated administrative charge which is  
10 based on identifiable differences in legitimate  
11 administrative costs and which is applied uni-  
12 formly for individuals enrolling through the  
13 same method of enrollment. Nothing in this  
14 subparagraph may be construed as preventing a  
15 qualified small employer purchasing group from  
16 negotiating a unique administrative charge with  
17 an insurer for a group health plan.

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

1           qualified small employer purchasing group in  
2           such area.

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

12   **“SEC. 721D. RATING PRACTICES AND PAYMENT OF PRE-**  
13                           **MIUMS.**

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

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

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

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

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

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

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

22       “(b) PAYMENT OF PREMIUMS.—

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

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

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

17 **“SEC. 721E. QUALIFIED SMALL EMPLOYER PURCHASING**  
 18 **GROUPS.**

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

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

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

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

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

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

9 “(E) offers a program under which quali-  
10 fied group health plans are offered to eligible  
11 employees and eligible individuals through its  
12 member employers and to certain uninsured in-  
13 dividuals in accordance with section 721D; and

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

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

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

20 “(2) STATE CERTIFICATION.—A qualified small  
21 employer purchasing group formed under this sec-  
22 tion shall submit an application to the State for cer-  
23 tification. The State shall determine whether to  
24 issue a certification and otherwise ensure compliance  
25 with the requirements of this subpart.

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

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

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

17          “(d) MEMBERSHIP.—

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

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

1       “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-  
 2 CHASING GROUPS.—Each qualified small employer pur-  
 3 chasing group shall—

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

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

8           “(3) enroll only eligible employees, eligible indi-  
 9 viduals, and certain uninsured individuals in quali-  
 10 fied group health plans, in accordance with section  
 11 721G;

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

13          “(5) meet the marketing requirements under  
 14 section 721I; and

15          “(6) carry out other functions provided for  
 16 under this subpart.

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

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

21           “(2) perform any activity (other than the re-  
 22 porting of noncompliance) relating to compliance of  
 23 qualified group health plans with the requirements  
 24 of this subpart;

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

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

6       “(g) RULES OF CONSTRUCTION.—

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

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

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

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

22          “(3) VOLUNTARY PARTICIPATION.—Nothing in  
23       this section shall be construed as requiring any indi-  
24       vidual or small employer to purchase a qualified

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

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

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

8 “(b) PAYROLL DEDUCTION.—

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

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

1 **“SEC. 721G. ENROLLING ELIGIBLE EMPLOYEES, ELIGIBLE**  
 2 **INDIVIDUALS, AND CERTAIN UNINSURED IN-**  
 3 **DIVIDUALS IN QUALIFIED GROUP HEALTH**  
 4 **PLANS.**

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

7 “(1) eligible employees,

8 “(2) eligible individuals, and

9 “(3) certain uninsured individuals,

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

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

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

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

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

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

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

7       “(b) DISCLOSURE OF PREMIUM RATES AND ADMIN-  
8       ISTRATIVE CHARGES.—Each qualified small employer  
9       purchasing group shall, prior to the time of enrollment,  
10      disclose to enrollees and other interested parties the pre-  
11      mium rate for a qualified group health plan, the adminis-  
12      trative charge for such plan, and the administrative charge  
13      of the group, separately.

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

15       “Each qualified small employer purchasing group  
16      shall market qualified group health plans to members  
17      through the entire community rating area served by the  
18      purchasing group.

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

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

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

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

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

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

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

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

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

1 **“SEC. 721K. QUALIFIED SMALL EMPLOYER PURCHASING**  
 2 **GROUPS ESTABLISHED BY A STATE.**

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

8 **“SEC. 721L. EFFECTIVE DATES.**

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

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

16 **“CHAPTER 2—REQUIRED COVERAGE OPTIONS**  
 17 **FOR ELIGIBLE EMPLOYEES AND DEPEND-**  
 18 **ENTS OF SMALL EMPLOYERS**

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

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

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

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

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

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

10          “(c) SPECIAL RULES.—

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

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

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

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

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

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

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

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

21 **“SEC. 722A. COMPLIANCE WITH APPLICABLE REQUIRE-**  
 22 **MENTS THROUGH MULTIPLE EMPLOYER**  
 23 **HEALTH ARRANGEMENTS.**

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

1 health plan which is a multiemployer plan, the require-  
 2 ments of section 722(a) shall be deemed to be met with  
 3 respect to such employee for such plan year if the em-  
 4 ployer requirements of subsection (b) are met with respect  
 5 to the eligible employee, irrespective of whether, or to what  
 6 extent, the employer makes employer contributions on be-  
 7 half of the eligible employee.

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

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

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

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

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

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

4 **“CHAPTER 3—REQUIRED COVERAGE OPTIONS**  
 5 **FOR INDIVIDUALS INSURED THROUGH ASSO-**  
 6 **CIATION PLANS**

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

8 **“SEC. 723. TREATMENT OF QUALIFIED ASSOCIATION**  
 9 **PLANS.**

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

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

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

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

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

4               “(1) the health insurance issuer makes an irrev-  
5 ovable election to be treated as a qualified small em-  
6 ployer purchasing group for purposes of section  
7 721D; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4           “(c) CERTIFICATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5           “(4) receives a substantial portion of its finan-  
6           cial support from its active, affiliated, or federation  
7           members.

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

11           **“Subchapter B—Special Rule for Church,**  
12           **Multiemployer, and Cooperative Plans**

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

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

18           “(1) except as otherwise provided in this sub-  
19           chapter, the plan shall be required to meet all appli-  
20           cable requirements of chapter 1 and chapter 2 for  
21           group health plans offered to and by small employ-  
22           ers;

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

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

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

7 “(b) MODIFIED STANDARDS.—

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

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

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

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

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

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

5               “(1) is a church plan (as defined in section  
6       414(e) of the Internal Revenue Code of 1986) which  
7       has at least 100 participants in the United States;

8               “(2) is a multiemployer plan which is main-  
9       tained by a health plan sponsor described in section  
10       3(16)(B)(iii) and which has at least 500 participants  
11       in the United States; or

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

16       (b) CONFORMING AMENDMENTS.—Section 731(d) of  
17       the Employee Retirement Income Security Act of 1974  
18       (29 U.S.C. 1186(d)) is amended by adding at the end the  
19       following:

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

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

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

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

10 **SEC. 102. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

11 **ACT RELATING TO THE GROUP MARKET.**

12           (a) IN GENERAL.—Subpart 2 of part A of title  
13 XXVII of the Public Health Service Act (42 U.S.C.  
14 300gg–4 et seq.) is amended—

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

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

18           and

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

1   **“CHAPTER 2—GENERAL INSURANCE COVERAGE**

2                               **REFORMS**

3               **“Subchapter A—Increased Availability and**

4                               **Continuity of Health Coverage**

5   **“SEC. 2707. DEFINITION.**

6            “‘As used in this chapter, the term ‘qualified group  
7 health plan’ means a group health plan, and a health in-  
8 surance issuer offering group health insurance coverage,  
9 that is designed to provide standard coverage (consistent  
10 with section 2707A(b)).

11   **“SEC. 2707A. ACTUARIAL EQUIVALENCE IN BENEFITS PER-**  
12                               **MITTED.**

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

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

23               “(2) CERTIFICATION.—If the Secretary deter-  
24 mines that the NAIC has submitted a set of rules  
25 that comply with the requirements of paragraph (1),  
26 the Secretary shall certify such set of rules for use

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

6 “(b) STANDARD COVERAGE.—

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

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

18 “(A) INITIAL DETERMINATION.—

19 “(i) IN GENERAL.—The NAIC is re-  
 20 quested to submit to the Secretary, within  
 21 6 months after the date of the enactment  
 22 of this chapter, a target actuarial value for  
 23 standard coverage equal to the average ac-  
 24 tuarial value of the coverage described in  
 25 clause (ii). No specific procedure or treat-

1           ment, or classes thereof, is required to be  
2           considered in such determination by this  
3           chapter or through regulations. The deter-  
4           mination of such value shall be based on a  
5           representative distribution of the popu-  
6           lation of eligible employees offered such  
7           coverage and a single set of standardized  
8           utilization and cost factors.

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

19          “(B) CERTIFICATION.—If the Secretary  
20          determines that the NAIC has submitted a tar-  
21          get actuarial value for standard coverage that  
22          complies with the requirements of subparagraph  
23          (A), the Secretary shall certify such value for  
24          use under this chapter. If the Secretary deter-  
25          mines that a target actuarial value has not been

1 submitted or does not comply with the require-  
 2 ments of subparagraph (A), the Secretary shall  
 3 promptly determine a target actuarial value that  
 4 meets such requirements.

5 “(c) SUBSEQUENT REVISIONS.—

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

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

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

25 “(a) ESTABLISHMENT OF GENERAL STANDARDS.—

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

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

24          “(3) EFFECTIVE DATE.—The standards speci-  
25          fied in the model regulations shall apply to group

1 health plans and health insurance issuers offering  
 2 group health insurance coverage in a State on or  
 3 after the respective date the standards are imple-  
 4 mented in the State.

5 “(b) NO PREEMPTION OF STATE LAW.—A State may  
 6 implement standards for group health plans available, and  
 7 health insurance issuers offering group health insurance  
 8 coverage offered, to small employers that are more strin-  
 9 gent than the standards under this section, except that  
 10 a State may not implement standards that prevent the of-  
 11 fering of at least one group health plan that provides  
 12 standard coverage (as described in section 2707A(b)).

13 **“SEC. 2707C. RATING LIMITATIONS FOR COMMUNITY-**  
 14 **RATED MARKET.**

15 “(a) STANDARD PREMIUMS WITH RESPECT TO COM-  
 16 MUNITY-RATED ELIGIBLE EMPLOYEES AND ELIGIBLE IN-  
 17 DIVIDUALS.—

18 “(1) IN GENERAL.—Each group health plan of-  
 19 fered, and each health insurance issuer offering  
 20 group health insurance coverage, to a small em-  
 21 ployer shall establish within each community rating  
 22 area in which the plan is to be offered, a standard  
 23 premium for enrollment of eligible employees and eli-  
 24 gible individuals for the standard coverage (as de-  
 25 fined under section 2707A(b)).

1           “(2) ESTABLISHMENT OF COMMUNITY RATING  
2       AREA.—

3           “(A) IN GENERAL.—Not later than Janu-  
4       ary 1, 2005, each State shall, in accordance  
5       with subparagraph (B), provide for the division  
6       of the State into 1 or more community rating  
7       areas. The State may revise the boundaries of  
8       such areas from time to time consistent with  
9       this paragraph.

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

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

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

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

24          “(3) ELIGIBLE INDIVIDUALS.—For purposes of  
25       this section, the term ‘eligible individuals’ includes

1 certain uninsured individuals (as described in section  
2 2707G).

3 “(b) UNIFORM PREMIUMS WITHIN COMMUNITY RAT-  
4 ING AREAS.—

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

13 “(2) APPLICATION TO ENROLLEES.—

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

18 “(i) the standard premium (estab-  
19 lished under paragraph (1));

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

24 “(iii) the age adjustment factor (spec-  
25 ified under subparagraph (C)).

1 “(B) FAMILY ADJUSTMENT FACTOR.—

2 “(i) IN GENERAL.—The standards es-  
3 tablished under section 2707B shall specify  
4 family adjustment factors that reflect the  
5 relative actuarial costs of benefit packages  
6 based on family classes of enrollment (as  
7 compared with such costs for individual en-  
8 rollment).

9 “(ii) CLASSES OF ENROLLMENT.—For  
10 purposes of this chapter, there are 4 class-  
11 es of enrollment:

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

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

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

24 “(IV) Coverage of a married cou-  
25 ple and one or more children (referred

1 to in this chapter as the ‘dual parent’  
 2 enrollment or class of enrollment).

3 “(iii) REFERENCES TO FAMILY AND  
 4 COUPLE CLASSES OF ENROLLMENT.—In  
 5 this chapter:

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

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

17 “(iv) SPOUSE; MARRIED; COUPLE.—

18 “(I) IN GENERAL.—In this chap-  
 19 ter, the terms ‘spouse’ and ‘married’  
 20 mean, with respect to an individual,  
 21 another individual who is the spouse  
 22 of, or is married to, the individual, as  
 23 determined under applicable State  
 24 law.

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

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

13               “(3) ADMINISTRATIVE CHARGES.—

14               “(A) IN GENERAL.—In accordance with  
15               the standards established under section 2707B,  
16               a group health plan which covers eligible em-  
17               ployees and eligible individuals may add a sepa-  
18               rately-stated administrative charge which is  
19               based on identifiable differences in legitimate  
20               administrative costs and which is applied uni-  
21               formly for individuals enrolling through the  
22               same method of enrollment. Nothing in this  
23               subparagraph may be construed as preventing a  
24               qualified small employer purchasing group from

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

3 “(B) ENROLLMENT THROUGH A QUALI-  
 4 FIED SMALL EMPLOYER PURCHASING GROUP.—

5 In the case of an administrative charge under  
 6 subparagraph (A) for enrollment through a  
 7 qualified small employer purchasing group, such  
 8 charge may not exceed the lowest charge of  
 9 such plan for enrollment other than through a  
 10 qualified small employer purchasing group in  
 11 such area.

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

21 **“SEC. 2707D. RATING PRACTICES AND PAYMENT OF PRE-**  
 22 **MIUMS.**

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

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

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

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

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

22 “(A) such plan or insurer is in compliance  
23 with the applicable provisions of this chapter;  
24 and

1           “(B) the rating methods are actuarially  
2           sound.

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

6           “(b) PAYMENT OF PREMIUMS.—

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

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

1 **“SEC. 2707E. QUALIFIED SMALL EMPLOYER PURCHASING**  
 2 **GROUPS.**

3 “(a) QUALIFIED SMALL EMPLOYER PURCHASING  
 4 GROUPS DESCRIBED.—

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

7 “(A) is a nonprofit entity certified under  
 8 State law;

9 “(B) has a membership consisting solely of  
 10 small employers;

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

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

17 “(E) offers a program under which quali-  
 18 fied group health plans are offered to eligible  
 19 employees and eligible individuals through its  
 20 member employers and to certain uninsured in-  
 21 dividuals in accordance with section 2707D;  
 22 and

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

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

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

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

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

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

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

25                  “(d) MEMBERSHIP.—

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

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

9           “(e) DUTIES OF QUALIFIED SMALL EMPLOYER PUR-  
 10          CHASING GROUPS.—Each qualified small employer pur-  
 11          chasing group shall—

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

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

16           “(3) enroll only eligible employees, eligible indi-  
 17          viduals, and certain uninsured individuals in quali-  
 18          fied group health plans, in accordance with section  
 19          2707G;

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

21           “(5) meet the marketing requirements under  
 22          section 2707I; and

23           “(6) carry out other functions provided for  
 24          under this chapter.

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

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

5               “(2) perform any activity (other than the re-  
6 porting of noncompliance) relating to compliance of  
7 qualified group health plans with the requirements of  
8 this chapter;

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

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

14       “(g) RULES OF CONSTRUCTION.—

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

17                      “(A) that a State organize, operate or oth-  
18 erwise establish a qualified small employer pur-  
19 chasing group, or otherwise require the estab-  
20 lishment of purchasing groups; and

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

24              “(2) SINGLE ORGANIZATION SERVING MUL-  
25 TIPLE AREAS AND STATES.—Nothing in this section

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

5 “(3) VOLUNTARY PARTICIPATION.—Nothing in  
 6 this section shall be construed as requiring any indi-  
 7 vidual or small employer to purchase a qualified  
 8 group health plan exclusively through a qualified  
 9 small employer purchasing group.

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

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

15 “(b) PAYROLL DEDUCTION.—

16 “(1) IN GENERAL.—Under an agreement under  
 17 this section between a small employer and a quali-  
 18 fied small employer purchasing group, the small em-  
 19 ployer shall deduct premiums from an eligible em-  
 20 ployee’s wages.

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

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

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

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

9 “(1) eligible employees,

10 “(2) eligible individuals, and

11 “(3) certain uninsured individuals,

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

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

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

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

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

3           “(1) the premium rate offered by such health  
 4       plan;

5           “(2) the administrative charge for such health  
 6       plan; and

7           “(3) the purchasing group administrative  
 8       charge for enrollment of eligible employees, eligible  
 9       individuals and certain uninsured individuals  
 10      through the group.

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

18   **“SEC. 2707I. MARKETING ACTIVITIES.**

19       “Each qualified small employer purchasing group  
 20      shall market qualified group health plans to members  
 21      through the entire community rating area served by the  
 22      purchasing group.

1 **“SEC. 2707J. GRANTS TO STATES AND QUALIFIED SMALL**  
2 **EMPLOYER PURCHASING GROUPS.**

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

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

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

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

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

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

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

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

6   **“SEC. 2707K. QUALIFIED SMALL EMPLOYER PURCHASING**  
7                           **GROUPS ESTABLISHED BY A STATE.**

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

13   **“SEC. 2707L. EFFECTIVE DATES.**

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

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

1 **“Subchapter B—Required Coverage Options for Eli-**  
 2 **gible Employees and Dependents of Small Em-**  
 3 **ployers**

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

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

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

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

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

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

21 “(c) SPECIAL RULES.—

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

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

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

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

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

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

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

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

7       **“SEC. 2708A. COMPLIANCE WITH APPLICABLE REQUIRE-**  
 8                   **MENTS THROUGH MULTIPLE EMPLOYER**  
 9                   **HEALTH ARRANGEMENTS.**

10       “(a) IN GENERAL.—In any case in which an eligible  
 11 employee is, for any plan year, a participant in a group  
 12 health plan which is a multiemployer plan, the require-  
 13 ments of section 2722(a) shall be deemed to be met with  
 14 respect to such employee for such plan year if the em-  
 15 ployer requirements of subsection (b) are met with respect  
 16 to the eligible employee, irrespective of whether, or to what  
 17 extent, the employer makes employer contributions on be-  
 18 half of the eligible employee.

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

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

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

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

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

10 “(4) in the case of a plan to which subchapter  
 11 A does not otherwise apply, the employer provides to  
 12 the employee a summary plan description described  
 13 in section 102(a)(1) of the Employee Retirement In-  
 14 come Security Act of 1974 in the form and manner  
 15 and at such times as are required under such sub-  
 16 chapter A with respect to employee welfare benefit  
 17 plans.

18 **“Subchapter C—Required Coverage Options for**  
 19 **Individuals Insured Through Association Plans**

20 **“SEC. 2709. TREATMENT OF QUALIFIED ASSOCIATION**  
 21 **PLANS.**

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

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

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

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

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

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

16           “(1) the health insurance issuer makes an irrev-  
17      ocable election to be treated as a qualified small em-  
18      ployer purchasing group for purposes of section  
19      2707D; and

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

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

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

1 tiple employer welfare arrangement or similar arrange-  
2 ment—

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

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

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

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

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

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

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

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

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

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

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

15 “(c) CERTIFICATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **“SEC. 2709C. SPECIAL RULE FOR CHURCH, MULTITEM-**  
22 **PLOYER, AND COOPERATIVE PLANS.**

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

1           “(1) except as otherwise provided in this sub-  
 2           chapter, the plan shall be required to meet all appli-  
 3           cable requirements of subchapter A and subchapter  
 4           B for group health plans offered to and by small em-  
 5           ployers;

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

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

15          “(b) MODIFIED STANDARDS.—

16               “(1) CERTIFYING AUTHORITY.—For purposes  
 17               of this chapter, the Secretary shall be the appro-  
 18               priate certifying authority with respect to a plan to  
 19               which this section applies.

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

23               “(3) ACCESS.—An employer which, pursuant to  
 24               a collective bargaining agreement, offers an em-  
 25               ployee the opportunity to enroll in a plan described

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

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

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

13 “(1) is a church plan (as defined in section  
 14 414(e) of the Internal Revenue Code of 1986) which  
 15 has at least 100 participants in the United States;

16 “(2) is a multiemployer plan which is main-  
 17 tained by a health plan sponsor described in section  
 18 3(16)(B)(iii) of the Employee Retirement Income  
 19 Security Act of 1974 and which has at least 500  
 20 participants in the United States; or

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

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

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

9 “(16) ELIGIBLE INDIVIDUAL.—The term ‘eligi-  
 10 ble individual’ means, with respect to an eligible em-  
 11 ployee, such employee, and any dependent of such  
 12 employee.

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

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

18 **SEC. 103. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

19 **ACT RELATING TO THE INDIVIDUAL MARKET.**

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

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

24 and

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

1 **“SEC. 2753. APPLICABILITY OF GENERAL INSURANCE MAR-**  
 2 **KET REFORMS.**

3 “The provisions of chapter 2 of subpart 2 of part A  
 4 shall apply to health insurance coverage offered by a  
 5 health insurance issuer in the individual market in the  
 6 same manner as they apply to health insurance coverage  
 7 offered by a health insurance issuer in connection with a  
 8 group health plan in the small or large group market.”.

9 **SEC. 104. EFFECTIVE DATE.**

10 The amendments made by this subtitle shall apply  
 11 with respect to health insurance coverage offered, sold,  
 12 issued, renewed, in effect, or operated on or after January  
 13 1, 2005.

14 **CHAPTER 2—TAX PROVISIONS**

15 **SEC. 111. ENFORCEMENT WITH RESPECT TO HEALTH IN-**  
 16 **SURANCE ISSUERS.**

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

20 **“SEC. 4980H. FAILURE OF INSURER TO COMPLY WITH CER-**  
 21 **TAIN STANDARDS FOR HEALTH INSURANCE**  
 22 **COVERAGE.**

23 “(a) IMPOSITION OF TAX.—

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

1       comply with the requirements applicable to such  
2       issuer under—

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

5               “(B) section 2753 of the Public Health  
6               Service Act; and

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

10              “(2) EXCEPTION.—Paragraph (1) shall not  
11              apply to a failure by a health insurance issuer in a  
12              State if the Secretary of Health and Human Serv-  
13              ices determines that the State has in effect a regu-  
14              latory enforcement mechanism that provides ade-  
15              quate sanctions with respect to such a failure by  
16              such an issuer.

17              “(b) AMOUNT OF TAX.—

18              “(1) IN GENERAL.—Subject to paragraph (2),  
19              the amount of the tax imposed by subsection (a)  
20              shall be \$100 for each day during which such failure  
21              persists for each person to which such failure re-  
22              lates. A rule similar to the rule of section  
23              4980D(b)(3) shall apply for purposes of this section.

24              “(2) LIMITATION.—The amount of the tax im-  
25              posed by subsection (a) for a health insurance issuer

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

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

7 “(d) LIMITATIONS ON AMOUNT OF TAX.—

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

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

13 “(B) such failure is corrected during the  
14 30-day period (or such period as the Secretary  
15 may determine appropriate) beginning on the  
16 first date the health insurance issuer knows, or  
17 exercising reasonable diligence could have  
18 known, that such failure existed.

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

1       “(e) DEFINITIONS.—For purposes of this section, the  
 2 terms ‘health insurance coverage’ and ‘health insurance  
 3 issuer’ have the meanings given such terms in section  
 4 2791 of the Public Health Service Act and section 733  
 5 of the Employee Retirement Income Security Act of  
 6 1974.”.

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

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

10 **SEC. 112. ENFORCEMENT WITH RESPECT TO SMALL EM-**  
 11 **PLOYERS.**

12       (a) IN GENERAL.—Chapter 47 of the Internal Rev-  
 13 enue Code of 1986 (relating to excise taxes on certain  
 14 group health plans) is amended by inserting after section  
 15 5000 the following new section:

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

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

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

23               “(2) section 2753 of the Public Health Service  
 24 Act; and

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

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

7           “(c) LIMITATION ON TAX.—

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

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

14               “(B) such failure is corrected during the  
15               30-day period (or such period as the Secretary  
16               may determine appropriate) beginning on the  
17               1st date any of the individuals on whom the tax  
18               is imposed knew, or exercising reasonable dili-  
19               gence would have known, that such failure ex-  
20               isted.

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

1       that the payment of such tax would be excessive rel-  
 2       ative to the failure involved.”.

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

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

6       **SEC. 113. ENFORCEMENT BY EXCISE TAX ON QUALIFIED AS-**  
 7                                   **SOCIATIONS.**

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

12      **“SEC. 4980I. FAILURE OF QUALIFIED ASSOCIATIONS, ETC.,**  
 13                                   **TO COMPLY WITH CERTAIN STANDARDS FOR**  
 14                                   **HEALTH INSURANCE COVERAGE.**

15      “(a) IMPOSITION OF TAX.—

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

1       quirements applicable to such association or plans  
2       under—

3               “(A) subchapter C of chapter 2 of subpart  
4               2 of part A of title XXVII of the Public Health  
5               Service Act;

6               “(B) section 2753 of the Public Health  
7               Service Act; and

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

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

21              “(b) AMOUNT OF TAX.—The amount of the tax im-  
22              posed by subsection (a) shall be \$100 for each day during  
23              which such failure persists for each person to which such  
24              failure relates. A rule similar to the rule of section  
25              4980D(b)(3) shall apply for purposes of this section.

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

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

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

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

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

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

1 (b) CONFORMING AMENDMENT.—The table of sec-  
 2 tions for such chapter 43, as amended by section 111, is  
 3 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.”.

## 4 **Subtitle B—COBRA Portability** 5 **Reform**

### 6 **SEC. 121. AMENDMENTS TO COBRA.**

7 (a) AMENDMENTS TO INTERNAL REVENUE CODE OF  
 8 1986.—

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

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

17 “(i) is identical to the coverage pro-  
 18 vided under the plan to similarly situated  
 19 beneficiaries under the plan with respect to  
 20 whom a qualifying event has not occurred,

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

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

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

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

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

17 (B) by redesignating subclause (II) as sub-  
 18 clause (III); and

19 (C) by inserting after subclause (I) the fol-  
 20 lowing:

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

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

1 Revenue Code of 1986 (relating to period of cov-  
 2 erage) is amended by striking “18 months” each  
 3 place it appears and inserting “24 months”.

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

8 “(VI) SPECIAL RULE FOR DE-  
 9 PENDENT CHILD.—In the case of a  
 10 qualifying event described in para-  
 11 graph (3)(E), the date that is 36  
 12 months after the date on which the  
 13 dependent child of the covered em-  
 14 ployee ceases to be a dependent child  
 15 under the plan.”.

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

18 (1) LOWER COST COVERAGE OPTIONS.—Para-  
 19 graph (1) of section 602 of the Employee Retire-  
 20 ment Income Security Act of 1974 (29 U.S.C.  
 21 1162(1)) (relating to continuation coverage require-  
 22 ments of group health plans) is amended to read as  
 23 follows:

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

4                   “(A) is identical to the coverage provided  
 5                   under the plan to similarly situated bene-  
 6                   ficiaries under the plan with respect to whom a  
 7                   qualifying event has not occurred,

8                   “(B) is so identical, except such coverage  
 9                   is offered with an annual \$1,000 deductible,  
 10                  and

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

13           If coverage under the plan is modified for any group  
 14           of similarly situated beneficiaries, the coverage shall  
 15           also be modified in the same manner for all individ-  
 16           uals who are qualified beneficiaries under the plan  
 17           pursuant to this subsection in connection with such  
 18           group.’’.

19           (2) TERMINATION OF COBRA COVERAGE AFTER  
 20           ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
 21           DAYS.—Subparagraph (D) of section 602(2) of the  
 22           Employee Retirement Income Security Act of 1974  
 23           (29 U.S.C. 1162(2)(D)) (relating to period of cov-  
 24           erage) is amended—

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

2 (i);

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

4 (iii); and

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

6 lowing:

7 “(ii) eligible for such employer-based

8 coverage for more than 90 days, or”.

9 (3) INCREASE OF PERIOD OF COVERAGE.—Sub-  
 10 paragraph (A) of section 602(2) of the Employee  
 11 Retirement Income Security Act of 1974 (29 U.S.C.  
 12 1162(2)(A)) (relating to period of coverage) is  
 13 amended by striking “18 months” each place it ap-  
 14 pears and inserting “24 months”.

15 (4) CONTINUATION COVERAGE FOR DEPENDENT  
 16 CHILD.—Subparagraph (A) of section 602(2) of the  
 17 Employee Retirement Income Security Act of 1974  
 18 (29 U.S.C. 1162(2)(A)) is amended by adding at the  
 19 end the following:

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

1                   ceases to be a dependent child under the  
2                   plan.”.

3           (c) AMENDMENTS TO PUBLIC HEALTH SERVICE  
4 ACT.—

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

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

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

17           “(B) is so identical, except such coverage  
18 is offered with an annual \$1,000 deductible,  
19 and

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

22           If coverage under the plan is modified for any group  
23 of similarly situated beneficiaries, the coverage shall  
24 also be modified in the same manner for all individ-  
25 uals who are qualified beneficiaries under the plan

1       pursuant to this subsection in connection with such  
2       group.”.

3               (2) TERMINATION OF COBRA COVERAGE AFTER  
4       ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
5       DAYS.—Subparagraph (D) of section 2202(2) of the  
6       Public Health Service Act (42 U.S.C. 300bb-  
7       2(2)(D)) (relating to period of coverage) is amend-  
8       ed—

9               (A) by striking “or” at the end of clause  
10       (i);

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

13              (C) by inserting after clause (i) the fol-  
14       lowing:

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

17              (3) INCREASE OF PERIOD OF COVERAGE.—Sub-  
18       paragraph (A) of section 2202(2) of the Public  
19       Health Service Act (42 U.S.C. 300bb-2(2)(A)) (re-  
20       lating to period of coverage) is amended by striking  
21       “18 months” each place it appears and inserting  
22       “24 months”.

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

1       2(2)(A)) is amended by adding at the end the fol-  
 2       lowing:

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

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

## 13       **Subtitle C—Providing Coverage for** 14       **Young Adults**

### 15       **SEC. 131. GRANTS FOR YOUNG ADULTS HEALTH INSUR-** 16       **ANCE COVERAGE.**

17       (a) IN GENERAL.—The Secretary of Health and  
 18       Human Services (referred to in this section as the “Sec-  
 19       retary”) shall award grants to State for the establishment  
 20       and demonstration of programs to provide incentives to  
 21       eligible young adults for the acquisition of health insur-  
 22       ance coverage.

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

1 and containing such information as the Secretary may re-  
2 quire, including a description of the program to be carried  
3 out by the State with amounts received under the grant.

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

11 (d) REQUIREMENT.—A State shall carry out a pro-  
12 gram under this section through an existing State pro-  
13 gram such as a State high risk pool.

14 (e) TERMINATION OF INCENTIVE.—A State shall en-  
15 sure that under the program established by the State  
16 under this section, the incentive provided to an individual  
17 shall terminate upon the individual being provided with  
18 the opportunity to purchase health insurance coverage  
19 through an employer.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There is  
21 authorized to be appropriated to carry out this section,  
22 \$4,000,000,000 for fiscal year 2005, and such sums as  
23 may be necessary for each fiscal year thereafter.

1     **Subtitle D—Low Income Coverage**  
 2                     **Outreach Program**

3     **SEC. 141. LOW INCOME COVERAGE OUTREACH PROGRAM.**

4             (a) ESTABLISHMENT.—The Secretary of Health and  
 5     Human Services, in conjunction with the Secretary of Ag-  
 6     riculture, the Administrator of the Social Security Admin-  
 7     istration, and other appropriate Federal officials, shall es-  
 8     tablish a program to provide outreach to improve the  
 9     public’s knowledge concerning—

10            (1) health insurance coverage and health serv-  
 11           ices available through Federal programs; and

12            (2) the public health benefits of health insur-  
 13           ance coverage, including the advantages of receiving  
 14           preventive and wellness items and services.

15           (b) TARGET POPULATIONS.—Outreach efforts under  
 16     the program under subsection (a) shall be targeted at pop-  
 17     ulations who may be eligible for assistance under pro-  
 18     grams described in subsection (a), as determined by the  
 19     Federal officials involved in administering the outreach  
 20     program, including recent immigrants and migrant and  
 21     seasonal farmworkers.

22           (c) CULTURALLY APPROPRIATE MESSAGE.—Infor-  
 23     mational and other materials provided through the pro-  
 24     gram established under subsection (a), shall be designed  
 25     in a culturally appropriate manner.

1 **TITLE II—EXPANSION OF THE**  
 2 **STATE CHILDREN’S HEALTH**  
 3 **INSURANCE PROGRAM AND**  
 4 **FAMILY COVERAGE**

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

6 (a) DEFINITION OF LOW-INCOME CHILD.—Section  
 7 2110(c)(4) of the Social Security Act (42 U.S.C. 42  
 8 U.S.C. 1397jj(c)(4)) is amended by striking “200” and  
 9 inserting “235”.

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

12 **SEC. 202. STATE OPTION TO EXPAND COVERAGE TO PAR-**  
 13 **ENTS AND PREGNANT WOMEN.**

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

17 **“SEC. 2111. OPTIONAL COVERAGE OF PARENTS OF TAR-**  
 18 **GETED LOW-INCOME CHILDREN AND PREG-**  
 19 **NANT WOMEN.**

20 “(a) OPTIONAL COVERAGE.—Notwithstanding any  
 21 other provision of this title, a State may provide for cov-  
 22 erage, through an amendment to its State child health  
 23 plan under section 2102, of parent health assistance for  
 24 targeted low-income parents, health care assistance for

1 targeted low-income pregnant women, or both, in accord-  
 2 ance with this section.

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

4 “(1) PARENT HEALTH ASSISTANCE.—The term  
 5 ‘parent health assistance’ has the meaning given the  
 6 term child health assistance in section 2110(a) as if  
 7 any reference to targeted low-income children were  
 8 a reference to targeted low-income parents.

9 “(2) PARENT.—The term ‘parent’ has the  
 10 meaning given the term ‘caretaker relative’ for pur-  
 11 poses of carrying out section 1931.

12 “(3) HEALTH CARE ASSISTANCE FOR PREG-  
 13 NANT WOMEN.—The term ‘health care assistance for  
 14 pregnant women’ has the meaning given the term  
 15 child health assistance in section 2110(a) as if any  
 16 reference to targeted low-income children were a ref-  
 17 erence to targeted low-income pregnant women.

18 “(4) TARGETED LOW-INCOME PARENT.—The  
 19 term ‘targeted low-income parent’ has the meaning  
 20 given the term targeted low-income child in section  
 21 2110(b) as if the reference to a child were deemed  
 22 a reference to a parent (as defined in paragraph (3))  
 23 of the child; except that in applying such section—

24 “(A) there shall be substituted for the in-  
 25 come level described in paragraph (1)(B)(ii)(I)

1 the applicable income level in effect for a tar-  
 2 geted low-income child;

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

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

7 “(5) TARGETED LOW-INCOME PREGNANT  
 8 WOMAN.—The term ‘targeted low-income pregnant  
 9 woman’ has the meaning given the term targeted  
 10 low-income child in section 2110(b) as if any ref-  
 11 erence to a child were a reference to a woman dur-  
 12 ing pregnancy and through the end of the month in  
 13 which the 60-day period beginning on the last day  
 14 of her pregnancy ends; except that in applying such  
 15 section—

16 “(A) there shall be substituted for the in-  
 17 come level described in paragraph (1)(B)(ii)(I)  
 18 the applicable income level in effect for a tar-  
 19 geted low-income child;

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

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

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

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

5       “(1) Any reference in this title (other than in  
 6       subsection (b)) to a targeted low-income child is  
 7       deemed to include a reference to a targeted low-in-  
 8       come parent or a targeted low-income pregnant  
 9       woman (as applicable).

10       “(2) Any such reference to child health assist-  
 11       ance—

12               “(A) with respect to such parents is  
 13       deemed a reference to parent health assistance;  
 14       and

15               “(B) with respect to such pregnant women,  
 16       is deemed a reference to health care assistance  
 17       for pregnant women.

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

1           “(4) In applying section 2110(b)(4), any ref-  
 2           erence to ‘section 1902(l)(2) or 1905(n)(2) (as se-  
 3           lected by a State)’ is deemed a reference to the ef-  
 4           fective income level applicable to parents under sec-  
 5           tion 1931 or under a waiver approved under section  
 6           1115, or, in the case of a pregnant woman, the in-  
 7           come level established under section 1902(l)(2)(A).

8           “(5) In applying section 2102(b)(3)(B), any  
 9           reference to children found through screening to be  
 10          eligible for medical assistance under the State med-  
 11          icaid plan under title XIX is deemed a reference to  
 12          parents and pregnant women.”.

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

## 17       **TITLE III—MEDICARE PROGRAM** 18       **INTEGRITY ACTIVITIES**

### 19       **SEC. 301. INCREASED FUNDING FOR THE MEDICARE INTEG-** 20       **RITY PROGRAM.**

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

24                       “(vi) For each of fiscal years 2002,  
 25                       2003, and 2004, such amount shall be not

1 less than \$710,000,000 and not more than  
2 \$720,000,000.

3 “(vii) For fiscal year 2005, such  
4 amount shall be not less than  
5 \$760,000,000 and not more than  
6 \$770,000,000.

7 “(viii) For fiscal year 2006, such  
8 amount shall be not less than  
9 \$810,000,000 and not more than  
10 \$820,000,000.

11 “(ix) For fiscal year 2007, such  
12 amount shall be not less than  
13 \$860,000,000 and not more than  
14 \$870,000,000.

15 “(x) For fiscal year 2008, such  
16 amount shall be not less than  
17 \$920,000,000 and not more than  
18 \$930,000,000.

19 “(xi) For each fiscal year after fiscal  
20 year 2008, such amount shall be not less  
21 than \$990,000,000 and not more than  
22 \$1,000,000,000.”.

23

1 **TITLE IV—REDUCING MEDICAL**  
 2 **ERRORS AND INCREASING**  
 3 **THE USE OF MEDICAL TECH-**  
 4 **NOLOGY**

5 **SEC. 401. MEDICAL ERRORS REDUCTION.**

6 Title IX of the Public Health Service Act (42 U.S.C.  
 7 299 et seq.) is amended—

8 (1) by redesignating part C as part D;

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

11 (3) in section 938(1) (as so redesignated), by  
 12 striking “921” and inserting “931”; and

13 (4) by inserting after part B the following:

14 **“PART C—REDUCING ERRORS IN HEALTH CARE**

15 **“SEC. 921. DEFINITIONS.**

16 “In this part:

17 “(1) ADVERSE EVENT.—The term ‘adverse  
 18 event’ means an injury resulting from medical man-  
 19 agement rather than the underlying condition of the  
 20 patient.

21 “(2) ERROR.—The term ‘error’ means the fail-  
 22 ure of a planned action to be completed as intended  
 23 or the use of a wrong plan to achieve the desired  
 24 outcome.

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

5           “(4) HEALTH CARE-RELATED ERROR.—The  
6           term “health care-related error” means a prevent-  
7           able adverse event related to a health care interven-  
8           tion or a failure to intervene appropriately.

9           “(5) MEDICATION-RELATED ERROR.—The term  
10          ‘medication-related error’ means a preventable ad-  
11          verse event related to the administration of a medi-  
12          cation.

13          “(6) SAFETY.—The term ‘safety’ with respect  
14          to an individual means that such individual has a  
15          right to be free from preventable serious injury.

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

21   **“SEC. 922. ESTABLISHMENT OF STATE-BASED MEDICAL**  
22                   **ERROR REPORTING SYSTEMS.**

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

1 porting systems designed to reduce medical errors and im-  
2 prove health care quality.

3 “(b) REQUIREMENT.—

4 “(1) IN GENERAL.—To be eligible to receive a  
5 grant under subsection (a), the State involved shall  
6 provide assurances to the Secretary that amounts re-  
7 ceived under the grant will be used to establish and  
8 implement a medical error reporting system using  
9 guidelines (including guidelines relating to the con-  
10 fidentiality of the reporting system) developed by the  
11 Agency for Healthcare Research and Quality with  
12 input from interested, non-governmental parties in-  
13 cluding patient, consumer and health care provider  
14 groups.

15 “(2) GUIDELINES.—Not later than 90 days  
16 after the date of enactment of this part, the Agency  
17 for Healthcare Research and Quality shall develop  
18 and publish the guidelines described in paragraph  
19 (1).

20 “(c) DATA.—

21 “(1) AVAILABILITY.—A State that receives a  
22 grant under subsection (a) shall make the data pro-  
23 vided to the medical error reporting system involved  
24 available only to the Agency for Healthcare Research

1 and Quality and may not otherwise disclose such in-  
 2 formation.

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

6 “(d) APPLICATION.—To be eligible for a grant under  
 7 this section, a State shall prepare and submit to the Sec-  
 8 retary an application at such time, in such manner and  
 9 containing, such information as the Secretary shall re-  
 10 quire.

11 **“SEC. 923. DEMONSTRATION PROJECTS TO REDUCE MED-**  
 12 **ICAL ERRORS, IMPROVE PATIENT SAFETY,**  
 13 **AND EVALUATE REPORTING.**

14 “(a) ESTABLISHMENT.—The Secretary, acting  
 15 through the Director of the Agency for Healthcare Re-  
 16 search and Quality and in conjunction with the Adminis-  
 17 trator of the Health Care Financing Administration, may  
 18 establish a program under which funding will be provided  
 19 for not less than 15 demonstration projects, to be competi-  
 20 tively awarded, in health care facilities and organizations  
 21 in geographically diverse locations, including rural and  
 22 urban areas (as determined by the Secretary), to deter-  
 23 mine the causes of medical errors and to—

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

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

3           “(3) develop mechanisms that encourage report-  
4           ing, prompt review, and corrective action with re-  
5           spect to medical errors; and

6           “(4) develop methods to minimize any addi-  
7           tional paperwork burden on health care profes-  
8           sionals.

9           “(b) ACTIVITIES.—

10           “(1) IN GENERAL.—A health care provider par-  
11           ticipating in a demonstration project under sub-  
12           section (a) shall—

13           “(A) utilize all available and appropriate  
14           technologies to reduce the probability of future  
15           medical errors; and

16           “(B) carry out other activities consistent  
17           with subsection (a).

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

20           “(A) 5 of the demonstration projects per-  
21           mit the voluntary reporting by participating  
22           health care providers of any adverse events,  
23           sentinel events, health care-related errors, or  
24           medication-related errors to the Secretary;

1           “(B) 5 of the demonstration projects re-  
2           quire participating health care providers to re-  
3           port any adverse events, sentinel events, health  
4           care-related errors, or medication-related errors  
5           to the Secretary; and

6           “(C) 5 of the demonstration projects re-  
7           quire participating health care providers to re-  
8           port any adverse events, sentinel events, health  
9           care-related errors, or medication-related errors  
10          to the Secretary and to the patient involved and  
11          a family member or guardian of the patient.

12          “(3) CONFIDENTIALITY.—

13               “(A) IN GENERAL.—The Secretary and the  
14               participating grantee organization shall ensure  
15               that information reported under this section re-  
16               mains confidential.

17               “(B) USE.—The Secretary may use the in-  
18               formation reported under this section only for  
19               the purpose of evaluating the ability to reduce  
20               errors in the delivery of care. Such information  
21               shall not be used for enforcement purposes.

22               “(C) DISCLOSURE.—The Secretary may  
23               not disclose the information reported under this  
24               section.

1                   “(D) NONADMISSIBILITY.—Information re-  
2                   ported under this section shall be privileged,  
3                   confidential, shall not be admissible as evidence  
4                   or discoverable in any civil or criminal action or  
5                   proceeding or subject to disclosure, and shall  
6                   not be subject to the Freedom of Information  
7                   Act (5 U.S.C. App). This paragraph shall apply  
8                   to all information maintained by the reporting  
9                   entity and the entities who receive such reports.

10                  “(c) USE OF TECHNOLOGIES.—The Secretary shall  
11                  encourage, as part of the demonstration projects con-  
12                  ducted under subsection (a), the use of appropriate tech-  
13                  nologies to reduce medical errors, such as hand-held elec-  
14                  tronic prescription pads, training simulators for medical  
15                  education, and bar-coding of prescription drugs and pa-  
16                  tient bracelets.

17                  “(d) DATABASE.—The Secretary shall provide for the  
18                  establishment and operation of a national database of  
19                  medical errors to be used as provided for by the Secretary.  
20                  The information provided to the Secretary under sub-  
21                  section (b)(2) shall be contained in the database.

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

1 submit the results of such evaluations as part of the re-  
2 ports under section 926(b).

3 “(f) REPORTING.—Prior to October 1, of the third  
4 fiscal year for which funds are made available under this  
5 section, the Secretary shall prepare and submit to the ap-  
6 propriate committees of Congress an interim report con-  
7 cerning the results of such demonstration projects.

8 **“SEC. 924. PATIENT SAFETY IMPROVEMENT.**

9 “(a) IN GENERAL.—The Secretary shall provide in-  
10 formation to educate patients and family members about  
11 their role in reducing medical errors. Such information  
12 shall be provided to all individuals who participate in Fed-  
13 erally-funded health care programs.

14 “(b) DEVELOPMENT OF PROGRAMS.—The Secretary  
15 shall develop programs that encourage patients to take a  
16 more active role in their medical treatment, including en-  
17 couraging patients to provide information to health care  
18 providers concerning pre-existing conditions and medica-  
19 tions.

20 **“SEC. 925. PRIVATE, NONPROFIT EFFORTS TO REDUCE**  
21 **MEDICAL ERRORS.**

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

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

3 “(b) APPLICATION.—To be eligible for a grant under  
4 this section, an entity shall prepare and submit to the Sec-  
5 retary an application at such time, in such manner and  
6 containing, such information as the Secretary shall re-  
7 quire.

8 **“SEC. 926. REPORT TO CONGRESS.**

9 “(a) INITIAL REPORT.—Not later than 180 days  
10 after the date of enactment of this part, the Secretary  
11 shall prepare and submit to the appropriate committees  
12 of Congress a report concerning the costs associated with  
13 implementing a program that identifies factors that con-  
14 tribute to errors and which includes upgrading the health  
15 care computer systems and other technologies in the  
16 United States in order to reduce medical errors, including  
17 computerizing hospital systems for the coordination of  
18 prescription drugs and handling of laboratory specimens,  
19 and contains recommendations on ways in which to reduce  
20 those factors.

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

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

3           “(2) the data submitted by States under section  
4       922(c);

5           “(3) the best methods for reducing medical er-  
6       rors;

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

9           “(5) the manner in which other Federal agen-  
10      cies can share information on best practices in order  
11      to reduce medical errors in all Federal health care  
12      programs.

13   **“SEC. 927. AUTHORIZATION OF APPROPRIATIONS.**

14       “‘There is authorized to be appropriated such sums  
15   as may be necessary to carry out this part.’”.

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

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

21   **“SEC. 9511. TRUST FUND FOR MEDICAL TREATMENT OUT-**  
22                   **COMES RESEARCH.**

23       “(a) CREATION OF TRUST FUND.—There is estab-  
24   lished in the Treasury of the United States a trust fund  
25   to be known as the “Trust Fund for Medical Treatment

1 Outcomes Research’ (referred to in this section as the  
 2 ‘Trust Fund’), consisting of such amounts as may be ap-  
 3 propriated or credited to the Trust Fund as provided in  
 4 this section or section 9602(b).

5 “(b) TRANSFERS TO TRUST FUND.—There is hereby  
 6 appropriated to the Trust Fund an amount equivalent to  
 7 the taxes received in the Treasury under section 4491 (re-  
 8 lating to tax on health insurance policies).

9 “(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—  
 10 On an annual basis and without further appropriation the  
 11 Secretary shall distribute the amounts in the Trust Fund  
 12 to the Secretary of Health and Human Services for use  
 13 by the Agency for Healthcare Research and Quality. Such  
 14 amounts shall be available to pay for research activities  
 15 related to medical treatment outcomes and shall be in ad-  
 16 dition to any other amounts appropriated for such pur-  
 17 poses.”.

18 (b) CONFORMING AMENDMENT.—The table of sec-  
 19 tions for subchapter A of chapter 98 of such Code is  
 20 amended by adding at the end the following:

“Sec. 9511. Trust Fund for Medical Treatment Outcomes Re-  
 search.”.

21 **SEC. 403. INCREASING THE USE OF MEDICAL TECHNOLOGY**

22 The Secretary of Health and Human Services shall—

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

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

6           (3) coordinate information technology-related  
7           activities taken by the Federal Government and en-  
8           sure that such activities will further national health  
9           information and infrastructure.

10 **TITLE V—IMPROVING HEALTH**  
11 **CARE QUALITY, EFFICIENCY,**  
12 **AND CONSUMER EDUCATION**

13 **SEC. 501. GRANTS FOR DEMONSTRATION PROJECTS.**

14           (a) IN GENERAL.—The Secretary of Health and  
15 Human Services (referred to in this section as the “Sec-  
16 retary”) shall award grants to eligible entities for the es-  
17 tablishment of demonstration projects to educate the pub-  
18 lic concerning their health care choices.

19           (b) ELIGIBILITY.—To be eligible to receive a grant  
20 under subsection (a), an entity shall be a public or non-  
21 profit private entity and prepare and submit to the Sec-  
22 retary an application at such time, in such manner, and  
23 containing such information as the Secretary may require.

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

1 ties to provide educational materials to individuals to in-  
2 form such individuals about—

3 (1) health care choices;

4 (2) health care costs;

5 (3) health care quality control; and

6 (4) other matter determined appropriate by the  
7 Secretary.

8 (d) PUBLIC SERVICE ANNOUNCEMENTS.— the Sec-  
9 retary shall provide for the development of public service  
10 announcements to educate the public about their health  
11 care choices.

12 (e) ADVANCE DIRECTIVES.—In carrying out this sec-  
13 tion, the Secretary shall develop ways to improve the effec-  
14 tiveness and portability of advance directives and living  
15 wills.

16 (f) AUTHORIZATION OF APPROPRIATIONS.—There is  
17 authorized to be appropriated, such sums as may be nec-  
18 essary to carry out this section.

1           **TITLE VI—PRIMARY AND**  
2           **PREVENTIVE CARE PROVIDERS**

3   **SEC. 601. INCREASED MEDICARE REIMBURSEMENT FOR**  
4                   **PHYSICIAN ASSISTANTS, NURSE PRACTI-**  
5                   **TIONERS, AND CLINICAL NURSE SPECIAL-**  
6                   **ISTS.**

7           (a)    FEE       SCHEDULE       AMOUNT.—Section  
8   1833(a)(1)(O) of the Social Security Act (42 U.S.C.  
9   1395l(a)(1)(O)) is amended by striking “85 percent” and  
10 inserting “90 percent” each place it appears.

11          (b)       TECHNICAL        AMENDMENT.—Section  
12 1833(a)(1)(O) of the Social Security Act (42 U.S.C.  
13 1395l(a)(1)(O)) is amended by striking “clinic” and in-  
14 serting “clinical”.

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

18   **SEC. 602. REQUIRING COVERAGE OF CERTAIN NONPHYSI-**  
19                   **CIAN PROVIDERS UNDER THE MEDICAID**  
20                   **PROGRAM.**

21          (a) IN GENERAL.—Section 1905(a) of the Social Se-  
22 curity Act (42 U.S.C. 1396d(a)), as amended by section  
23 301(c)(1), is amended—

24               (1) in paragraph (27), by striking “and” at the  
25       end;

1           (2) by redesignating paragraph (28) as para-  
2       graph (29); and

3           (3) by inserting after paragraph (27) the fol-  
4       lowing:

5           “(28) services furnished by a physician assist-  
6       ant, nurse practitioner, clinical nurse specialist (as  
7       defined in section 1861(aa)(5)), or certified reg-  
8       istered nurse anesthetist (as defined in section  
9       1861(bb)(2)); and”.

10       (b)       CONFORMING       AMENDMENT.—Section  
11   1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C.  
12   1396a(a)(10)(C)(iv)), as amended by section 301(c)(3), is  
13   amended by striking “and (27)” and inserting “, (27), and  
14   (28)”.

15       (c) EFFECTIVE DATE.—The amendments made by  
16   this section shall apply to medical assistance furnished  
17   under title XIX of the Social Security Act (42 U.S.C.  
18   1396 et seq.) beginning with the first fiscal year quarter  
19   that begins after the date of enactment of this Act.

20   **SEC. 603. MEDICAL STUDENT TUTORIAL PROGRAM**  
21               **GRANTS.**

22       Part C of title VII of the Public Health Service Act  
23   (42 U.S.C. 293j et seq.) is amended by adding at the end  
24   the following:

1 **“SEC. 749. MEDICAL STUDENT TUTORIAL PROGRAM**  
2 **GRANTS.**

3 “(a) ESTABLISHMENT.—The Secretary shall estab-  
4 lish a program to award grants to eligible schools of medi-  
5 cine or osteopathic medicine to enable such schools to pro-  
6 vide medical students for tutorial programs or as partici-  
7 pants in clinics designed to interest high school or college  
8 students in careers in general medical practice.

9 “(b) APPLICATION.—To be eligible to receive a grant  
10 under this section, a school of medicine or osteopathic  
11 medicine shall prepare and submit to the Secretary an ap-  
12 plication at such time, in such manner, and containing  
13 such information as the Secretary may require, including  
14 assurances that the school will use amounts received under  
15 the grant in accordance with subsection (c).

16 “(c) USE OF FUNDS.—

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

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

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

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

3           “(C) conduct summer institutes for high  
4           school and college students to promote careers  
5           in medicine.

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

9           “(A) give medical students desiring to  
10          practice general medicine access to the local  
11          community;

12          “(B) provide information to high school  
13          and college students concerning medical school  
14          and the general practice of medicine; and

15          “(C) promote careers in general medicine.

16          “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
17          are authorized to be appropriated to carry out this section,  
18          \$5,000,000 for fiscal year 2005, and such sums as may  
19          be necessary for fiscal year 2006.”.

20   **SEC. 604. GENERAL MEDICAL PRACTICE GRANTS.**

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

1   **“SEC. 749A. GENERAL MEDICAL PRACTICE GRANTS.**

2           “(a) ESTABLISHMENT.—The Secretary shall estab-  
3   lish a program to award grants to eligible public or private  
4   nonprofit schools of medicine or osteopathic medicine, hos-  
5   pitals, residency programs in family medicine or pedi-  
6   atrics, or to a consortium of such entities, to enable such  
7   entities to develop effective strategies for recruiting med-  
8   ical students interested in the practice of general medicine  
9   and placing such students into general practice positions  
10  upon graduation.

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

18          “(c) USE OF FUNDS.—Amounts received under a  
19  grant awarded under this section shall be used to fund  
20  programs under which effective strategies are developed  
21  and implemented for recruiting medical students inter-  
22  ested in the practice of general medicine and placing such  
23  students into general practice positions upon graduation.

24          “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
25  are authorized to be appropriated to carry out this section,  
26  \$25,000,000 for each of the fiscal years 2005 through

- 1 2007, and such sums as may be necessary for fiscal years
- 2 thereafter.”.

