

108TH CONGRESS  
1ST SESSION

# S. 1030

To expand the number of individuals and families with health insurance coverage, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MAY 8, 2003

Mr. BINGAMAN introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To expand the number of individuals and families with health insurance coverage, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Health Coverage, Affordability, Responsibility, and Eq-  
6 uity Act of 2003” or the “HealthCARE Act of 2003”.

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

Sec. 1. Short title; table of contents.

TITLE I—INCREASING HEALTH CARE COVERAGE

Subtitle A—Medicaid and SCHIP

- Sec. 101. State option to offer medicaid coverage based on need.
- Sec. 102. State option to provide coverage of children under SCHIP in excess of the State’s allotment.

Subtitle B—Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals and Families

- Sec. 111. Credit for health insurance costs of certain low-income individuals.
- Sec. 112. Advance payment of credit for health insurance costs of eligible low-income individuals.

TITLE II—IMPROVING ACCESS TO HEALTH PLANS

- Sec. 201. Definitions.
- Sec. 202. Establishment of health insurance purchasing pools.
- Sec. 203. Purchasing pools.
- Sec. 204. Purchasing pool operators.
- Sec. 205. Contracts with participating insurers.
- Sec. 206. Options for health benefits coverage.
- Sec. 207. Enrollment process for eligible individuals.
- Sec. 208. Plan premiums.
- Sec. 209. Enrollee premium share.
- Sec. 210. Payments to purchasing pool operators and payments to participating insurers.
- Sec. 211. State-based reinsurance programs.
- Sec. 212. Coverage under individual health insurance.
- Sec. 213. Use of premium subsidies to unify family coverage with members enrolled in medicaid and SCHIP.
- Sec. 214. Coverage through employer-sponsored health insurance.
- Sec. 215. Participation by small employers.
- Sec. 216. Report.
- Sec. 217. Authorization of appropriations.

TITLE III—NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE

- Sec. 301. National Advisory Commission on Expanded Access to Health Care.
- Sec. 302. Congressional action.

TITLE IV—STATE WAIVERS

- Sec. 401. State waivers.

1     **TITLE I—INCREASING HEALTH**  
 2                     **CARE COVERAGE**

3     **Subtitle A—Medicaid and SCHIP**

4     **SEC. 101. STATE OPTION TO OFFER MEDICAID COVERAGE**  
 5                     **BASED ON NEED.**

6             (a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of  
 7 the Social Security Act (42 U.S.C. 1396a) is amended—

1           (1) by striking “or” at the end of subclause  
2           (XVII);

3           (2) by adding “or” at the end of subclause  
4           (XVIII); and

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

6                                 “(XIX) who are not otherwise el-  
7                                 igible for medical assistance under  
8                                 this title and whose income does not  
9                                 exceed such income level as the State  
10                                may establish, expressed as a percent-  
11                               age (not to exceed 100) of the income  
12                               official poverty line (as defined by the  
13                               Office of Management and Budget,  
14                               and revised annually in accordance  
15                               with section 673(2) of the Omnibus  
16                               Budget Reconciliation Act of 1981)  
17                               applicable to a family of the size in-  
18                               volved;”.

19           (b) INCREASED FMAP.—Section 1905 of the Social  
20           Security Act (42 U.S.C. 1396d) is amended—

21           (1) in the first sentence of subsection (b)—

22                               (A) by striking “and (4)” and inserting  
23                               “(4)”; and

24                               (B) by inserting before the period the fol-  
25                               lowing: “, and (5) in the case of a State that

1 meets the conditions described in paragraph (1)  
2 of subsection (x), the Federal medical assist-  
3 ance percentage shall be equal to the need-  
4 based enhanced FMAP described in paragraph  
5 (2) of subsection (x)”; and

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

7 “(x)(1) For purposes of clause (5) of the first sen-  
8 tence of subsection (b), the conditions described in this  
9 subsection are the following:

10 “(A) The State provides medical assistance to  
11 individuals described in subsection  
12 (a)(10)(A)(ii)(XIX).

13 “(B) The State uses streamlined enrollment  
14 and outreach measures to all individuals described in  
15 subparagraph (A) including—

16 “(i) the same application and retention  
17 procedures (such as 1-page enrollment forms  
18 and enrollment by mail) used by the majority of  
19 State programs under title XXI during the pre-  
20 ceding year; and

21 “(ii) outreach efforts proportional in scope  
22 and reasonably expected effectiveness to those  
23 employed by the State during a comparable  
24 stage of implementation of the State’s program  
25 under title XXI.

1           “(C) The State applies eligibility standards and  
2           methodologies under this title with respect to indi-  
3           viduals residing in the State who have not attained  
4           age 65 that are not more restrictive (as determined  
5           under section 1902(a)(10)(C)(i)(III)) than the  
6           standards and methodologies that applied under this  
7           title with respect to such individuals as of July 1,  
8           2003.

9           “(2)(A) For purposes of clause (5) of the first sen-  
10          tence of subsection (b), the need-based enhanced FMAP  
11          for a State for a fiscal year, is equal to the Federal med-  
12          ical assistance percentage (as defined in the first sentence  
13          of subsection (b)) for the State increased, subject to sub-  
14          paragraph (B), by such percentage increase as would com-  
15          pensate all States for the additional expenditures that  
16          would be incurred by all States if the States were to pro-  
17          vide medical assistance to all individuals whose income  
18          does not exceed 100 percent of the income official poverty  
19          line (as defined by the Office of Management and Budget,  
20          and revised annually in accordance with section 673(2) of  
21          the Omnibus Budget Reconciliation Act of 1981) applica-  
22          ble to a family of the size involved and who are eligible  
23          for such assistance only on the basis of section  
24          1902(a)(10)(A)(ii)(XIX).

1       “(B) In the case of a State that provides medical as-  
2       sistance to individuals described in section  
3       1902(a)(10)(A)(ii)(XIX) but limits such assistance to in-  
4       dividuals with income at or below a percentage of the in-  
5       come official poverty line (as defined by the Office of Man-  
6       agement and Budget, and revised annually in accordance  
7       with section 673(2) of the Omnibus Budget Reconciliation  
8       Act of 1981) applicable to a family of the size involved  
9       that is less than 100, the Secretary shall reduce the need-  
10      based enhanced FMAP otherwise determined for the State  
11      under subparagraph (A) by a proportion based on the na-  
12      tional income distribution of all individuals in all States  
13      who are (regardless of whether such individuals are en-  
14      rolled under this title) eligible for medical assistance only  
15      on the basis of section 1902(a)(10)(A)(ii)(XIX).”.

16      (c) CONFORMING AMENDMENTS.—Section 1905(a) of  
17      the Social Security Act (42 U.S.C. 1396d(a)) is amended  
18      in the matter preceding paragraph (1)—

19              (1) by striking “or” at the end of clause (xii);

20              (2) by adding “or” at the end of clause (xiii);

21      and

22              (3) by inserting after clause (xiii) the following:

23              “(xiv) individuals who are eligible for medical  
24      assistance on the basis of section  
25      1902(a)(10)(A)(ii)(XIX);”.

1 (d) EFFECTIVE DATE.—The amendments made by  
 2 this section take effect on October 1, 2004, and apply to  
 3 medical assistance provided on or after that date, without  
 4 regard to whether final regulations to carry out such  
 5 amendments have been promulgated by such date.

6 **SEC. 102. STATE OPTION TO PROVIDE COVERAGE OF CHIL-**  
 7 **DREN UNDER SCHIP IN EXCESS OF THE**  
 8 **STATE'S ALLOTMENT.**

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

12 **“SEC. 2111. STATE OPTION TO PROVIDE COVERAGE OF**  
 13 **CHILDREN IN EXCESS OF THE STATE'S AL-**  
 14 **LOTMENT.**

15 “(a) STATE OPTION.—In the case of a State that  
 16 meets the condition described in subsection (b), the fol-  
 17 lowing shall apply:

18 “(1) Notwithstanding section 2105 and without  
 19 regard to the State’s allotment under section 2104,  
 20 the Secretary shall pay the State an amount for  
 21 each quarter equal to the enhanced FMAP of ex-  
 22 penditures incurred in the quarter that are described  
 23 in section 2105(a)(1).

24 “(2) The Secretary shall reduce the State’s al-  
 25 lotment under section 2104, for the first fiscal year

1 for which the State amendment described in sub-  
2 section (b) applies, and for each fiscal year there-  
3 after, by an amount equal to the amount that the  
4 Secretary determines the State would have expended  
5 to provide child health assistance to targeted low-in-  
6 come children during that fiscal year if that State  
7 had not elected the State option to provide such as-  
8 sistance in accordance with this section.

9 “(3) Subsections (f) and (g) of section 2104  
10 shall not apply to the State’s reduced allotment  
11 (after the application of paragraph (2)).

12 “(b) CONDITION DESCRIBED.—For purposes of sub-  
13 section (a), the condition described in this subsection is  
14 that the State has made an irrevocable election, through  
15 a plan amendment, to provide child health assistance to  
16 all targeted low-income children residing in the State  
17 (without regard to date of application for assistance) and  
18 to cover health services listed in the State plan whenever  
19 medically necessary.”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 this section takes effect on October 1, 2004, and apply  
22 to child health assistance provided on or after that date,  
23 without regard to whether final regulations to carry out  
24 such amendment have been promulgated by such date.

1 **Subtitle B—Refundable Tax Credit**  
 2 **for Health Insurance Costs of**  
 3 **Low-Income Individuals and**  
 4 **Families**

5 **SEC. 111. CREDIT FOR HEALTH INSURANCE COSTS OF CER-**  
 6 **TAIN LOW-INCOME INDIVIDUALS.**

7 (a) IN GENERAL.—Subpart C of part IV of sub-  
 8 chapter A of chapter 1 of the Internal Revenue Code of  
 9 1986 (relating to refundable credits) is amended by redес-  
 10 ignating section 36 as section 37 and inserting after sec-  
 11 tion 35 the following new section:

12 **“SEC. 36. HEALTH INSURANCE COSTS OF ELIGIBLE LOW-IN-**  
 13 **COME INDIVIDUALS.**

14 “(a) IN GENERAL.—In the case of an individual,  
 15 there shall be allowed as a credit against the tax imposed  
 16 by this subtitle for the taxable year an amount equal to  
 17 the applicable percentage of the amount paid by the tax-  
 18 payer (or on behalf of the taxpayer) for coverage of the  
 19 taxpayer or qualifying family members under qualified  
 20 health insurance for eligible coverage months beginning in  
 21 such taxable year.

22 “(b) APPLICABLE PERCENTAGE.—For purposes of  
 23 this section—

24 “(1) IN GENERAL.—Subject to paragraph (2),  
 25 the term ‘applicable percentage’ means the standard

1 Government contribution (determined for full-time  
2 Federal employees enrolling in coverage for which  
3 such contribution is not limited by section  
4 8906(b)(1) of title 5, United States Code) for an  
5 employee enrolled in a health benefits plan under  
6 chapter 89 of title 5, United States Code, for the  
7 calendar year in which the taxable year begins, ex-  
8 pressed as a percentage of the total premium for  
9 such plan.

10 “(2) INCREASED PERCENTAGE FOR CERTAIN  
11 TAXPAYERS.—

12 “(A) IN GENERAL.—In the case of a tax-  
13 payer whose adjusted gross income for the pre-  
14 ceeding taxable year does not exceed 150 percent  
15 of the poverty level, the applicable percentage  
16 determined under paragraph (1) shall be in-  
17 creased by such percentage points as the Sec-  
18 retary determines will fully compensate such an  
19 individual for the individual’s limited pur-  
20 chasing power in comparison to individuals  
21 whose adjusted gross income equals the average  
22 adjusted gross income for all Federal employ-  
23 ees, to the extent that the amount of the result-  
24 ing increase in the credit amount for all such  
25 eligible low-income individuals for the taxable

1 year is not reasonably expected to exceed the  
2 5 percentage point dollar amount for that year,  
3 as determined under subparagraph (B).

4 “(B) DETERMINATION OF 5 PERCENTAGE  
5 POINT DOLLAR AMOUNT.—For purposes of sub-  
6 paragraph (A), the 5 percentage point dollar  
7 amount for any taxable year is the product of—

8 “(i) the total number of individuals  
9 receiving credits under this section for  
10 such year, and

11 “(ii) the amount equal to 5 percent of  
12 the average health insurance premium  
13 amount to which such credits are applied.

14 “(C) RULE OF CONSTRUCTION.—Nothing  
15 in this paragraph shall be construed to prevent  
16 the Secretary from establishing more than 1  
17 level of supplemental assistance that provides  
18 greater assistance to individuals with lower in-  
19 come, determined as a percentage of poverty.

20 “(3) APPLICATION OF FEHBP COVERAGE CAT-  
21 EGORIES TO DETERMINATION OF CREDIT.—The per-  
22 centages described in paragraphs (1) and (2) shall  
23 be applied to a taxpayer consistent with the coverage  
24 categories (such as self or family coverage) applied

1 with respect to a health benefits plan under chapter  
2 89 of title 5, United States Code.

3 “(c) MAXIMUM PREMIUM AMOUNT.—The amount  
4 paid for qualified health insurance taken into account  
5 under subsection (a) for any taxable year shall not exceed  
6 an amount equal to the capped premium established for  
7 the applicable State under section 204(c)(10) of the  
8 Health Coverage, Affordability, Responsibility, and Equity  
9 Act of 2003 for the calendar year in which the such tax-  
10 able year begins.

11 “(d) ELIGIBLE COVERAGE MONTH.—For purposes of  
12 this section—

13 “(1) IN GENERAL.—The term ‘eligible coverage  
14 month’ means any month if during such month the  
15 taxpayer or a qualifying family member—

16 “(A) is an eligible low-income individual,

17 “(B) is covered by qualified health insur-  
18 ance, the premium for which is paid by the tax-  
19 payer (or on behalf of the taxpayer),

20 “(C) does not have other specified cov-  
21 erage, and

22 “(D) is not imprisoned under Federal,  
23 State, or local authority.

24 “(2) JOINT RETURNS.—In the case of a joint  
25 return, the requirement of paragraph (1)(A) shall be

1 treated as met with respect to any month if at least  
2 1 spouse satisfies such requirement.

3 “(e) ELIGIBLE LOW-INCOME INDIVIDUAL.—For pur-  
4 poses of this section—

5 “(1) IN GENERAL.—The term ‘eligible low-in-  
6 come individual’ means an individual—

7 “(A) who has not attained age 65,

8 “(B) whose adjusted gross income does not  
9 exceed 200 percent of the poverty level,

10 “(C) who is ineligible for the medicaid pro-  
11 gram or the State children’s health insurance  
12 program under title XIX or XXI of the Social  
13 Security Act (other than under section 1928 of  
14 such Act),

15 “(D) who has limited access to health in-  
16 surance coverage through the employer of the  
17 individual or a member of the individual’s fam-  
18 ily (either because the employer does not offer  
19 such coverage to the individual or because the  
20 employee contribution for such coverage would  
21 exceed an amount equal to 5 percent of the  
22 household income of such individual, as deter-  
23 mined in accordance with paragraph (2)),

24 “(E) who applies for a credit under this  
25 section not later than 60 days after receiving

1 notice of potential eligibility for such credit,  
2 under procedures established by the Secretary,  
3 and

4 “(F) who resides in a State where the eli-  
5 gibility standards and methodologies applied  
6 under the medicaid and State children’s health  
7 insurance programs with respect to individuals  
8 residing in the State who have not attained age  
9 65 are not more restrictive (as determined  
10 under section 1902(a)(10)(C)(i)(III) of the So-  
11 cial Security Act) than the standards and meth-  
12 odologies that applied under such programs  
13 with respect to such individuals as of July 1,  
14 2003.

15 “(2) DETERMINATION OF ELIGIBILITY.—

16 “(A) SCHIP AGENCY.—

17 “(i) IN GENERAL.—The determination  
18 of whether an individual is an eligible low-  
19 income individual for purposes of this sec-  
20 tion shall be made by the State agency  
21 with responsibility for determining the eli-  
22 gibility of individuals for assistance under  
23 the State children’s health insurance pro-  
24 gram under title XXI of the Social Secu-  
25 rity Act.

1                   “(ii) APPLICATION OF SCREEN AND  
2 ENROLL REQUIREMENTS.—

3                   “(I) IN GENERAL.—The State  
4 agency referred to in clause (i) shall  
5 ensure that individuals applying for a  
6 certificate of eligibility are screened  
7 for potential eligibility under the med-  
8 icaid and State children’s health in-  
9 surance programs and that individuals  
10 found through screening to be eligible  
11 for assistance under such a program  
12 are enrolled for assistance under the  
13 appropriate program. To the max-  
14 imum extent possible pursuant to  
15 State options under title XIX of the  
16 Social Security Act, and notwith-  
17 standing any otherwise applicable pro-  
18 vision of, or State plan provision  
19 under, such title, screening and enroll-  
20 ment activities described in the pre-  
21 vious sentence shall use the proce-  
22 dures employed by the State chil-  
23 dren’s health insurance program oper-  
24 ated under title XXI of the Social Se-  
25 curity Act, if such procedures differ

1 from those ordinarily employed by the  
2 State program operated under title  
3 XIX of such Act.

4 “(II) NO DELAY OF ISSUANCE OF  
5 CERTIFICATE.—The application of the  
6 screen and enroll requirements of  
7 clause (i) shall not delay the issuance  
8 of a certificate of eligibility to an indi-  
9 vidual for purposes of this section.  
10 The State agency referred to in clause  
11 (i) shall adopt procedures to ensure  
12 that an individual issued a certificate  
13 of eligibility under this paragraph who  
14 is subsequently determined to be eligi-  
15 ble for the State medicaid program  
16 under title XIX of the Social Security  
17 Act or the State children’s health in-  
18 surance program under XXI of such  
19 Act shall be enrolled in the appro-  
20 priate program without an interrup-  
21 tion in the individual’s health insur-  
22 ance coverage.

23 “(B) STANDARDS.—

1           “(i) IN GENERAL.—An individual is  
2 an eligible low-income individual for pur-  
3 poses of this section if—

4                   “(I) on the basis of the individ-  
5 ual’s tax return for the preceding tax-  
6 able year, the individual meets the re-  
7 quirements of paragraph (1)(B), and  
8 the individual otherwise satisfies the  
9 requirements of paragraph (1), or

10                   “(II) the individual is determined  
11 to satisfy the requirements of para-  
12 graph (1) after the application of the  
13 same eligibility methodologies as  
14 would apply for purposes of deter-  
15 mining the eligibility of an individual  
16 for assistance under the State chil-  
17 dren’s health insurance program  
18 under title XXI of the Social Security  
19 Act.

20           “(ii) APPLICATION OF SCHIP INCOME  
21 DETERMINATION METHODOLOGIES.—For  
22 purposes of clause (i)(II), determinations  
23 of income levels shall be made using the  
24 methodologies described in that clause, to  
25 the extent such methodologies for

1           ascertaining household income differ from  
2           any otherwise applicable method for deter-  
3           mining adjusted gross income or the defini-  
4           tion of adjusted gross income.

5           “(C) CERTIFICATE OF ELIGIBILITY.—

6                   “(i) IN GENERAL.—An individual who  
7           is determined to be an eligible low-income  
8           individual shall be issued a certificate of  
9           eligibility by the State agency referred to  
10          in subparagraph (A).

11                   “(ii) CERTIFICATE AMOUNT.—Such  
12          certificate shall indicate the applicable per-  
13          centage of the amount paid for coverage  
14          under qualified health insurance that the  
15          individual is eligible for under this section  
16          (including any supplemental assistance  
17          which the individual may be eligible for  
18          under subsection (b)(2), unless the indi-  
19          vidual elects to not receive such supple-  
20          mental assistance).

21                   “(iii) 12-MONTH PERIOD OF ISSUE.—  
22          The certificate of eligibility shall apply for  
23          a 12-month period from the date of issue,  
24          notwithstanding any changes in household  
25          circumstances following the individual’s ap-

1                   plication for a credit under this section or  
2                   supplemental assistance.

3                   “(D) SUPPLEMENTAL ASSISTANCE.—The  
4                   State agency described in subparagraph (A)  
5                   shall determine an individual’s eligibility for  
6                   supplemental assistance under subsection (b)(2)  
7                   based on the methodologies referred to in sub-  
8                   paragraph (B)(ii).

9                   “(f) QUALIFYING FAMILY MEMBER.—For purposes  
10 of this section—

11                   “(1) IN GENERAL.—The term ‘qualifying family  
12                   member’ means—

13                   “(A) the taxpayer’s spouse, and

14                   “(B) any dependent of the taxpayer with  
15                   respect to whom the taxpayer is entitled to a  
16                   deduction under section 151(c).

17                   Such term does not include any individual who is  
18                   not an eligible low-income individual under sub-  
19                   section (e)(1).

20                   “(2) SPECIAL DEPENDENCY TEST IN CASE OF  
21                   DIVORCED PARENTS, ETC.—If paragraph (2) or (4)  
22                   of section 152(e) applies to any child with respect to  
23                   any calendar year, in the case of any taxable year  
24                   beginning in such calendar year, such child shall be  
25                   treated as described in paragraph (1)(B) with re-

1       spect to the custodial parent (within the meaning of  
2       section 152(e)(1)) and not with respect to the non-  
3       custodial parent.

4       “(g) QUALIFIED HEALTH INSURANCE.—For pur-  
5       poses of this section—

6               “(1) IN GENERAL.—The term ‘qualified health  
7       insurance’ means any of the following:

8               “(A) Coverage under an insurance plan  
9       participating in a purchasing pool established  
10       pursuant to section 203 of the Health Cov-  
11       erage, Affordability, Responsibility, and Equity  
12       Act of 2003.

13              “(B) Coverage under individual health in-  
14       surance pursuant to section 212 of such Act.

15              “(C) Coverage, pursuant to section 213 of  
16       such Act, under the medicaid program or the  
17       State children’s health insurance program if 1  
18       or more family members qualifies for coverage  
19       under such program.

20              “(D) Coverage, pursuant to section 214 of  
21       such Act, under an employer-sponsored insur-  
22       ance plan, including—

23                      “(i) coverage under a COBRA con-  
24       tinuation provision (as defined in section  
25       9832(d)(1)),

1           “(ii) State-based continuation cov-  
 2           erage provided under a State law that re-  
 3           quires such coverage,

4           “(iii) coverage voluntarily offered by a  
 5           former employer of the individual or family  
 6           member; or

7           “(iv) coverage under a group health  
 8           plan that is available through the employ-  
 9           ment of the individual or a family member.

10           “(2) EXCEPTION.—The term ‘qualified health  
 11           insurance’ shall not include—

12           “(A) a flexible spending or similar ar-  
 13           rangement, and

14           “(B) any insurance if substantially all of  
 15           its coverage is of excepted benefits described in  
 16           section 9832(e).

17           “(3) DEFINITIONS.—For purposes of this sub-  
 18           section—

19           “(A) EMPLOYER-SPONSORED INSUR-  
 20           ANCE.—

21           “(i) IN GENERAL.—The term ‘em-  
 22           ployer-sponsored insurance’ means any in-  
 23           surance which covers medical care under  
 24           any health plan maintained by any em-

1            employer (or former employer) of the tax-  
2            payer or the taxpayer's spouse.

3            “(ii) TREATMENT OF CAFETERIA  
4            PLANS.—For purposes of clause (i), the  
5            cost of coverage shall be treated as paid or  
6            incurred by an employer to the extent the  
7            coverage is in lieu of a right to receive cash  
8            or other qualified benefits under a cafe-  
9            teria plan (as defined in section 125(d)).

10          “(B) INDIVIDUAL HEALTH INSURANCE.—  
11          The term ‘individual health insurance’ means  
12          any insurance which constitutes medical care  
13          offered to individuals other than in connection  
14          with a group health plan and does not include  
15          Federal- or State-based health insurance cov-  
16          erage.

17          “(h) OTHER SPECIFIED COVERAGE.—For purposes  
18          of this section, an individual has other specified coverage  
19          for any month if, as of the first day of such month—

20                “(1) COVERAGE UNDER MEDICARE.—Such indi-  
21          vidual is entitled to benefits under part A of title  
22          XVIII of the Social Security Act or is enrolled under  
23          part B of such title.

24                “(2) CERTAIN OTHER COVERAGE.—Such indi-  
25          vidual—

1           “(A) is enrolled in a health benefits plan  
2           under chapter 89 of title 5, United States Code,  
3           or

4           “(B) is entitled to receive benefits under  
5           chapter 55 of title 10, United States Code.

6           “(i) FEDERAL POVERTY LEVEL; POVERTY LEVEL;  
7 POVERTY.—For purposes of this section, the terms ‘Fed-  
8 eral poverty level’, ‘poverty level’, and ‘poverty’ mean the  
9 income official poverty line (as defined by the Office of  
10 Management and Budget, and revised annually in accord-  
11 ance with section 673(2) of the Omnibus Budget Rec-  
12 onciliation Act of 1981) applicable to a family of the size  
13 involved.

14          “(j) SPECIAL RULES.—

15           “(1) COORDINATION WITH ADVANCE PAYMENTS  
16 OF CREDIT.—With respect to any taxable year, the  
17 amount which would (but for this subsection) be al-  
18 lowed as a credit to the taxpayer under subsection  
19 (a) shall be reduced (but not below zero) by the ag-  
20 gregate amount paid on behalf of such taxpayer  
21 under section 7528 for months beginning in such  
22 taxable year.

23           “(2) COORDINATION WITH OTHER DEDUC-  
24 TIONS.—Amounts taken into account under sub-  
25 section (a) shall not be taken into account in deter-

1 mining any deduction allowed under section 162(l)  
2 or 213.

3 “(3) MSA DISTRIBUTIONS.—Amounts distrib-  
4 uted from an Archer MSA (as defined in section  
5 220(d)) shall not be taken into account under sub-  
6 section (a).

7 “(4) DENIAL OF CREDIT TO DEPENDENTS.—No  
8 credit shall be allowed under this section to any indi-  
9 vidual with respect to whom a deduction under sec-  
10 tion 151 is allowable to another taxpayer for a tax-  
11 able year beginning in the calendar year in which  
12 such individual’s taxable year begins.

13 “(5) BOTH SPOUSES ELIGIBLE LOW-INCOME IN-  
14 DIVIDUALS.—The spouse of the taxpayer shall not  
15 be treated as a qualifying family member for pur-  
16 poses of subsection (a), if—

17 “(A) the taxpayer is married at the close  
18 of the taxable year,

19 “(B) the taxpayer and the taxpayer’s  
20 spouse are both eligible low-income individuals  
21 during the taxable year, and

22 “(C) the taxpayer files a separate return  
23 for the taxable year.

24 “(6) MARITAL STATUS; CERTAIN MARRIED IN-  
25 DIVIDUALS LIVING APART.—Rules similar to the

1 rules of paragraphs (3) and (4) of section 21(e)  
2 shall apply for purposes of this section.

3 “(7) INSURANCE WHICH COVERS OTHER INDI-  
4 VIDUALS.—For purposes of this section, rules simi-  
5 lar to the rules of section 213(d)(6) shall apply with  
6 respect to any contract for qualified health insurance  
7 under which amounts are payable for coverage of an  
8 individual other than the taxpayer and qualifying  
9 family members.

10 “(8) TREATMENT OF PAYMENTS.—For pur-  
11 poses of this section:

12 “(A) PAYMENTS BY SECRETARY.—Any  
13 payment made by the Secretary on behalf of  
14 any individual under section 7528 (relating to  
15 advance payment of credit for health insurance  
16 costs of eligible low-income individuals) shall be  
17 treated as having been made by the taxpayer  
18 (or on behalf of the taxpayer) on the first day  
19 of the month for which such payment was  
20 made.

21 “(B) PAYMENTS BY TAXPAYER.—Any pay-  
22 ment made by the taxpayer (or on behalf of the  
23 taxpayer) for eligible coverage months shall be  
24 treated as having been so made on the first day

1 of the month for which such payment was  
2 made.

3 “(9) REGULATIONS.—

4 “(A) IN GENERAL.—The Secretary, in con-  
5 sultation with the Secretary of Health and  
6 Human Services, shall administer the credit al-  
7 lowed under this section and shall prescribe  
8 such regulations and other guidance as may be  
9 necessary or appropriate to carry out this sec-  
10 tion, section 6050U, and section 7528.

11 “(B) ELIGIBILITY DETERMINATIONS.—  
12 Such regulations shall include such standards  
13 as the Secretary of Health and Human Services  
14 may specify with respect to the requirements  
15 for eligibility determinations under subsection  
16 (e)(2).

17 “(C) MEASURES TO COMBAT FRAUD AND  
18 ABUSE.—Such regulations shall include appro-  
19 priate procedures to deter, detect, and penalize  
20 fraudulent efforts to obtain a credit under this  
21 section by individuals, providers of qualified  
22 health insurance, and others.”.

23 (b) CONFORMING AMENDMENTS.—



1 in such manner, at such time, and containing such  
2 information as the Secretary may require.

3 (3) APPROPRIATION.—Out of any money in the  
4 Treasury of the United States not otherwise appro-  
5 priated, there are appropriated such sums as may be  
6 necessary to carry out this subsection.

7 **SEC. 112. ADVANCE PAYMENT OF CREDIT FOR HEALTH IN-**  
8 **SURANCE COSTS OF ELIGIBLE LOW-INCOME**  
9 **INDIVIDUALS.**

10 (a) IN GENERAL.—Chapter 77 of the Internal Rev-  
11 enue Code of 1986 (relating to miscellaneous provisions)  
12 is amended by adding at the end the following new section:

13 **“SEC. 7528. ADVANCE PAYMENT OF CREDIT FOR HEALTH**  
14 **INSURANCE COSTS OF ELIGIBLE LOW-IN-**  
15 **COME INDIVIDUALS.**

16 “(a) GENERAL RULE.—Not later than August 1,  
17 2005, the Secretary shall establish a program for making  
18 payments on behalf of certified individuals to providers of  
19 qualified health insurance (as defined in section 36(g)) for  
20 such individuals.

21 “(b) LIMITATION ON ADVANCE PAYMENTS DURING  
22 ANY TAXABLE YEAR.—The Secretary may make pay-  
23 ments under subsection (a) only to the extent that the  
24 total amount of such payments made on behalf of any indi-  
25 vidual during the taxable year is not reasonably expected

1 to exceed the applicable percentage (as defined in section  
 2 36(b)) of the amount paid by the taxpayer (or on behalf  
 3 of the taxpayer) for coverage of the taxpayer and quali-  
 4 fying family members under qualified health insurance for  
 5 eligible coverage months beginning in the taxable year.

6 “(c) CERTIFIED INDIVIDUAL.—For purposes of this  
 7 section, the term ‘certified individual’ means any indi-  
 8 vidual for whom a health coverage eligibility certificate is  
 9 in effect.

10 “(d) HEALTH COVERAGE ELIGIBILITY CERTIFI-  
 11 CATE.—For purposes of this section, the term ‘health cov-  
 12 erage eligibility certificate’ means any written statement  
 13 that an individual is an eligible low-income individual (as  
 14 defined in section 36(e)) if such statement provides such  
 15 information as the Secretary may require for purposes of  
 16 this section and is issued by the State agency responsible  
 17 for administering the State children’s health insurance  
 18 program under title XXI of the Social Security Act.”.

19 (b) DISCLOSURE OF RETURN INFORMATION FOR  
 20 PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE  
 21 PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF  
 22 ELIGIBLE LOW-INCOME INDIVIDUALS.—

23 (1) IN GENERAL.—Subsection (1) of section  
 24 6103 of the Internal Revenue Code of 1986 (relating  
 25 to disclosure of returns and return information for

1 purposes other than tax administration) is amended  
2 by adding at the end the following new paragraph:

3 “(19) DISCLOSURE OF RETURN INFORMATION  
4 FOR PURPOSES OF CARRYING OUT A PROGRAM FOR  
5 ADVANCE PAYMENT OF CREDIT FOR HEALTH INSUR-  
6 ANCE COSTS OF ELIGIBLE LOW-INCOME INDIVID-  
7 UALS.—The Secretary may disclose to providers of  
8 health insurance for any certified individual (as de-  
9 fined in section 7528(c)) return information with re-  
10 spect to such certified individual only to the extent  
11 necessary to carry out the program established by  
12 section 7528 (relating to advance payment of credit  
13 for health insurance costs of eligible low-income indi-  
14 viduals).”.

15 (2) PROCEDURES AND RECORDKEEPING RE-  
16 LATED TO DISCLOSURES.—Subsection (p) of such  
17 section is amended—

18 (A) in paragraph (3)(A) by striking “or  
19 (18)” and inserting “(18), or (19)”, and

20 (B) in paragraph (4), as amended by sec-  
21 tion 202(b)(2)(B) of the Trade Act of 2002  
22 (Public Law 107–210; 116 Stat. 961), by strik-  
23 ing “or (17)” after “any other person described  
24 in subsection (l)(16)” each place it appears and  
25 inserting “(18), or (19)”.

1           (3) UNAUTHORIZED INSPECTION OF RETURNS  
 2           OR           RETURN           INFORMATION.—Section  
 3           7213A(a)(1)(B) of such Code is amended by striking  
 4           “section 6103(n)” and inserting “subsection (l)(18)  
 5           or (19) or (n) of section 6103”.

6           (c) INFORMATION REPORTING.—

7           (1) IN GENERAL.—Subpart B of part III of  
 8           subchapter A of chapter 61 of the Internal Revenue  
 9           Code of 1986 (relating to information concerning  
 10          transactions with other persons) is amended by in-  
 11          serting after section 6050T the following new sec-  
 12          tion:

13       **“SEC. 6050U. RETURNS RELATING TO CREDIT FOR HEALTH**  
 14                               **INSURANCE COSTS OF ELIGIBLE LOW-IN-**  
 15                               **COME INDIVIDUALS.**

16          “(a) REQUIREMENT OF REPORTING.—Every person  
 17          who is entitled to receive payments for any month of any  
 18          calendar year under section 7528 (relating to advance pay-  
 19          ment of credit for health insurance costs of eligible low-  
 20          income individuals) with respect to any certified individual  
 21          (as defined in section 7528(c)) shall, at such time as the  
 22          Secretary may prescribe, make the return described in  
 23          subsection (b) with respect to each such individual.

24          “(b) FORM AND MANNER OF RETURNS.—A return  
 25          is described in this subsection if such return—

1           “(1) is in such form as the Secretary may pre-  
2       scribe, and

3           “(2) contains—

4               “(A) the name, address, and TIN of each  
5       individual referred to in subsection (a),

6               “(B) the number of months for which  
7       amounts were entitled to be received with re-  
8       spect to such individual under section 7528 (re-  
9       lating to advance payment of credit for health  
10      insurance costs of eligible low-income individ-  
11      uals),

12              “(C) the amount entitled to be received for  
13      each such month, and

14              “(D) such other information as the Sec-  
15      retary may prescribe.

16           “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
17   UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
18   QUIRED.—Every person required to make a return under  
19   subsection (a) shall furnish to each individual whose name  
20   is required to be set forth in such return a written state-  
21   ment showing—

22              “(1) the name and address of the person re-  
23      quired to make such return and the phone number  
24      of the information contact for such person, and

1           “(2) the information required to be shown on  
2           the return with respect to such individual.

3   The written statement required under the preceding sen-  
4   tence shall be furnished on or before January 31 of the  
5   year following the calendar year for which the return  
6   under subsection (a) is required to be made.”.

7           (2) ASSESSABLE PENALTIES.—

8           (A) Subparagraph (B) of section  
9           6724(d)(1) of such Code (relating to defini-  
10          tions) is amended by redesignating clauses (xii)  
11          through (xviii) as clauses (xiii) through (xix),  
12          respectively, and by inserting after clause (xi)  
13          the following new clause:

14                   “(xii) section 6050U (relating to re-  
15                   turns relating to credit for health insur-  
16                   ance costs of eligible low-income individ-  
17                   uals),”.

18           (B) Paragraph (2) of section 6724(d) of  
19          such Code is amended by striking “or” at the  
20          end of subparagraph (AA), by striking the pe-  
21          riod at the end of subparagraph (BB) and in-  
22          serting “, or”, and by adding after subpara-  
23          graph (BB) the following new subparagraph:

1 “(CC) section 6050U (relating to returns  
2 relating to credit for health insurance costs of  
3 eligible low-income individuals).”.

4 (d) CLERICAL AMENDMENTS.—

5 (1) ADVANCE PAYMENT.—The table of sections  
6 for chapter 77 of the Internal Revenue Code of 1986  
7 is amended by adding at the end the following new  
8 item:

“Sec. 7528. Advance payment of credit for health insurance costs  
of eligible low-income individuals.”.

9 (2) INFORMATION REPORTING.—The table of  
10 sections for subpart B of part III of subchapter A  
11 of chapter 61 of such Code is amended by inserting  
12 after the item relating to section 6050T the fol-  
13 lowing new item:

“Sec. 6050U. Returns relating to credit for health insurance costs  
of eligible low-income individuals.”.

14 (e) EFFECTIVE DATE.—The amendments made by  
15 this section shall take effect on January 1, 2006.

16 **TITLE II—IMPROVING ACCESS**  
17 **TO HEALTH PLANS**

18 **SEC. 201. DEFINITIONS.**

19 In this title:

20 (1) ELIGIBLE INDIVIDUAL.—The term “eligible  
21 individual” means an individual with respect to  
22 whom a tax credit is allowed under section 36 of the

1 Internal Revenue Code of 1986 (as added by section  
2 111).

3 (2) PARTICIPATING INSURER.—The term “par-  
4 ticipating insurer” means an entity with a contract  
5 under section 205(a).

6 (3) PRIVATE GROUP HEALTH INSURANCE  
7 PLAN.—The term “private group health insurance  
8 plan” means a plan offered by a participating in-  
9 surer that provides health benefits coverage to eligi-  
10 ble individuals and that meets the requirements of  
11 this title.

12 (4) PURCHASING POOL OPERATOR.—The term  
13 “purchasing pool operator” means the entity des-  
14 ignated by the State under section 204.

15 (5) SECRETARY.—The term “Secretary” means  
16 the Secretary of Health and Human Services.

17 (6) SMALL EMPLOYER.—The term “small em-  
18 ployer” means an employer with not less than 2 and  
19 not more than 100 employees.

20 **SEC. 202. ESTABLISHMENT OF HEALTH INSURANCE PUR-**  
21 **CHASING POOLS.**

22 There is established a program under which the Sec-  
23 retary shall ensure that each eligible individual has the  
24 opportunity to enroll, through a purchasing pool operator,

1 in a private group health insurance plan offered by a par-  
2 ticipating insurer under this title.

3 **SEC. 203. PURCHASING POOLS.**

4 (a) ESTABLISHMENT OF PURCHASING POOLS.—Each  
5 State participating in the program under this title shall  
6 establish a purchasing pool that is available to each eligi-  
7 ble individual who resides in the State.

8 (b) TYPES OF PURCHASING POOLS.—

9 (1) IN GENERAL.—A purchasing pool estab-  
10 lished under subsection (a) shall be 1 of the fol-  
11 lowing:

12 (A) A statewide purchasing pool operated  
13 by the State.

14 (B) A statewide purchasing pool operated  
15 on behalf of the State by the Director of the  
16 Office of Personnel Management, or the des-  
17 ignee of such Director.

18 (2) OPM OPERATED POOL.—In the case of a  
19 statewide purchasing pool described in paragraph  
20 (1)(B), the Director of the Office of Personnel Man-  
21 agement or the Director's designee, may limit par-  
22 ticipating insurers in such pool to those described in  
23 section 205(e), except that the Director or such des-  
24 ignee shall ensure that additional private group  
25 health insurance plans participate in such a pool to

1 the extent necessary to meet the requirements of  
2 section 204(c)(9).

3 (c) STATE ELECTION PROCESS.—

4 (1) IN GENERAL.—Each State participating in  
5 the program under this title shall notify the Sec-  
6 retary, not later than January 4, 2005, of the type  
7 of purchasing pool that applies to residents of the  
8 State.

9 (2) DEFAULT CHOICE.—If a State participating  
10 in the program under this title fails to notify the  
11 Secretary of the type of purchasing pool elected by  
12 the State by the date described in paragraph (1),  
13 the State shall be deemed to have elected the type  
14 of purchasing pool described in subsection (b)(1)(B).

15 (3) CHANGE OF ELECTION.—The Secretary  
16 shall establish procedures under which a State par-  
17 ticipating in the program under this title may  
18 change the election of the type of purchasing pool  
19 applicable to residents of the State.

20 **SEC. 204. PURCHASING POOL OPERATORS.**

21 (a) DESIGNATION.—Each State shall designate a  
22 purchasing pool operator that shall be responsible for op-  
23 erating the purchasing pool established under section  
24 203(a). A purchasing pool operator may be (or, to have  
25 1 or more of its functions performed, may contract with)

1 a private entity that has entered into a contract with the  
2 State if such entity meets requirements established by the  
3 Secretary for purposes of the program under this title.

4 (b) OPERATION SIMILAR TO FEHBP.—Each pur-  
5 chasing pool operator shall operate the purchasing pool  
6 established under section 203(a) in a manner that is simi-  
7 lar to the manner in which the Director of the Office of  
8 Personnel Management operates the Federal employees’  
9 health benefits program under chapter 89 of title 5,  
10 United States Code, including (but not limited to) the per-  
11 formance of the specific functions described in subsection  
12 (c).

13 (c) SPECIFIC FUNCTIONS DESCRIBED.—The specific  
14 functions described in this subsection include the fol-  
15 lowing:

16 (1) Each purchasing pool operator shall offer  
17 one-stop shopping for eligible individuals to enroll  
18 for health benefits coverage under private, group  
19 health insurance plans offered by participating in-  
20 surers.

21 (2) Each purchasing pool operator shall limit  
22 participating insurers to those that meet the condi-  
23 tions for participation described in this title.

24 (3) Each purchasing pool operator shall nego-  
25 tiate (or, in the case of a purchasing pool described

1 in section 203(b)(1)(B), shall negotiate or otherwise  
2 determine) bids and terms of coverage with insurers.

3 (4) Each purchasing pool operator shall provide  
4 eligible individuals with comparative information on  
5 private group health insurance plans offered by par-  
6 ticipating insurers.

7 (5) Each purchasing pool operator shall assist  
8 eligible individuals in enrolling with a private group  
9 health insurance plan offered by a participating in-  
10 surer.

11 (6) Each purchasing pool operator shall collect  
12 private group health insurance plan premium pay-  
13 ments for participating insurers and process such  
14 premium payments.

15 (7) Each purchasing pool operator shall rec-  
16 oncile from year to year aggregate premium pay-  
17 ments and claims costs of private group health in-  
18 surance plans consistent with practices under the  
19 Federal employees' health benefits program under  
20 chapter 89 of title 5, United States Code.

21 (8) Each purchasing pool operator shall offer  
22 customer service to eligible individuals enrolled for  
23 health benefits coverage under a private group  
24 health insurance plan offered by a participating in-  
25 surer.

1           (9) Each purchasing pool operator shall ensure  
2           that each eligible individual has the option of enroll-  
3           ing in either of at least 2 benchmark or benchmark-  
4           equivalent plans with—

5                   (A) a premium at or below a cap estab-  
6                   lished by the pool operator for purposes of this  
7                   title; and

8                   (B) coverage of essential services included  
9                   in the report required under section 301(e)(2),  
10                  with cost-sharing consistent with such report.

11          (10) Each purchasing pool operator shall estab-  
12          lish a premium cap for purposes of determining the  
13          credit limitation under section 36(c) of the Internal  
14          Revenue Code of 1986, as added by section 111(a).  
15          The cap required under this paragraph may not be  
16          less than the premium charged to Federal employees  
17          by the most highly-enrolled health plan under the  
18          Federal employees' health benefits program under  
19          chapter 89 of title 5, United States Code. If the  
20          most highly-enrolled plan in that program differs for  
21          Federal enrollees in the State and all Federal enroll-  
22          ees nationally in such plan, the minimum permitted  
23          premium cap shall be the lower of such premiums.

1 **SEC. 205. CONTRACTS WITH PARTICIPATING INSURERS.**

2 (a) IN GENERAL.—Each purchasing pool operator  
3 shall negotiate and enter into contracts for the provision  
4 of health benefits coverage under the program under this  
5 title with entities that meet the conditions of participation  
6 described in subsection (b) and other applicable require-  
7 ments of this Act.

8 (b) CONSUMER INFORMATION.—In carrying out its  
9 duty under section 204(c)(4) to inform eligible individuals  
10 about private group health plans, the purchasing pool op-  
11 erator shall provide information that meets the require-  
12 ments of section 212(b)(2).

13 (c) STATE LICENSURE.—

14 (1) IN GENERAL.—Subject to paragraph (2), a  
15 health plan shall not be a participating insurer un-  
16 less the plan has a State license to provide State  
17 residents with the private group coverage health in-  
18 surance plans that it offers through the pool.

19 (2) EXCEPTION.—A pool operator may enter  
20 into a contract under subsection (a) to cover pool  
21 participants through a health plan without a State  
22 license described in paragraph (1) if such plan is of-  
23 fered to Federal employees nationwide and, with re-  
24 spect to such employees, is exempt from State health  
25 insurance regulation. Nothing in this paragraph  
26 shall be construed to permit coverage of pool partici-

1 pants through such a plan except with groups, con-  
2 tracts, and premium rates that are entirely distinct  
3 from those used for individuals covered under the  
4 Federal employee's health benefits program under  
5 chapter 89 of title 5, United States Code.

6 (d) ADDITIONAL STOP-LOSS COVERAGE AND REIN-  
7 SURANCE.—Purchasing pool operators are authorized to  
8 encourage participation in the program under this title,  
9 improve covered benefits, reduce out-of-pocket cost-shar-  
10 ing, limit premiums, or achieve other objectives of this Act  
11 by—

12 (1) funding stop-loss coverage above levels oth-  
13 erwise offered in the purchasing pool; or

14 (2) providing or subsidizing reinsurance in ad-  
15 dition to that provided under section 211.

16 (e) PARTICIPATION OF FEHBP PLANS.—

17 (1) IN GENERAL.—Each entity with a contract  
18 under section 8902 of title 5, United States Code,  
19 shall be a participating insurer unless such entity  
20 notifies the Secretary in writing of its intention not  
21 to participate in the program under this title prior  
22 to such time as is designated by the Secretary so as  
23 to allow such decisions to be taken into account with  
24 respect to eligible individuals' choice of a private  
25 group health insurance plan under such program.

1 Such participation in the program under this title  
2 shall include at least the covered benefits and pro-  
3 vider networks available through such an entity and  
4 shall not involve greater out-of-pocket cost-sharing  
5 than the plan offered by such entity pursuant to its  
6 contract under section 8902 of title 5, United States  
7 Code.

8 (2) NO EFFECT ON FEHBP COVERAGE.—The  
9 Director of Office of Personnel Management shall  
10 take such steps as are necessary to ensure that each  
11 individual enrolled for health benefits coverage under  
12 the program under chapter 89 of title 5, United  
13 States Code, is not adversely affected by eligible in-  
14 dividuals or others enrolled for coverage under the  
15 program under this title. Such steps shall include  
16 (but need not be limited to) the establishment of  
17 separate risk pools, separate contracts with partici-  
18 pating insurers, and separately negotiated pre-  
19 miums.

20 **SEC. 206. OPTIONS FOR HEALTH BENEFITS COVERAGE.**

21 (a) SCOPE OF HEALTH BENEFITS COVERAGE.—The  
22 health benefits coverage provided to an eligible individual  
23 under a private group health insurance plan offered by  
24 a participating insurer shall consist of any of the fol-  
25 lowing:

1           (1) BENCHMARK COVERAGE.—Health benefits  
2 coverage that is equivalent to the benefits coverage  
3 in a benchmark benefit package described in sub-  
4 section (b).

5           (2) BENCHMARK-EQUIVALENT COVERAGE.—  
6 Health benefits coverage that meets the following re-  
7 quirements:

8                   (A) INCLUSION OF ESSENTIAL SERV-  
9 ICES.—The coverage includes each of the essen-  
10 tial services identified by the National Advisory  
11 Commission on Expanded Access to Health  
12 Care and adopted by Congress under title III.

13                   (B) AGGREGATE ACTUARIAL VALUE EQUIV-  
14 ALENT TO BENCHMARK PACKAGE.—The cov-  
15 erage has an aggregate actuarial value that is  
16 equal to or greater than the actuarial value of  
17 one of the benchmark benefit packages.

18           (3) ALTERNATIVE COVERAGE.—Any other  
19 health benefits coverage that the Secretary deter-  
20 mines, upon application by a State, offers health  
21 benefits coverage equivalent to or greater than a  
22 plan described in and offered under section 8903(1)  
23 of title 5, United States Code.

24           (b) BENCHMARK BENEFIT PACKAGES.—The bench-  
25 mark benefit packages are as follows:

1           (1) FEHBP-EQUIVALENT HEALTH BENEFITS  
2           COVERAGE.—The plan described in and offered  
3           under chapter 89 of title 5, United States Code with  
4           the highest number of enrollees under such section  
5           for the year preceding the year in which the private  
6           group health insurance plan is proposed to be of-  
7           fered.

8           (2) PUBLIC PROGRAM-EQUIVALENT HEALTH  
9           BENEFITS COVERAGE.—Coverage provided under the  
10          State plan approved under the medicaid program  
11          under title XIX of the Social Security Act or the  
12          State children’s health insurance program under  
13          title XXI of such Act (42 U.S.C. 1396 et seq.,  
14          1397aa et seq.) (without regard to coverage provided  
15          under a waiver of the requirements of either such  
16          program).

17          (3) COVERAGE OFFERED THROUGH HMO.—The  
18          health insurance coverage plan that—

19                  (A) is offered by a health maintenance or-  
20                  ganization (as defined in section 2791(b)(3) of  
21                  the Public Health Service Act (42 U.S.C. 33gg-  
22                  91(b)(3))), and

23                  (B) has the largest insured commercial,  
24                  nonmedicaid enrollment of covered lives of such

1 coverage plans offered by such a health mainte-  
 2 nance organization in the State.

3 (4) STATE EMPLOYEE COVERAGE.—The health  
 4 insurance plan that is offered to State employees  
 5 and has the largest enrollment of covered lives of  
 6 any such plan.

7 (5) APPLICATION OF BENCHMARK STAND-  
 8 ARDS.—A private group health plan offers bench-  
 9 mark benefits if, with respect to a benchmark plan  
 10 described in paragraph (1), (2), (3), or (4), the pri-  
 11 vate group health plan covers all items and services  
 12 offered by the benchmark plan, with out-of-pocket  
 13 cost-sharing for such items and services that is not  
 14 greater than under the benchmark plan. Nothing in  
 15 this title shall be construed to forbid a private group  
 16 health plan from offering additional items and serv-  
 17 ices not covered by such a benchmark plan or reduc-  
 18 ing out-of-pocket cost-sharing below levels applicable  
 19 under such plan.

20 **SEC. 207. ENROLLMENT PROCESS FOR ELIGIBLE INDIVID-**  
 21 **UALS.**

22 (a) IN GENERAL.—The Secretary shall establish a  
 23 process through which an eligible individual—

24 (1) may make an annual election to enroll in  
 25 any private group health insurance plan offered by

1 a participating insurer that has been awarded a con-  
2 tract under section 205(a) and serves the geographic  
3 area in which the individual resides, provided that  
4 such insurer's geographic area of service and guar-  
5 anteed issuance under this section is conterminous  
6 with, or includes all of, a geographic area served  
7 pursuant to an entity's contract under section 8902  
8 of title 5, United States Code; and

9 (2) may make an annual election to change the  
10 election under this clause.

11 (b) RULES.—In establishing the process under sub-  
12 section (a), the Secretary shall use rules similar to the  
13 rules for enrollment, disenrollment, and termination of en-  
14 rollment under the Federal employees health benefits pro-  
15 gram under chapter 89 of title 5, United States Code, in-  
16 cluding the application of the guaranteed issuance provi-  
17 sion described in subsection (c).

18 (c) GUARANTEED ISSUANCE.—An eligible individual  
19 who is eligible to enroll for health benefits coverage under  
20 a private group health insurance plan that has been  
21 awarded a contract under section 205(a) at a time during  
22 which elections are accepted under this title with respect  
23 to the plan shall not be denied enrollment based on any  
24 health status-related factor (described in section

1 2702(a)(1) of the Public Health Service Act (42 U.S.C.  
2 300gg-1(a)(1))) or any other factor.

3 **SEC. 208. PLAN PREMIUMS.**

4 (a) IN GENERAL.—Each purchasing pool operator  
5 shall negotiate (or, in the case of a purchasing pool oper-  
6 ated pursuant to section 203(b)(1)(B), shall otherwise de-  
7 termine) a premium for each private group health insur-  
8 ance plan offered by a participating insurer.

9 (b) PERMITTED PROFIT MARGINS.—

10 (1) IN GENERAL.—Each premium negotiated  
11 under subsection (a) may not permit a profit margin  
12 that exceeds the applicable percentage (as defined in  
13 paragraph (2)).

14 (2) APPLICABLE PERCENTAGE DEFINED.—In  
15 this subsection, the term “applicable percentage”  
16 means—

17 (A) for the first 3 years that a purchasing  
18 pool is operated, 2 percent;

19 (B) for any subsequent year, the percent-  
20 age determined by the purchasing pool oper-  
21 ator, which may not be—

22 (i) less than the profit margin per-  
23 mitted under the Federal employees health  
24 benefits program under chapter 89 of title  
25 5, United States Code; or

1 (ii) more than a multiple, established  
2 by the Secretary for purposes of this sub-  
3 section, of profit margins permitted under  
4 such program.

5 **SEC. 209. ENROLLEE PREMIUM SHARE.**

6 (a) IN GENERAL.—A participating insurer offering a  
7 private group health insurance plan that has been awarded  
8 a contract under section 205(a) in which the eligible indi-  
9 vidual is enrolled may not deny, limit, or condition the  
10 coverage (including out-of-pocket cost-sharing) or provi-  
11 sion of health benefits coverage or vary or increase the  
12 enrollee premium share under the plan based on any  
13 health status-related factor described in section  
14 2702(a)(1) of the Public Health Service Act (42 U.S.C.  
15 300gg–1(a)(1)) or any other factor.

16 (b) RISK-ADJUSTED PLAN PAYMENTS AND PRE-  
17 MIUMS CHARGED TO ENROLLEES.—

18 (1) IN GENERAL.—For each private group  
19 health insurance plan operated by a participating in-  
20 surer, the pool operator shall adjust premium pay-  
21 ments to compensate for the difference in health risk  
22 factors between plan enrollees and State residents as  
23 a whole (including residents who are not eligible in-  
24 dividuals). Such adjustments shall employ risk-ad-  
25 justment mechanisms promulgated by the Secretary.

1           (2) ADDITIONAL ADJUSTMENTS.—The pool op-  
 2 erator shall also provide additional adjustments to  
 3 premium payments that compensate participating in-  
 4 surers for the cost of keeping out-of-pocket cost-  
 5 sharing amounts consistent with section  
 6 204(c)(9)(B).

7           (3) ENROLLEE PREMIUM COSTS.—The adjust-  
 8 ments described in this subsection shall not affect  
 9 enrollee premium shares, which shall be based on the  
 10 premium that would be charged for enrollees with  
 11 health risk factors for State residents as a whole (as  
 12 described in paragraph (1)), without taking into ac-  
 13 count cost-sharing adjustments under section  
 14 204(c)(9)(B).

15       (c) AMOUNT OF PREMIUM.—The amount of the en-  
 16 rollee premium share shall be equal to premium amounts  
 17 (if any) above the applicable cap set pursuant to section  
 18 204(c)(10), plus 100 percent of the remainder minus the  
 19 applicable percentage (as defined in section 36(b) of the  
 20 Internal Revenue Code of 1986, as added by section 111).

21 **SEC. 210. PAYMENTS TO PURCHASING POOL OPERATORS**  
 22 **AND PAYMENTS TO PARTICIPATING INSUR-**  
 23 **ERS.**

24       The Secretary shall establish procedures for making  
 25 payments to each purchasing pool operator as follows:

1           (1) RISK-ADJUSTMENT PAYMENT.—The Sec-  
2           retary shall pay each purchasing pool operator for  
3           the net costs of risk-adjusted payments to plans  
4           under section 209(b), to the extent the sum of up-  
5           ward adjustments exceeds the sum of downward ad-  
6           justments for the pool operator.

7           (2) STOP-LOSS AND REINSURANCE PAY-  
8           MENTS.—

9           (A) IN GENERAL.—The Secretary shall pay  
10          each purchasing pool operator for the applicable  
11          percentage (as defined in subparagraph (B))  
12          of—

13                 (i) the costs of any stop-loss coverage  
14                 funded by the purchasing pool operator  
15                 under section 205(d)(1); and

16                 (ii) any reinsurance provided in ac-  
17                 cordance with section 205(d)(2).

18          (B) APPLICABLE PERCENTAGE DE-  
19          FINED.—In this paragraph, the term “applica-  
20          ble percentage” means—

21                 (i) for the first 3 years that a pur-  
22                 chasing pool is operated, 100 percent;

23                 (ii) for the next 2 years that such  
24                 purchasing pool is operated, 50 percent;  
25                 and

1 (iii) for any subsequent year, 0 per-  
2 cent.

3 (3) PAYMENTS NECESSARY TO KEEP COST-  
4 SHARING WITHIN APPLICABLE LIMITS.—The Sec-  
5 retary shall make payments to purchasing pool oper-  
6 ators to reimburse purchasing pool operators for the  
7 amount paid by such operators to participating in-  
8 surers necessary to keep out-of-pocket cost-sharing  
9 for individuals with limited ability to pay within ap-  
10 plicable limits.

11 (4) PAYMENT FOR ADMINISTRATIVE COSTS.—  
12 The Secretary shall make payments to each pur-  
13 chasing pool operator for necessary pool administra-  
14 tive expenses.

15 (5) PAYMENTS TO OPM.—In the case of a pur-  
16 chasing pool described in section 203(b)(1)(B), pay-  
17 ments under this section shall be made to the Direc-  
18 tor of the Office of Personnel Management.

19 **SEC. 211. STATE-BASED REINSURANCE PROGRAMS.**

20 (a) ESTABLISHMENT.—The Secretary shall establish  
21 standards for State-based reinsurance programs for eligi-  
22 ble individuals to guard against adverse selection and to  
23 improve the functioning of the individual health insurance  
24 market.

1 (b) GRANTS FOR STATEWIDE REINSURANCE PRO-  
2 GRAMS.—

3 (1) IN GENERAL.—The Secretary may award  
4 grants to States for the reasonable costs incurred in  
5 providing reinsurance under this section, consistent  
6 with standards developed by the Secretary, for cov-  
7 erage offered in the individual health insurance mar-  
8 ket and through State-based purchasing pools de-  
9 scribed in section 203.

10 (2) LIMITATION.—Such grants may not pay for  
11 reinsurance extending beyond individuals in the top  
12 3 percent of the national health care spending dis-  
13 tribution, as determined by the Secretary.

14 (3) APPLICATION.—A State desiring a grant  
15 under this section shall submit an application to the  
16 Secretary in such manner, at such time, and con-  
17 taining such information as the Secretary may re-  
18 quire.

19 (4) AUTHORIZATION OF APPROPRIATIONS.—  
20 There are authorized to be appropriated to the Sec-  
21 retary such sums as may be necessary for making  
22 grants under this section.

1 **SEC. 212. COVERAGE UNDER INDIVIDUAL HEALTH INSUR-**  
2 **ANCE.**

3 (a) IN GENERAL.—Eligible individuals may use cred-  
4 its allowed under the Internal Revenue Code of 1986 (in-  
5 cluding supplemental assistance provided under such  
6 Code) for the purchase of health insurance coverage to en-  
7 roll in State-licensed individual health insurance meeting  
8 the conditions of participation described in subsection (b).

9 (b) CONDITIONS OF PARTICIPATION.—The Secretary  
10 shall promulgate regulations that establish the terms and  
11 conditions under which an entity may participate in the  
12 program under this section and that include the following:

13 (1) PLAN MARKETING.—Conditions of partici-  
14 pation for plans in the individual market (as devel-  
15 oped by the Secretary) that—

16 (A) ensure that consumers receive the con-  
17 sumer information described in paragraph (2)  
18 before selecting a plan; and

19 (B) detect, deter, and penalize marketing  
20 fraud by entities offering or purporting to offer  
21 individual insurance.

22 (2) CONSUMER INFORMATION.—Requirements  
23 for each entity offering individual insurance to pro-  
24 vide eligible individuals with information in a uni-  
25 form and easily comprehensible manner that allows  
26 for informed comparisons by eligible individuals and

1 that includes information regarding the health bene-  
2 fits coverage, costs, provider networks, quality, the  
3 amount and proportion of health insurance premium  
4 payments that go directly to patient care, and the  
5 plan's coverage rules (including amount, duration,  
6 and scope limits) and out-of-pocket cost-sharing  
7 (both inside and outside plan networks) for each es-  
8 sential service recommended by the National Advi-  
9 sory Commission on Expanded Access to Health  
10 Care and adopted by Congress under title III (which  
11 shall be prominently identified as an essential serv-  
12 ice, including by reference to the Commission rec-  
13 ommendation denoting the service as essential). To  
14 the maximum extent feasible, such requirements  
15 shall specify that the content and presentation of the  
16 information shall be provided in the same manner as  
17 similar information is presented to enrollees in the  
18 Federal employees health benefits program under  
19 chapter 89 of title 5, United States Code.

20 (3) OTHER CONDITIONS, INCLUDING THE  
21 ELIMINATION OF BARRIERS TO AFFORDABLE COV-  
22 ERAGE.—

23 (A) IN GENERAL.—Requirements for each  
24 entity offering individual insurance to abide by  
25 conditions of participation that the Secretary

1 believes are reasonable and appropriate meas-  
 2 ures to address barriers to affordable health in-  
 3 surance coverage.

4 (B) SPECIFIC CONDITIONS.—The require-  
 5 ments developed by the Secretary under sub-  
 6 paragraph (A) shall include (but need not be  
 7 limited to)—

8 (i) guaranteed renewability, without  
 9 premium increases based on changed indi-  
 10 vidual risk; and

11 (ii) limits on risk rating.

12 (4) RULE OF CONSTRUCTION.—Nothing in this  
 13 section shall be construed to authorize the Secretary  
 14 to impose any requirements on individual insurance,  
 15 except with respect to eligible individuals purchasing  
 16 individual insurance using advance payment of a tax  
 17 credit provided under section 36 of the Internal Rev-  
 18 enue Code of 1986.

19 **SEC. 213. USE OF PREMIUM SUBSIDIES TO UNIFY FAMILY**  
 20 **COVERAGE WITH MEMBERS ENROLLED IN**  
 21 **MEDICAID AND SCHIP.**

22 Notwithstanding any other provision of law, the Sec-  
 23 retary shall establish procedures under which, in the case  
 24 of a family with 1 or more members enrolled in with a  
 25 managed care entity under the State medicaid program

1 under title XIX of the Social Security Act or the State  
2 children's health insurance program under title XXI of  
3 such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) and  
4 1 or more members who are an eligible individual under  
5 this title, the family shall have the option to enroll all fam-  
6 ily members with the managed care entity under either  
7 or both such State programs. The procedures established  
8 by the Secretary shall provide that premiums charged to  
9 eligible individuals for enrollment with such an entity shall  
10 be based on the capitated payments established for adults  
11 or children, excluding adults and children who are known  
12 to be pregnant, blind, disabled, or (in the case of adults)  
13 elderly, under the applicable State program (except that,  
14 in the case of an eligible individual known to be pregnant,  
15 premiums shall reflect capitated payments established  
16 under such State program for individuals known to be  
17 pregnant) plus reasonable administrative costs.

18 **SEC. 214. COVERAGE THROUGH EMPLOYER-SPONSORED**

19 **HEALTH INSURANCE.**

20 (a) IN GENERAL.—Eligible individuals may use cred-  
21 its allowed under the Internal Revenue Code of 1986 and  
22 supplemental assistance to enroll in coverage offered by  
23 eligible employers.

1 (b) ELIGIBLE EMPLOYERS.—For purposes of this  
2 section, the term “eligible employers” includes the fol-  
3 lowing:

4 (1) The current employer of the eligible indi-  
5 vidual or a member of such individual’s family.

6 (2) A former employer required to offer cov-  
7 erage of the eligible individual under a COBRA con-  
8 tinuation provision (as defined in section 9832(d)(1)  
9 of the Internal Revenue Code) or a State law requir-  
10 ing continuation coverage; and

11 (3) A former employer voluntarily offering cov-  
12 erage of the eligible individual.

13 (c) APPLICATION OF DISREGARD OF PREEXISTING  
14 CONDITIONS EXCLUSIONS.—Notwithstanding any other  
15 provision of law, in the case of an individual who experi-  
16 ences a qualifying event (as defined in section 603 of the  
17 Employee Retirement Income Security Act of 1974 (29  
18 U.S.C. 1163) and who, not later than 6 months after such  
19 event, is determined to be an eligible individual under this  
20 title, the same rules with respect to preexisting conditions  
21 as apply to a nonelecting TAA-eligible individual under  
22 section 605(b) of the Employee Retirement Income Secu-  
23 rity Act of 1974 (29 U.S.C. 1165(b)) shall apply with re-  
24 spect to such individual, regardless of which type of quali-  
25 fied coverage the individual purchases.

1 (d) EXTENSION OF COBRA ELECTION PERIOD.—  
2 Notwithstanding any other provision of law, in the case  
3 of an individual who experiences a qualifying event (as de-  
4 fined in section 603 of the Employee Retirement Income  
5 Security Act of 1974 (29 U.S.C. 1163) and who, not later  
6 than 6 months after such event, is determined to be an  
7 eligible individual under this title, the same rules with re-  
8 spect to the temporary extension of a COBRA election pe-  
9 riod as apply to a nonelecting TAA-eligible individual  
10 under section 605(b) of the Employee Retirement Income  
11 Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with  
12 respect to such individual.

13 (e) CURRENT EMPLOYER COVERAGE.—If an eligible  
14 individual uses the credits allowed under the Internal Rev-  
15 enue Code of 1986 and supplemental assistance to pur-  
16 chase coverage from an employer described in subsection  
17 (b), such credits and assistance shall apply as a percent-  
18 age, not of the total premium amount for the eligible indi-  
19 vidual, but of the employee’s or former employee’s share  
20 of premium payments.

21 **SEC. 215. PARTICIPATION BY SMALL EMPLOYERS.**

22 (a) IN GENERAL.—Notwithstanding any other provi-  
23 sion of this title, the Secretary shall establish procedures  
24 under which, during annual open enrollment periods, a  
25 small employer shall have the option of purchasing group

1 coverage for employees and dependents of employees, in-  
2 cluding individuals who are not otherwise eligible individ-  
3 uals under this title, through a purchasing pool established  
4 under section 203(a).

5 (b) CONDITIONS OF PARTICIPATION.—

6 (1) IN GENERAL.—Except as otherwise pro-  
7 vided in this subsection, the same requirements that  
8 apply with respect to participating insurers covering  
9 eligible low-income individuals under section 203  
10 shall apply with respect to coverage offered by such  
11 insurers through a small employer.

12 (2) RISK ADJUSTMENT.—

13 (A) INCREASED PAYMENTS.—If employees  
14 of a small employer who are not otherwise eligi-  
15 ble individuals under this title enroll in a pri-  
16 vate group health insurance plan under this  
17 title and have a collective risk level that exceeds  
18 the statewide average (as determined pursuant  
19 to risk adjustment mechanisms developed by  
20 the Secretary consistent with section  
21 209(b)(1)), the Secretary (through a pool oper-  
22 ator) shall provide participating insurers with  
23 such small employer enrollment bonus payments  
24 as are necessary to compensate the insurers for  
25 such increased risk. The premium charged to

1           enrollees under this section shall be the same  
2           premium that is the basis of premium charges  
3           to enrollees who are eligible low-income individ-  
4           uals.

5           (B) REDUCED PAYMENTS.—A pool oper-  
6           ator shall reduce payments to any plan with a  
7           risk level that falls below the statewide average  
8           (as so determined).

9           (3) ADMINISTRATIVE GUIDELINES.—The Sec-  
10          retary shall develop guidelines for pool operators to  
11          use in serving small employers, which shall be mod-  
12          eled after existing, successful, longstanding small  
13          business purchasing cooperatives, and shall include  
14          administratively simple methods for small employers  
15          and licensed insurance brokers to participate in the  
16          program established under this title.

17          (c) INFORMATION CAMPAIGN.—

18           (1) IN GENERAL.—The pool operator for a  
19          State shall establish and conduct, directly or  
20          through 1 or more public or private entities (which  
21          may include licensed insurance brokers), a health in-  
22          surance information program to inform small em-  
23          ployers about health coverage for employees.

24           (2) REQUIREMENTS.—The program established  
25          under paragraph (1) shall educate small employers

1 with respect to matters that include (but are not  
2 limited to) the following:

3 (A) The benefits of providing health insur-  
4 ance to employees, including tax benefits to  
5 both the employer and employees, increased  
6 productivity, and decreased employee turnover.

7 (B) The rights of small employers under  
8 Federal and State health insurance reform  
9 laws.

10 (C) Options for purchasing coverage, in-  
11 cluding (but not limited to) through the State's  
12 purchasing pool operated pursuant to section  
13 203.

14 (d) GRANTS TO HELP STATE-BASED POOLS PRO-  
15 MOTE SMALL BUSINESS COVERAGE.—

16 (1) IN GENERAL.—The Secretary may award  
17 grants to a pool operator for the following:

18 (A) The net costs of risk-adjusted pay-  
19 ments under paragraph (b)(2), to the extent the  
20 sum of upward adjustments exceeds the sum of  
21 downward adjustments for the pool operator.

22 (B) The reasonable cost of the information  
23 campaign under subsection (c).

24 (C) The pool operator's reasonable admin-  
25 istrative costs to implement this section.

1           (2) **LIMITATION.**—This section shall not apply  
2           to a State’s pool unless sufficient grant funds have  
3           been received under this subsection to implement  
4           this section on a fiscally sound basis and such re-  
5           ceipt is certified by the pool operator.

6           (3) **APPLICATION.**—A pool operator desiring a  
7           grant under this section shall submit an application  
8           to the Secretary in such manner, at such time, and  
9           containing such information as the Secretary may  
10          require.

11          (4) **AUTHORIZATION OF APPROPRIATIONS.**—  
12          There are authorized to be appropriated to the Sec-  
13          retary such sums as may be necessary for making  
14          grants under this section.

15 **SEC. 216. REPORT.**

16          Not later than 1 year after the date of enactment  
17          of this Act, the Secretary shall submit to Congress a re-  
18          port containing recommendations for such legislative and  
19          administrative changes as the Secretary determines are  
20          appropriate to permit affinity groups related for reasons  
21          other than a common employer to participate in pur-  
22          chasing pools established under section 203.

1 **SEC. 217. AUTHORIZATION OF APPROPRIATIONS.**

2 (a) IN GENERAL.—There are authorized to be appro-  
3 priated, such sums as may be necessary to carry out this  
4 title for fiscal year 2006 and each fiscal year thereafter.

5 (b) RULE OF CONSTRUCTION.—Amounts appro-  
6 priated in accordance with subsection (a) shall be in addi-  
7 tion to other amounts appropriated directly under this  
8 title and nothing in subsection (a) shall be construed to  
9 relieve the Secretary of mandatory payment obligations re-  
10 quired under this title.

11 **TITLE III—NATIONAL ADVISORY**  
12 **COMMISSION ON EXPANDED**  
13 **ACCESS TO HEALTH CARE**

14 **SEC. 301. NATIONAL ADVISORY COMMISSION ON EXPANDED**  
15 **ACCESS TO HEALTH CARE.**

16 (a) ESTABLISHMENT.—Not later than October 1,  
17 2003, the Secretary of Health and Human Services (re-  
18 ferred to in this section as the “Secretary”), shall estab-  
19 lish an entity to be known as the National Advisory Com-  
20 mission on Expanded Access to Health Care (referred to  
21 in this section as the “Commission”).

22 (b) APPOINTMENT OF MEMBERS.—

23 (1) IN GENERAL.—Not later than 45 days after  
24 the date of enactment of this Act, the House and  
25 Senate Majority and Minority Leaders shall each ap-

1 point 4 members of the Commission and the Sec-  
2 retary shall appoint 1 member.

3 (2) CRITERIA.—Members of the Commission  
4 shall include representatives of the following:

5 (A) Consumers of health insurance.

6 (B) Health care professionals.

7 (C) State officials.

8 (D) Economists.

9 (E) Health care providers.

10 (F) Experts on health insurance.

11 (G) Experts on expanding health care to  
12 individuals who are uninsured.

13 (3) CHAIRPERSON.—At the first meeting of the  
14 Commission, the Commission shall select a Chair-  
15 person from among its members.

16 (c) MEETINGS.—

17 (1) IN GENERAL.—After the initial meeting of  
18 the Commission which shall be called by the Sec-  
19 retary, the Commission shall meet at the call of the  
20 Chairperson.

21 (2) QUORUM.—A majority of the members of  
22 the Commission shall constitute a quorum, but a  
23 lesser number of members may hold hearings.

24 (3) SUPERMAJORITY VOTING REQUIREMENT.—  
25 To approve a report required under paragraph (2)

1 or (3) of subsection (e), at least 60 percent of the  
2 membership of the Commission must vote in favor  
3 of such a report.

4 (d) DUTIES.—The Commission shall—

5 (1) assess the effectiveness of programs de-  
6 signed to expand health care coverage or make  
7 health care coverage affordable to the otherwise un-  
8 insured individuals through identifying the accom-  
9 plishments and needed improvements of each pro-  
10 gram;

11 (2) make recommendations about benefits and  
12 cost-sharing to be included in health care coverage  
13 for various groups, taking into account—

14 (A) the special health care needs of chil-  
15 dren and individuals with disabilities;

16 (B) the different ability of various popu-  
17 lations to pay out-of-pocket costs for services;

18 (C) incentives for efficiency and cost-con-  
19 trol; and

20 (D) preventative care, disease management  
21 services, and other factors;

22 (3) recommend mechanisms to discourage indi-  
23 viduals and employers from voluntarily opting out of  
24 health insurance coverage;

1           (4) recommend mechanisms to expand health  
2           care coverage to uninsured individuals with incomes  
3           above 200 percent of the official income poverty line  
4           (as defined by the Office of Management and Budget  
5           et, and revised annually in accordance with section  
6           673(2) of the Omnibus Budget Reconciliation Act of  
7           1981) applicable to a family of the size involved;

8           (5) recommend automatic enrollment and reten-  
9           tion procedures and other measures to increase  
10          health care coverage among those eligible for assist-  
11          ance;

12          (6) review the roles, responsibilities, and rela-  
13          tionship between Federal and State agencies with re-  
14          spect to health care coverage and recommend im-  
15          provements; and

16          (7) analyze the size, effectiveness, and efficiency  
17          of current tax and other subsidies for health care  
18          coverage and recommend improvements.

19          (e) REPORTS.—

20                (1) ANNUAL REPORT.—The Commission shall  
21                submit annual reports to the President and Con-  
22                gress addressing the matters identified in subsection  
23                (d).

24                (2) BIENNIAL REPORT.—

1 (A) IN GENERAL.—The Commission shall  
2 submit biennial reports to the President and  
3 Congress, which shall contain—

4 (i) recommendations concerning essen-  
5 tial benefits and maximum out-of-pocket  
6 cost-sharing (for the general population  
7 and for individuals with limited ability to  
8 pay, which shall not exceed the out-of-  
9 pocket cost-sharing permitted under sec-  
10 tion 2103(e) of the Social Security Act (42  
11 U.S.C. 1397cc(e))) for the coverage op-  
12 tions described in title II; and

13 (ii) proposed legislative language to  
14 implement such recommendations.

15 (B) CONGRESSIONAL ACTION.—The legis-  
16 lative language proposed under subparagraph  
17 (A)(ii) shall proceed to immediate consideration  
18 on the floor of the House of Representatives  
19 and the Senate and shall be approved or re-  
20 jected, without amendment, using procedures  
21 employed for recommendations of military base  
22 closing commissions.

23 (3) COMMISSION REPORT.—No later than Janu-  
24 ary 15, 2007, the Commission shall submit a report  
25 to the President and Congress, which shall include—

1 (A) recommendations on policies to provide  
2 health care coverage to uninsured individuals  
3 with incomes above 200 percent of the official  
4 income poverty line (as defined by the Office of  
5 Management and Budget, and revised annually  
6 in accordance with section 673(2) of the Omni-  
7 bus Budget Reconciliation Act of 1981) applica-  
8 ble to a family of the size involved;

9 (B) recommendations on changes to poli-  
10 cies enacted under this Act; and

11 (C) proposed legislative language to imple-  
12 ment such recommendations.

13 (f) ADMINISTRATION.—

14 (1) POWERS.—

15 (A) HEARINGS.—The Commission may  
16 hold such hearings, sit and act at such times  
17 and places, take such testimony, and receive  
18 such evidence as the Commission considers ad-  
19 visable to carry out this section.

20 (B) INFORMATION FROM FEDERAL AGEN-  
21 CIES.—The Commission may secure directly  
22 from any Federal department or agency such  
23 information as the Commission considers nec-  
24 essary to carry out this section. Upon request  
25 of the Chairperson of the Commission, the head

1 of such department or agency shall furnish such  
2 information to the Commission.

3 (C) POSTAL SERVICES.—The Commission  
4 may use the United States mails in the same  
5 manner and under the same conditions as other  
6 departments and agencies of the Federal Gov-  
7 ernment.

8 (D) GIFTS.—The Commission may accept,  
9 use, and dispose of gifts or donations of serv-  
10 ices or property.

11 (2) COMPENSATION.—While serving on the  
12 business of the Commission (including travel time),  
13 a member of the Commission shall be entitled to  
14 compensation at the per diem equivalent of the rate  
15 provided for level IV of the Executive Schedule  
16 under section 5315 of title 5, United States Code,  
17 and while so serving away from home and the mem-  
18 ber's regular place of business, a member may be al-  
19 lowed travel expenses, as authorized by the chair-  
20 person of the Commission. All members of the Com-  
21 mission who are officers or employees of the United  
22 States shall serve without compensation in addition  
23 to that received for their services as officers or em-  
24 ployees of the United States.

25 (3) STAFF.—

1           (A) IN GENERAL.—The Chairperson of the  
2 Commission may, without regard to the civil  
3 service laws and regulations, appoint and termi-  
4 nate an executive director and such other addi-  
5 tional personnel as may be necessary to enable  
6 the Commission to perform its duties. The em-  
7 ployment of an executive director shall be sub-  
8 ject to confirmation by the Commission.

9           (B) STAFF COMPENSATION.—The Chair-  
10 person of the Commission may fix the com-  
11 pensation of the executive director and other  
12 personnel without regard to chapter 51 and  
13 subchapter III of chapter 53 of title 5, United  
14 States Code, relating to classification of posi-  
15 tions and General Schedule pay rates, except  
16 that the rate of pay for the executive director  
17 and other personnel may not exceed the rate  
18 payable for level V of the Executive Schedule  
19 under section 5316 of such title.

20           (C) DETAIL OF GOVERNMENT EMPLOY-  
21 EES.—Any Federal Government employee may  
22 be detailed to the Commission without reim-  
23 bursement, and such detail shall be without  
24 interruption or loss of civil service status or  
25 privilege.

1           (D) PROCUREMENT OF TEMPORARY AND  
2 INTERMITTENT SERVICES.—The Chairperson of  
3 the Commission may procure temporary and  
4 intermittent services under section 3109(b) of  
5 title 5, United States Code, at rates for individ-  
6 uals which do not exceed the daily equivalent of  
7 the annual rate of basic pay prescribed for level  
8 V of the Executive Schedule under section 5316  
9 of such title.

10       (g) TERMINATION.—Except with respect to activities  
11 in connection with the ongoing biennial report required  
12 under subsection (e)(2), the Commission shall terminate  
13 90 days after the date on which the Commission submits  
14 the report required under subsection (e)(3).

15       (h) AUTHORIZATION OF APPROPRIATIONS.—There  
16 are authorized to be appropriated, such sums as may be  
17 necessary to carry out this section for fiscal year 2004  
18 and each fiscal year thereafter.

19 **SEC. 302. CONGRESSIONAL ACTION.**

20       (a) BILL INTRODUCTION.—

21           (1) IN GENERAL.—Any legislative language in-  
22 cluded in the report required under section  
23 301(e)(3) may be introduced as a bill by request in  
24 the following manner:

1 (A) HOUSE OF REPRESENTATIVES.—In the  
2 House of Representatives, by the Majority  
3 Leader and the Minority Leader not later than  
4 10 days after receipt of the legislative language.

5 (B) SENATE.—In the Senate, by the Ma-  
6 jority Leader and the Minority Leader not later  
7 than 10 days after receipt of the legislative lan-  
8 guage.

9 (2) ALTERNATIVE BY ADMINISTRATION.—The  
10 President may submit legislative language based on  
11 the recommendations of the Commission and such  
12 legislative language may be introduced in the man-  
13 ner described in paragraph (1).

14 (b) COMMITTEE CONSIDERATION.—

15 (1) IN GENERAL.—Any legislative language  
16 submitted pursuant to paragraph (1) or (2) of sub-  
17 section (a) (in this section referred to as “imple-  
18 menting legislation”) shall be referred to the appro-  
19 priate committees of the House of Representatives  
20 and the Senate.

21 (2) REPORTING.—

22 (A) COMMITTEE ACTION.—If, not later  
23 than 150 days after the date on which the im-  
24 plementing legislation is referred to a com-  
25 mittee under paragraph (1), the committee has

1 reported the implementing legislation or has re-  
2 ported an original bill whose subject is related  
3 to reforming the health care system, or to pro-  
4 viding access to affordable health care coverage  
5 for Americans, the regular rules of the applica-  
6 ble House of Congress shall apply to such legis-  
7 lation.

8 (B) DISCHARGE FROM COMMITTEES.—

9 (i) SENATE.—

10 (I) IN GENERAL.—If the imple-  
11 menting legislation or an original bill  
12 described in subparagraph (A) has not  
13 been reported by a committee of the  
14 Senate within 180 days after the date  
15 on which such legislation was referred  
16 to committee under paragraph (1), it  
17 shall be in order for any Senator to  
18 move to discharge the committee from  
19 further consideration of such imple-  
20 menting legislation.

21 (II) SEQUENTIAL REFERRALS.—

22 Should a sequential referral of the im-  
23 plementing legislation be made, the  
24 additional committee has 30 days for  
25 consideration of implementing legisla-

1           tion before the discharge motion de-  
2           scribed in subclause (I) would be in  
3           order.

4           (III) PROCEDURE.—The motion  
5           described in subclause (I) shall not be  
6           in order after the implementing legis-  
7           lation has been placed on the cal-  
8           endar. While the motion described in  
9           subclause (I) is pending, no other mo-  
10          tions related to the motion described  
11          in subclause (I) shall be in order. De-  
12          bate on a motion to discharge shall be  
13          limited to not more than 10 hours,  
14          equally divided and controlled by the  
15          Majority Leader and the Minority  
16          Leader, or their designees. An amend-  
17          ment to the motion shall not be in  
18          order, nor shall it be in order to move  
19          to reconsider the vote by which the  
20          motion is agreed or disagreed to.

21          (IV) EXCEPTION.—If imple-  
22          menting language is submitted on a  
23          date later than May 1 of the second  
24          session of a Congress, the committee  
25          shall have 90 days to consider the im-

1                   plementing legislation before a motion  
2                   to discharge under this clause would  
3                   be in order.

4                   (ii) HOUSE OF REPRESENTATIVES.—

5                   If the implementing legislation or an origi-  
6                   nal bill described in subparagraph (A) has  
7                   not been reported out of a committee of  
8                   the House of Representatives within 180  
9                   days after the date on which such legisla-  
10                  tion was referred to committee under para-  
11                  graph (1), then on any day on which the  
12                  call of the calendar for motions to dis-  
13                  charge committees is in order, any member  
14                  of the House of Representatives may move  
15                  that the committee be discharged from  
16                  consideration of the implementing legisla-  
17                  tion, and this motion shall be considered  
18                  under the same terms and conditions, and  
19                  if adopted the House of Representatives  
20                  shall follow the procedure described in sub-  
21                  section (c)(1).

22                  (c) FLOOR CONSIDERATION.—

23                  (1) MOTION TO PROCEED.—If a motion to dis-  
24                  charge made pursuant to subsection (b)(2)(B)(i) or  
25                  (b)(2)(B)(ii) is adopted, then, not earlier than 5 leg-

1 islative days after the date on which the motion to  
2 discharge is adopted, a motion may be made to pro-  
3 ceed to the bill.

4 (2) FAILURE OF MOTION.—If the motion to dis-  
5 charge made pursuant to subsection (b)(2)(B)(i) or  
6 (b)(2)(B)(ii) fails, such motion may be made not  
7 more than 2 additional times, but in no case more  
8 frequently than within 30 days of the previous mo-  
9 tion. Debate on each of such motions shall be limited  
10 to 5 hours, equally divided.

11 (3) APPLICABLE RULES.—Once the Senate is  
12 debating the implementing legislation the regular  
13 rules of the Senate shall apply.

## 14 **TITLE IV—STATE WAIVERS**

### 15 **SEC. 401. STATE WAIVERS.**

16 (a) IN GENERAL.—Notwithstanding any other provi-  
17 sion of law, a State may apply to the Secretary of Health  
18 and Human Services for waivers of such provisions of law  
19 as may be necessary for the State to implement policies  
20 that make comprehensive, affordable health coverage  
21 available for all State residents, including access to essen-  
22 tial benefits with limits on cost-sharing, as provided in the  
23 most recent report under section 301(e)(2).

24 (b) REQUIREMENTS.—In order to ensure that waivers  
25 under this section benefit rather than harm health care

1 consumers, a State shall not be eligible for a waiver under  
2 this section unless—

3           (1) the State reasonably expects to achieve a  
4 level of enrollment in coverage described in sub-  
5 section (a) that is at least equal to the level of cov-  
6 erage (taking into account the number of insured in-  
7 dividuals, covered benefits, and premium and out-of-  
8 pocket costs to the consumer for such coverage) that  
9 the State would have achieved if the State had fully  
10 implemented the coverage options available under ti-  
11 tles I and II of this Act;

12           (2) no individual who would have qualified for  
13 assistance under the State medicaid program under  
14 title XIX of the Social Security Act or the State  
15 children's health insurance program under title XXI  
16 of such Act, as of either the date of the waiver re-  
17 quest or the date of enactment of this Act, will be  
18 denied eligibility for such program, have a reduction  
19 in benefits under such program, have reduced access  
20 to geographically and linguistically appropriate care  
21 or essential community providers, or be subject to  
22 increased premiums or cost-sharing under the waiver  
23 program under this section; and

24           (3) the State agrees to comply with such stand-  
25 ards or guidelines as the Secretary of Health and

1 Human Services may require to ensure that the re-  
2 quirements of paragraphs (1) and (2) are satisfied.

3 (c) FEDERAL PAYMENTS.—

4 (1) IN GENERAL.—The Secretary of Health and  
5 Human Services shall pay a State with a waiver ap-  
6 proved under this section an amount each quarter  
7 equal to the sum of—

8 (A) the Federal payments the State and  
9 residents of the State (including, but not lim-  
10 ited to, through the credit allowed under section  
11 36 of the Internal Revenue Code of 1986 for  
12 health insurance costs) would have received if  
13 the State had exercised the coverage options  
14 under titles I and II of this Act with respect to  
15 residents of the State who have not attained  
16 age 65; and

17 (B) the amount of any grants authorized  
18 by this Act that the State would have received  
19 if the State had applied for such grants.

20 (2) ADDITIONAL PAYMENT FOR MEDICARE  
21 BENEFICIARIES UNDER AGE 65.—

22 (A) IN GENERAL.—In the case of a State  
23 that elects to enroll an individual described in  
24 subparagraph (B) in coverage described in sub-  
25 section (a), the amount described in paragraph

1 (1) with respect to a quarter shall be increased  
2 by the amount described in subparagraph (C).

3 (B) INDIVIDUAL DESCRIBED.—An indi-  
4 vidual is described in this subparagraph if the  
5 individual—

6 (i) has not attained age 65;

7 (ii) is eligible for coverage under title  
8 XVIII of the Social Security Act; and

9 (iii) voluntarily elects to enroll in cov-  
10 erage described in subsection (a).

11 (C) AMOUNT DESCRIBED.—The amount  
12 described in this subparagraph is the amount  
13 equal to the amount that the Federal Govern-  
14 ment would have incurred with respect to a  
15 quarter for providing coverage to an individual  
16 described in subparagraph (B) under title  
17 XVIII of the Social Security Act (42 U.S.C.  
18 1395 et seq.).

19 (d) IMPLEMENTATION DATE.—No State may submit  
20 a request for a waiver under this section before October  
21 1, 2007.

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