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107TH CONGRESS
2D SESSION

H. R. 4170

To amend the Public Health Service Act to provide for cooperative governing of health insurance policies by primary and secondary States and to provide assistance to States to promote the establishment of qualified high risk pools, to provide financial incentives to encourage health coverage for employees and individuals, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 11, 2002

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

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A BILL

To amend the Public Health Service Act to provide for cooperative governing of health insurance policies by primary and secondary States and to provide assistance to States to promote the establishment of qualified high risk pools, to provide financial incentives to encourage health coverage for employees and individuals, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''State Cooperative Health Care Access Plan Act of 2002''.

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

TITLE I—COOPERATIVE GOVERNING

SEC. 101. COOPERATIVE GOVERNING OF HEALTH INSURANCE POLICIES.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXVIII—COOPERATIVE GOVERNING OF HEALTH INSURANCE POLICIES

"SEC. 2801. PRIMARY STATE.

''(a) IN GENERAL.—A health insurance issuer offering a health insurance policy in the individual or group market shall abide by the product, rate, and form filing laws of the primary State.

''(b) PRIMARY STATE DEFINED.—For purposes of this title, the term 'primary State' means, with respect to a health insurance policy offered by a health insurance issuer, the State which includes the primary location for the issuer's health insurance business but only if the policy is filed and approved with the applicable primary State authority for that State.

"SEC. 2802. SECONDARY STATES.

''(a) IN GENERAL.—A health insurance issuer offering a health insurance policy that is approved by the applicable primary State authority for the primary State—

''(1) may offer such policy type in a secondary State;

''(2) is bound by the laws of the primary State for such policy; and

''(3) must comply with the applicable provisions of the mechanism developed by the National Association of Insurance Commissioners under section 102(a)(2) of the State Cooperative Health Care Access Plan Act of 2002.

''(b) APPLICATION OF LAWS OF PRIMARY STATE TO SECONDARY STATE.—For purposes of subsection (a), the product, rate, and form filing laws of the primary State shall apply to the health insurance policy offered by health insurance issuer in a secondary State. The product, rate, and form filing laws of the secondary State shall not apply to the health insurance issuer for such a policy that complies with the product, rate, and form filing laws of the primary State.

''(c) DEFINITION.—For purposes of this title, the term 'secondary State' means any State that is not the primary State.

''(d) CONSUMER FRAUD.—For purposes of enforcement of an action consisting of consumer fraud in the case of a policy that complies with the laws of the primary State, the State insurance commission of a secondary

State shall treat the policy as if the policy was primarily licensed in the secondary State.

"SEC. 2803. ENFORCEMENT.

"(a) ENFORCEMENT.—In the case of a health insurance policy that is approved by the applicable primary State authority for the primary State, a secondary State may enforce the product, rate, and form filing laws of the primary State.

"(b) GRANTS TO STATES.—

"(1) IN GENERAL.—The Secretary shall award grants to the States for the purpose of carrying out the provisions of this section.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary for grants under paragraph (1), $50,000,000 for each of fiscal years 2004 and 2005.

"SEC. 2804. DEFINITIONS.

"(a) IN GENERAL.—For purposes of this title, the terms 'State', 'health insurance coverage', 'health insurance issuer', 'individual market', and 'group market' have the meanings given such terms in section 2791.

"(b) APPLICABLE PRIMARY STATE AUTHORITY.—The term 'applicable primary State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated

by the State to enforce requirements of this title for the State involved with respect to such issuer.

''(c) HEALTH INSURANCE POLICY.—The term 'health insurance policy' means a policy, certificate, or contract that constitutes health insurance coverage.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 24 months after the date of the enactment of this Act, except that the authorization of appropriations provided in such amendment is effective on the date of the enactment of this Act.

SEC. 102. DEVELOPMENT OF PROCESS TO ASSIST COOPERATIVE GOVERNING OF STATES.

(a) NAIC DEVELOPMENT OF COOPERATIVE GOVERNING PROCESS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide the funds necessary to enable the National Association of Insurance Commissioners to develop a mechanism to assist States in meeting the requirements of title XXVIII of the Public Health Service Act (as added by section 101(a)).

(2) STATE ENFORCEMENT AND INFORMATION EXCHANGE ASSISTANCE.—Such mechanism shall include—

(A) implementation of an enforcement process;

(B) information exchange of applicability of the laws of a primary State to a policy offered in a secondary State; and

(C) establishment of a process for purposes of consumer fraud enforcement, pursuant to section 2802(e) of the Public Health Service Act, for an individual who purchases a health insurance policy in a State other than the State of residence of such individual.

(3) INTERIM REPORT.—Not later than 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners shall provide an interim report to the States and Congress on such mechanism.

(4) FINAL REPORT.—Not later than 18 months after the date of the enactment of this Act, the National Association of Insurance Commissioners shall provide a final report to the States and Congress on such mechanism to assist the States in meeting the requirements of title XXVIII of the Public Health Service Act.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 to carry

out the provisions of this section for each of fiscal years 2003 and 2004.

SEC. 103. FINDINGS; SEVERABILITY.

(a) FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.—Congress finds the following in relation to the provisions of this title:

(1) Health insurance products are increasingly provided through the Internet and the application of multiple variations in State law impact the ability to provide access to affordable health coverage to individuals and employees seeking employment in interstate commerce, thereby impeding such commerce.

(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

(3) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation.

(b) SEVERABILITY.—If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE II—ASSISTANCE TO STATES TO PROMOTE THE ESTABLISHMENT OF QUALIFIED HIGH RISK POOLS

SEC. 201. FUNDING STATES TO PROMOTE QUALIFIED HIGH RISK POOLS.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2744 the following new section:

"SEC. 2745. PROMOTION OF QUALIFIED HIGH RISK POOLS.

''(a) SEED GRANTS TO STATES.—The Secretary shall provide from the funds appropriated under subsection (d)(1) a grant of up to $1,000,000 to each State that has not created a qualified high risk pool as of the date of the enactment of this section for the State's costs of creation and initial operation of such a pool.

''(b) MATCHING FUNDS FOR OPERATION OF POOLS.—

''(1) IN GENERAL.—In the case of a State that has established a qualified high risk pool that restricts premiums charged under the pool to no more than 200 percent of the premium for applicable standard risk rates, that has been in operation for at least 1 year, and that offers a choice of two or more coverage options through the pool, from the

funds appropriated under subsection (c)(2) and allotted to the State under paragraph (2), the Secretary shall provide a grant for a percentage of the losses incurred by the State risk pool in connection with the operation of the pool as follows:

''(A) 25 percent (multiplied by the poverty adjustment factor) of the losses for risk pools with premiums that exceed 150 percent, but are less than 200 percent, of the premium for applicable standard risk rates, but not to exceed an aggregate amount under the grant of 50 cents per capita based upon the State's population.

''(B) 50 percent (multiplied by the poverty adjustment factor under paragraph (3)) of the losses for risk pools with premiums which exceed 125 percent, but are less than 150 percent, of the premium for applicable standard risk rates, but not to exceed an aggregate amount under the grant of 50 cents per capita based upon the State's population.

''(C) 60 percent (multiplied by the poverty adjustment factor) of the losses for risk pools with premiums which do not exceed 125 percent of the premium for applicable standard risk rates, but not to exceed an aggregate amount

under the grant of $1 per capita based upon the State's population.

''(2) ALLOTMENT.—The amounts appropriated under subsection (d)(1)(B) for a fiscal year shall be made available to the States in accordance with a formula established by the Secretary that is based upon the number of uninsured individuals in the States and only to States that provide for matching funds.

''(3) POVERTY ADJUSTMENT FACTOR.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the 'poverty adjustment factor' for a State for a fiscal year is equal to the ratio of—

''(i) the Federal medical assistance percentage for that State for that fiscal year (as determined under section 1905(b) of the Social Security Act), to

''(ii) the weighted average of the Federal medical assistance percentages for the 50 States and the District of Columbia for that fiscal year.

''(B) SPECIAL RULE FOR SMALL STATES.—The poverty adjustment factor shall

not be less than 1.0 for a State with a population of under 2,000,000.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a State from supplementing the funds made available under this subsection for the support and operation of qualified high risk pools.

''(c) ASSISTANCE FOR LOW-INCOME INDIVIDUALS.—

''(1) IN GENERAL.—The Secretary shall establish a program of grants to States to enable States to provide financial assistance to low-income individuals who are receiving the health coverage tax credit under section 35 of the Internal Revenue Code of 1986, who obtain coverage through enrollment in a qualified high risk pool, and who, because of the increased premium of coverage available through such pool, would be otherwise unable to afford such coverage.

''(2) APPLICATION.—No grant may be made to a State under this subsection except upon application by the State to the Secretary. Such application shall include a description of the individuals who qualify for assistance and the amount of such assistance.

''(3) REQUIREMENTS.—A grant under this subsection may only be provided to a State if the State provides the Secretary with satisfactory assurances that—

''(A) the State will provide for the expenditure of State funds towards financial assistance described in paragraph (1) an amount equal to at least 10 percent of the amount of the grant; and

''(B) the funds under the grant will only be used to reduce the premiums otherwise applicable to low-income individuals and will not be diverted or otherwise transferred to the general fund of the State.

''(d) FUNDING.—

''(1) SEED GRANTS AND OPERATIONS SUPPORT.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated—

''(A) such sums as may be required for fiscal year 2003 to carry out subsection (a); and

''(B) $100,000,000 for each of fiscal years 2003 through 2007 to carry out subsection (b).

''(2) LOW-INCOME ASSISTANCE.—There are authorized to be appropriated $64,000,000 for each of

fiscal years 2003 and 2004 to carry out subsection (c).

''(3) AVAILABILITY OF APPROPRIATIONS.—Funds appropriated under this subsection for a fiscal year shall remain available for obligation through the end of the following fiscal year.

''(4) NO ENTITLEMENT.—Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

''(e) DEFINITIONS.—For purposes of this section:

''(1) QUALIFIED HIGH RISK POOL.—The term 'qualified high risk pool' means such a pool as defined in section 2744(c)(2) but only if the pool—

''(A) is open continuously;

''(B) does not have any cap on enrollment;

''(C) offers a choice of two or more coverage options;

''(D) is the State alternative mechanism used by State under section 2744 of the Public Health Service Act; and

''(E) has a mechanism for continual funding (in addition to any funding provided under this section).

''(2) STATE.—The term 'State' means any of the 50 States and the District of Columbia.''.

(b) CONSTRUCTION.—Nothing in this section shall be construed as affecting the ability of a State to use mechanisms, described in sections 2741(c) and 2744 of the Public Health Service Act, as an alternative to applying the guaranteed availability provisions of section 2741(a) of such Act.

TITLE III—CLARIFICATION OF DEFINITION OF GROUP HEALTH PLAN UNDER HIPAA

SEC. 301. CLARIFICATION OF DEFINITION OF GROUP HEALTH PLAN UNDER HIPAA.

(a) AMENDMENT TO ERISA.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following new sentence: ''Such term does not include an arrangement maintained by a small employer (as defined in section 712(c)(1)(B)) the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1) of the Public Health Service Act).''.

(b) AMENDMENT TO PHSA.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1)) is amended by adding at the end the following new sentence: ''Such term does not include an arrangement main-

tained by a small employer the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market.''.

(c) AMENDMENT TO IRC.—Section 9832(a) of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting before the period at the end the following: '', except that such term does not include an arrangement maintained by a small employer (as defined in section 4980D(d)(2)(A)) the sole effect of which is to provide reimbursement to employees for the purchase by such employees of health insurance coverage offered in the individual market (as defined in section 2791(e)(1) of the Public Health Service Act)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after the date of the enactment of this Act.

TITLE IV—TAX PROVISIONS

SEC. 401. REFUNDABLE CREDIT FOR HEALTH COVERAGE.

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

"SEC. 35. HEALTH COVERAGE CREDIT.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the amount paid by the taxpayer during the taxable year for qualified health coverage for the taxpayer and his spouse and dependents.

''(b) MONTHLY LIMITATIONS.—

''(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations during such taxable year.

''(2) MONTHLY LIMITATION DEFINED.—The monthly limitation for any eligible month is the amount equal to 1/12 of—

''(A) $1,000 if, as of the first day of such month, the taxpayer has self-only coverage under qualified health coverage, and

''(B) $2,000 if, as of the first day of such month, the taxpayer has family coverage under qualified health coverage.

''(3) AMOUNT OF EMPLOYEE CONTRIBUTION.—In the case of any calendar month for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer, the amount

allowed as a credit under subsection (a) for such month shall not exceed the amount paid by the taxpayer for coverage under such plan for such month.

''(4) CERTAIN OTHER COVERAGE.—Amounts paid for coverage of an individual for any month shall not be taken into account under subsection (a) if, as of the first day of such month, such individual—

''(A) is eligible for health care benefits under title XVIII of the Social Security Act (relating to medicare),

''(B) is covered under a medical care program described in title XIX or XXI of the Social Security Act (relating to medicaid and State children's health insurance program, respectively),

''(C) is eligible for health care benefits under chapter 55 of title 10, United States Code (relating to Armed Forces medical and dental care),

''(D) is covered under a medical care program described in chapter 17 of title 38, United States Code (relating to veterans' hospital, nursing home, domiciliary, and medical care), or

''(E) is covered under a medical care program described in the Indian Health Care Improvement Act.

''(5) PRISONERS.—Amounts paid for coverage of an individual for any month shall not be taken into account under subsection (a) if, as of the first day of such month, such individual is incarcerated under Federal, State, or local authority pursuant to a conviction for crime.

''(c) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—

''(1) IN GENERAL.—The aggregate amount which would (but for this subsection) be allowed as a credit under this section shall be reduced (but not below zero) by the amount determined under paragraph (2).

''(2) AMOUNT OF REDUCTION.—

''(A) IN GENERAL.—The amount determined under this paragraph shall be the amount which bears the same ratio to such aggregate amount as—

''(i) the excess of—

''(I) the taxpayer's modified adjusted gross income for such taxable year, over

"(II) the applicable dollar amount, bears to

"(ii) $15,000 ($30,000 in the case of a joint return, surviving spouse, or head of household).

"(B) ROUNDING.—Any amount determined under subparagraph (A) which is not a multiple of $10 shall be rounded to the next lowest $10.

"(3) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income increased by any amount excluded from gross income under section 911, 931, or 933.

"(4) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (2), the term 'applicable dollar amount' means—

"(A) $35,000 in the case of a taxpayer whose qualified health coverage covers more than 1 individual referred to in subsection (a) and who files a joint return or a surviving spouse,

"(B) $30,000 in the case of a taxpayer whose qualified health coverage covers more than 1 individual referred to in subsection (a)

and who files a return as head of household, and

"(C) $20,000—

"(i) in any case not described in subparagraph (A) or (B), and

"(ii) in the case of a married individual filing a separate return.

For purposes of this paragraph, marital status shall be determined under section 7703, and the terms 'surviving spouse' and 'head of household' shall have the meanings given such terms by section 2.

"(d) QUALIFIED HEALTH COVERAGE.—For purposes of this section, the term 'qualified health coverage' means health insurance coverage (as defined in section 9832(b)(1)) and coverage under a high deductible plan (as defined in section 220(c)(2)), under a COBRA continuation provision (as defined in section 9832(d)(1)), under a group health plan (as defined in section 5000(b)(1)) providing medical care (as defined in section 9832(d)(3)), and under a qualified high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

"(e) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—

"(1) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If any payment is made by the Secretary

under section 7527 during any calendar year to a person furnishing qualified health coverage for an individual, then the tax imposed by this chapter for the individual's last taxable year beginning in such calendar year shall be increased by the aggregate amount of such payments.

''(2) RECONCILIATION OF PAYMENTS ADVANCED AND CREDIT ALLOWED.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit allowed by subsection (a)(1)) allowable under this part.

''(f) ARCHER MSA CONTRIBUTIONS.—

''(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 to the taxpayer for a payment for the taxable year to the Archer MSA of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health coverage for such individual.

''(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 for that portion of the payments otherwise allowable as a deduction under section 220 for the taxable year which is

equal to the amount of taken into account under subsection (a) for such taxable year by reason of this subsection.

''(g) SPECIAL RULES.—

''(1) EXCLUSION IF PARTICIPANT IN CAFETERIA PLAN OR FLEXIBLE SPENDING ARRANGEMENT.—Subsection (a) shall not apply to a taxpayer for a taxable year if any amount is not includible in the gross income of the taxpayer for such taxable year by reason of section 106 with respect to—

''(A) a benefit consisting of qualified health coverage under a cafeteria plan (as defined in section 125(d)), or

''(B) a benefit consisting of qualified health coverage under a flexible spending or similar arrangement.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the amount taken into account under this section for such year.

''(3) COORDINATION WITH DEDUCTION FOR QUALIFIED HEALTH COVERAGE COSTS.—No credit shall be allowed under this section for the taxable

year if any amount paid for qualified health coverage is taken into account in determining the deduction allowed for such year under section 223.

''(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(5) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

''(6) MARITAL STATUS.—An individual legally separated from his spouse under a decree of divorce or of separate maintenance shall not be considered as married.

''(7) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of a taxable year beginning after 2003, each dollar amount in subsection (d)(4) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2002' for 'calendar year 1992' in subparagraph (B) thereof.

''(B) ROUNDING.—If any amount as adjusted under subparagraph (A) is not a multiple of $100, such amount shall be rounded to the next lowest multiple of $100.

''(h) RESTRICTIONS ON TAXPAYERS WHO IMPROPERLY CLAIMED CREDIT IN PRIOR YEAR.—For purposes of this section, rules similar to the rules of section 32(k) shall apply.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

''SEC. 6050T. RETURNS RELATING TO HEALTH COVERAGE CREDIT.

''(a) REQUIREMENT OF REPORTING.—Every person—

''(1) who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for qualified health coverage (as defined in section 35(d)) of such individual or any other individual, and

''(2) who claims a reimbursement for an advance credit amount,

shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each individual from whom such payments were received or for whom such a reimbursement is claimed.

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

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

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

''(B) the aggregate of the advance credit amounts provided to such individual and for which reimbursement is claimed,

''(C) the number of months for which such advance credit amounts are so provided, and

''(D) such other information as the Secretary may prescribe.

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

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

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

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

''(d) ADVANCE CREDIT AMOUNT.—For purposes of this section, the term 'advance credit amount' means an amount for which the person can claim a reimbursement pursuant to a program established by the Secretary under section 7527.''

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to defini-

tions) is amended by redesignating clauses (xi) through (xvii) as clauses (xii) through (xviii), respectively, and by inserting after clause (x) the following new clause:

''(xi) section 6050T (relating to returns relating to health coverage credit),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (Z), by striking the period at the end of subparagraph (AA) and inserting '', or'', and by adding after subparagraph (AA) the following new subparagraph:

''(BB) section 6050T (relating to returns relating to health coverage credit).''

(c) ADVANCE PAYMENT OF HEALTH COVERAGE CREDIT.—Chapter 77 of such Code (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7527. ADVANCE PAYMENT OF HEALTH COVERAGE CREDIT.

''(a) GENERAL RULE.—The Secretary shall establish a program for making payments on behalf of eligible individuals to persons furnishing qualified health coverage for such individuals.

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible individual' means any individual for whom a qualified health coverage credit eligibility certificate is in effect.

''(2) CERTIFICATE IN EFFECT.—A qualified health coverage credit eligibility certificate shall take effect on the first day of a coverage month and shall remain in effect with respect to the individual until the earlier of revocation by the individual, another such certificate takes effect under this section with respect to the individual, or cancellation of the qualified health coverage by the person furnishing such coverage.

''(3) COVERAGE MONTH.—For purposes of paragraph (2), the term 'coverage month' means any month in which the eligible individual has coverage under qualified health coverage (as defined in section 35(d)) unless on the first day of such month such individual is eligible for benefits or covered under a program, as the case may be, described in section 35(b)(4) or is described in section 35(b)(5).

''(c) QUALIFIED HEALTH COVERAGE CREDIT ELIGIBILITY CERTIFICATE.—

''(1) IN GENERAL.—For purposes of this section, a qualified health coverage credit eligibility certificate is a statement certified by the person furnishing qualified health coverage for an eligible individual which—

''(A) certifies that the individual is covered by qualified health coverage as of the first day of any month, and

''(B) provides such other information as the Secretary may require for purposes of this section.

''(2) RELIANCE ON INFORMATION PROVIDED BY INDIVIDUALS.—In preparing the statement required by paragraph (1), the such person may rely on any representation made by the eligible individual with respect to such statement unless such person has actual notice or knowledge (within the meaning of section 6323(i)(1)) that any such representation is false.

''(3) DUTY TO PROVIDE UPDATED INFORMATION.—If any information provided with respect to the statement required by paragraph (1) is no longer accurate, the person providing such statement shall inform the person furnishing qualified health coverage within 30 days of any change of information.

"(d) QUALIFIED HEALTH COVERAGE.—For purposes of this section, the term 'qualified health coverage' has the meaning given such term by section 35(d).".

(d) TECHNICAL AMENDMENTS.—

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

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 35 and inserting the following new items:

"Sec. 35. Health coverage credit.
"Sec. 36. Overpayments of tax.".

(3) The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050S the following new item:

"Sec. 6050T. Returns relating to health coverage credit.".

(4) The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

"Sec. 7527. Advance payment of health coverage credit.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2002.

SEC. 402. DEDUCTION FOR QUALIFIED HEALTH COVERAGE COSTS OF EMPLOYEES AND OTHER INDIVIDUALS INELIGIBLE FOR HEALTH COVERAGE REFUNDABLE TAX CREDIT.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 223 as section 224 and by inserting after section 222 the following new section:

"SEC. 223. COSTS OF QUALIFIED HEALTH COVERAGE.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the amount paid during the taxable year for qualified health coverage for the taxpayer and his spouse and dependents.

''(b) LIMITATIONS.—

''(1) AMOUNT OF EMPLOYEE CONTRIBUTION TO SUBSIDIZED PLAN.—In the case of any year for which the taxpayer is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer, the amount allowed as a deduction under subsection (a)

for such year shall not exceed the amount paid by the taxpayer for coverage under such plan for such year. For purposes of the preceding sentence, all health plans of persons treated as a single employer under subsection (b), (c), or (m) of section 414 shall be treated as 1 health plan.

''(2) EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND ARCHER MSAS.—Amounts contributed to a cafeteria plan, a flexible spending or similar arrangement, or an Archer MSA which are excluded from gross income under section 106 shall be treated as paid by the employer and not by the individual.

''(3) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under subsection (a) for a taxable year to any taxpayer allowed a credit under section 35 for such taxable year.

''(4) CERTAIN OTHER COVERAGE; PRISONERS.—Amounts paid for coverage of an individual for any month shall not be taken into account under subsection (a) if, as of the first day of such month, such individual is eligible for benefits or covered under a program, as the case may be, described in section 35(b)(4) or is described in section 35(b)(5).

''(5) ANCILLARY COVERAGE PREMIUMS.—Amounts paid for coverage of an individual for excepted benefits (as defined in section 9832(c)) shall not be taken into account under subsection (a).

''(c) QUALIFIED HEALTH COVERAGE.—For purposes of this section, the term 'qualified health coverage' has the meaning given such term by section 35(d).

''(d) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account by the taxpayer in computing the deduction under section 162(l) and in computing the deduction under section 213 shall not be taken into account under subsection (a).

''(e) ELECTION NOT TO HAVE SECTION APPLY.—A taxpayer may elect not to have this section apply with respect to amounts paid for qualified health coverage for any taxable year.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new item:

''(19) QUALIFIED HEALTH COVERAGE COSTS.—The deduction allowed by section 223.''.

(c) CONFORMING AMENDMENTS.—The table of sections for part VII of subchapter B of chapter 1 of such

Code is amended by striking the last item and inserting the following new items:

"Sec. 223. Costs of qualified health coverage.
"Sec. 224. Cross reference."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2002.

SEC. 403. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

"(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

"(1) IN GENERAL.—For purposes of this title—

"(A) notwithstanding subsection (d)(2), a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

"(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

''(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried forward from a plan to the extent such amounts exceed $500.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 404. EXCLUSION OF PREMIUM PAYMENTS FOR QUALIFIED HEALTH COVERAGE UNDER FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(d) QUALIFIED HEALTH COVERAGE UNDER FLEXIBLE SPENDING ARRANGEMENT.—For purposes of subsection (a), amounts paid under a flexible spending or similar arrangement (as defined in subsection (c)(2)) for qualified health coverage (as defined in section 35(d)) shall be treated as employer-provided coverage under an accident or health plan.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

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