EMPLOYMENT AND TRAINING ADMINISTRATION ADVISORY SYSTEM U.S. DEPARTMENT OF LABOR Washington, D.C. 20210	CLASSIFICATION WIA/HCTC
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ADVISORY: TRAINING AND EMPLOYMENT GUIDANCE LETTER NO. 25-09

TO: STATE WORKFORCE AGENCIES
STATE WORKFORCE ADMINISTRATORS
STATE WORKFORCE LIAISONS
STATE LABOR COMMISSIONERS

FROM: JANE OATES
Assistant Secretary

SUBJECT: Health Coverage Tax Credit National Emergency Grants

1. **Purpose.** To provide guidance and direction regarding the availability of Health Coverage Tax Credit (HCTC) National Emergency Grant (NEG) resources for health insurance coverage assistance and support services for eligible Trade Adjustment Assistance (TAA) recipients and other eligible individuals, as authorized under the Workforce Investment Act of 1998, and to inform potential applicants and current grantees of changes made to the program by the TAA Health Coverage Improvement Act of 2009.

2. **References.**

- Trade Adjustment Assistance Reform Act of 2002 (Trade Act of 2002) (P.L. No. 107-210), sections 201, 202, and 203
- TAA Health Coverage Improvement Act of 2009, Section 1899 et seq. of the Trade and Globalization Adjustment Assistance Act of 2009 (TGAAA), Part VI of subtitle I of title I of Division B of the American Recovery and Reinvestment Act of 2009 (Recovery Act) (P.L. No. 111-5)
- Workforce Investment Act (WIA), section 173 (29 U.S.C. 2918)
- Internal Revenue Code of 1986, as amended (IRC), section 35 (26 U.S.C. 35) and section 9801(c) (26 U.S.C. 9801(c))
- Training and Employment Guidance Letter (TEGL) No. 10-02, "Use of National Emergency Grant Funds Under the Workforce Investment Act, as Amended, to Develop Systems for Health Insurance Coverage Assistance for Trade-Impacted Workers," dated October 10, 2002

Rescissions	Expiration Date
TEGL No. 10-02, dated October 10, 2002 TEGL No. 20-02, dated March 3, 2003 TEGL No. 20-02, Change 1, dated May 13, 2004	Continuing

- TEGL No. 11-02, "Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade Act of 2002," dated October 10, 2002 (69 Fed. Reg. 60903 (2004))
- TEGL No. 11-02, Change 1, "Change 1 to the Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade Act of 2002," dated November 6, 2003
- TEGL No. 11-02, Change 2, "Change 2 to the Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade Act of 2002," dated August 10, 2004
- TEGL No. 11-02, Change 3, "Change 3 to the Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade Act of 2002 – Revised Eligibility Requirements for Trade Readjustment Assistance (TRA) and Health Coverage Tax Credit (HCTC)," dated May 25, 2006
- TEGL No. 20-02, "Use of National Emergency Grant (NEG) Funds Under the Workforce Investment Act (WIA), as Amended, to Support Health Insurance Coverage Assistance for Trade-Impacted Workers," dated March 3, 2003
- TEGL No. 20-02, Change 1, "Policy Guidance for Use of National Emergency Grant (NEG) Funds under the Workforce Investment Act (WIA), as Amended, to Support 'Gap-Filler' Payments for Individuals Eligible for the Health Coverage Tax Credit (HCTC)," dated May 13, 2004
- TEGL No. 16-03, "National Emergency Grant (NEG) Policy Guidance," dated January 26, 2004
- TEGL No. 17-08, "American Recovery and Reinvestment Act (Recovery Act) Funds Financial Reporting Requirements," dated April 23, 2009
- TEGL No. 22-08, "Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade and Globalization Adjustment Assistance Act of 2009," dated May 15, 2009
- TEGL No. 22-08, Change 1, " Change 1 to the Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade and Globalization Adjustment Act of 2009," dated November 20, 2009
- TEGL No. 24-08, "Workforce Investment Act and Wagner-Peyser Act Performance Accountability Reporting for the American Recovery and Reinvestment Act of 2009," dated May 21, 2009
- TEGL No. 1-09 and Changes 1 and 2, "Reporting Requirements under Section 1512 of the American Recovery and Reinvestment Act of 2009," dated August 14, 2009, September 21, 2009, and September 30, 2009
- Unemployment Insurance Program Letter (UIPL) No. 02-03, "Health Insurance Tax Credit for Eligible Trade Adjustment Assistance/Trade Readjustment Allowances (TAA/TRA) Recipients," dated October 10, 2002
- UIPL No. 21-09, "Health Coverage Tax Credit (HCTC) for Eligible Trade Adjustment Assistance (TAA) Recipients," dated April 3, 2009
- Office of Management and Budget (OMB) Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009, dated February 18, 2009 (OMB# M-09-10)
- OMB Updated Implementing Guidance for the American Recovery and Reinvestment Act of 2009, dated April 3, 2009 (OMB# M-09-15)

- OMB Implementing Guidance for the Reports on Use of Funds Pursuant to the American Recovery and Reinvestment Act of 2009, dated April 3, 2009 (OMB# M-09-21)
- Information Collection Forms – ETA 9103, 9104, 9105, 9106, 9107 and Project Narrative (OMB Control No. 1205-0439); ETA Form 9090 and the Workforce Investment Act Standard Record Data (WIASRD) format (OMB Control No. 1205-0420); and ETA Form 9130 (OMB Control No. 1205-0461)
- Information Collection Form – Internal Revenue Service (IRS) Form 13441 (OMB Control No. 1545-1842)

3. Background. The HCTC provides monthly payments directly to a health plan administrator on behalf of participants, allowing them to receive the benefit of the tax credit at the time of need. The HCTC provides health insurance coverage assistance to eligible TAA recipients and other eligible individuals, under the IRC as created by the Trade Act of 2002 and expanded by the TGAAA.

- The Trade Act of 2002 authorized the use of NEG funds to pay for health insurance for the three-month period that immediately precedes the first eligible coverage month for eligible TAA participants, as well as eligible Pension Benefits Guaranty Corporation (PBGC) pension recipients.

- The TAA Health Coverage Improvement Act of 2009, in Division B of the American Recovery and Reinvestment Act of 2009 (hereafter Recovery Act) increased the tax credit for eligible individuals under the HCTC program from 65 percent to 80 percent of the amount paid for qualified health coverage under section 35 of the IRC (26 USC 35).

- The Recovery Act also appropriated $150,000,000 to fund HCTC NEGs, as described in sections 173(f) and 174(c) of the WIA.

4. Related Guidance. This TEGL rescinds the following HCTC-related TEGLs. All relevant information from these TEGLs has been incorporated into this TEGL along with updated and revised language on the HCTC as it relates to the TAA Health Coverage Improvement Act of 2009.

- TEGL No. 10-02 outlined the health insurance coverage benefits and state-level responsibilities created by the Trade Act of 2002 and announced the availability of NEG funds for states to establish the system and procedures needed to carry out their responsibilities. This information can be found in this TEGL, under Section 7, Qualified Health Insurance Coverage, and Section 9, State Responsibilities.

- TEGL No. 20-02 outlined the establishment of the mechanism by which eligible TAA and Alternative Trade Adjustment Assistance (ATAA) participants, as well as eligible PBGC pension recipients, receive assistance in covering the cost of health insurance coverage. TEGL No. 20-02 also described the primary mechanism for such assistance as a Federal tax credit to be administered by the Internal Revenue Service (IRS).

To maintain connection to health care following dislocation, this TEGL authorizes the use of NEG funds under the WIA to assist in paying the cost of qualified health insurance coverage for eligible individuals. Information contained in TEGL No. 20-02 is embedded throughout this TEGL.

- TEGL No. 20-02, Change 1 introduced the concept of "gap filler" payments which is discussed in this TEGL in greater detail under Section 11, Use of NEG Funds.

5. <u>Changes</u>. This TEGL outlines procedures for submitting HCTC NEG applications and highlights changes to the HCTC program as a result of the passage of the TAA Health Coverage Improvement Act of 2009. The TAA Health Coverage Improvement Act of 2009 improved the affordability of health coverage by making the following changes through a temporary provision set to expire December 2010:

- Covering 80 percent (increased from 65 percent) of the premium amount paid by eligible individuals for qualified health insurance;

- Making these premium amounts retroactive for participants enrolled on or after January 1, 2009; and,

- Amending the definition of an eligible TAA recipient to include an individual who is in a break in approved training that exceeds 30 days, and the break falls within the period of receiving TRA provided under TAA **<u>or</u>** an individual who is receiving unemployment insurance of any type, for any day of such month, and who would be eligible to receive TRA (except that the individual has not exhausted unemployment compensation (UC)) for such month, without regard to the enrollment in training requirements.

The Department is working closely with the IRS to ensure that any subsequent changes to its administration of the HCTC program, or how HCTC NEGs are used to support the HCTC program, are clearly communicated to the states and result in a more streamlined process for participants to access HCTC program benefits. As a result of this collaboration with the IRS, the Department may release additional or revised guidelines related to HCTC NEGs in the future.

6. <u>Individuals Eligible for Assistance</u>. Under section 35(c) of the IRC, as amended by the Trade Act of 2002, an individual eligible for health insurance coverage assistance includes:

- "an eligible TAA recipient," defined as an individual who, with respect to any month, is receiving TRA, for any day of such month, under the TAA program, or would be eligible for TRA, except that they have not yet exhausted UC;

- "an eligible alternative TAA recipient," defined as an individual who is receiving, or did receive in the previous month, benefits under the program established for older workers under section 246 of the Trade Act of 1974 and is receiving benefit for such month under section 246(a)(2) of such Act;

- "an eligible PBGC pension recipient," defined as an individual who is 55 years of age or older and is receiving a pension benefit paid in whole or part by the PBGC.

In addition, coverage may also be provided for the spouse and dependents of an eligible individual where they are not otherwise covered by health insurance. Dependents are limited to those persons for whom the eligible individuals are entitled to claim a dependent deduction on the eligible individual's Federal tax return. Family members who have healthcare coverage paid for by an employer or former employer are excluded.

Section 1899A of the Recovery Act amended Section 35(a) of the IRC to improve the affordability of the tax credit by covering 80 percent (up from 65 percent) of the premium amount paid by eligible individuals for qualified health insurance beginning May 2009 through December 2010, and Section 1899B made these premium amounts retroactive to coverage months beginning after December 31, 2008. The IRS has advised individuals of these changes, as appropriate.

The new definition of an "eligible TAA recipient," as amended by Section 1899C, is effective March 2009 through December 2010. An "eligible TAA recipient" continues to be defined as an individual who receives TRA for any day of a month (and the next month following the last month the individual meets this definition) or who would receive TRA but for the fact that s/he has not exhausted UC, and is, therefore, potentially eligible for the HCTC for that month. In addition, Section 1899C added a Special Rule to Section 35(c)(2), to provide that, for any "eligible coverage month" (that is, any month an individual is eligible for the HCTC) from March 2009 through December 2010, an eligible TAA recipient also includes an individual, who:

- is in a break in approved training that exceeds 30 days, and the break falls within the period for receiving TRA provided under the Trade Act. (*See* TEGL No. 11-02, paragraph D.4., *Limitations on TRA* for an explanation of the "period for receiving TRA"), or

- is receiving UC (which includes regular UC, extended benefits (EB), and emergency unemployment compensation (EUC)) for any day of such month and who would be eligible to receive TRA (except that s/he has not exhausted UC) for such month, without regard to the enrollment in training requirements. (*See* TEGL No. 11-02, paragraphs D.2 and D.3, and TEGL No. 11-02, Change 3 for an explanation of the training requirement(s) in effect for petitions filed prior to May 18, 2009. TEGL No. 22-08 and TEGL No. 22-08, Change 1 provide guidance for petitions filed on or after May 18, 2009.)

Any individuals that meet one of the above criteria to be HCTC-eligible are also eligible to receive assistance under HCTC NEGs. However, a HCTC-eligible individual can not receive assistance from a HCTC NEG and the HCTC from the IRS for the same month.

7. **Qualified Health Insurance Coverage.** Under section 35(e) of the IRC, health insurance that can qualify for the tax credit includes:

(1) coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision;

(2) coverage under a state-based continuation provision;

(3) coverage through a qualified state high risk pool;

(4) coverage under a program offered to state employees;

(5) coverage under a state-based health insurance program comparable to a program for state employees;

(6) coverage through an arrangement between a state, and,
   - a group health plan,
   - an issuer of healthcare coverage,
   - an administrator, or
   - an employer;

(7) coverage offered through a state arrangement with a private sector healthcare coverage purchasing pool;

(8) coverage under a state-operated health plan that does not receive any Federal financial participation;

(9) coverage under a group health plan that is available through the employment of the eligible individual's spouse;

(10) coverage under individual health insurance in which the eligible individual was covered during the entire 30-day period that ended on the date of separation from employment which made the individual potentially TRA-eligible, or qualified the individual for the benefit under section 246 of the Act; and,

(11) coverage under an employee benefit plan, funded by a voluntary employees' beneficiary association established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, for eligible coverage months beginning before January 1, 2011.

The health insurance coverage mechanisms described under items (2) through (8) qualify for a tax credit only if the state elects to use those mechanisms and the coverage meets certain requirements. Those requirements, at section 35(e)(2) of the IRC, require that under such coverage (i) a "qualifying individual" is guaranteed enrollment; (ii) no pre-existing conditions are imposed; (iii) the premium charged is nondiscriminatory (i.e. a qualifying individual is not charged a greater amount than a similarly situated individual who is not a qualifying individual); and, (iv) the benefits are the same or substantially similar to similarly situated individuals who are not qualifying individuals. The term "qualifying individual" is defined in section 35(e)(2)(B)(i) of the IRC as an individual who is eligible for assistance as described in Section 6 - Individuals Eligible for Assistance and who, as of the date the individual seeks to enroll in one of these elected coverage mechanisms, had an aggregate period of creditable health insurance coverage (as defined in section 9801(c) of the IRC) of three months or longer. The individual also must not have other specified coverage or be imprisoned.

States must decide whether to elect to include all, some, or none of the coverage mechanisms described in items (2) through (8). States are encouraged to give consideration to these optional coverage mechanisms and evaluate their appropriateness in light of the particular circumstances in the state. (The Department is available to provide technical assistance regarding the election of the mechanisms.) The coverage mechanisms described in items (1), (9), (10), and (11) qualify for assistance under a NEG without election by the state, as do any of the state-elected coverage mechanisms.

Finally, it should be noted that with respect to continuation coverage under COBRA, section 203(e)(i)(B) of the Trade Act of 2002, added a new section 605(b) to the Employee Retirement Income Security Act of 1974 that provides an additional COBRA election period for certain TAA recipients. Under this provision, if the eligible TAA recipient did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, s/he may elect continuation coverage during a 60-day period that starts on the first day of the month in which the individual becomes a TAA-eligible individual. However, the election may not be made later than six months after the date s/he lost individual health coverage as a result of her/his separation from employment that resulted in her/him becoming a TAA-eligible individual. The TAA-eligible individual may elect continuation coverage for both herself/himself and her/his qualifying family members.

8. Entities Eligible for NEG Awards. This program is open to all WIA state grant recipient agencies designated by the Governor to apply for WIA NEG funds.

9. State Responsibilities. The Department believes that most states already have the necessary mechanisms in place to ensure eligibility of individuals for assistance, proper referral to and enrollment of eligible individuals in qualified coverage, and effective verification of benefit payments.

For states that do not have such mechanisms, or need to update their current systems, procedures and systems must include:

- eligibility verification;
- certification of state-based healthcare plans;
- notification to eligible individuals of available qualified healthcare insurance options;
- assistance to eligible individuals in enrolling in qualified programs;
- issuing processing certificates that confirm individuals are eligible for healthcare coverage assistance;
- transmission of lists of eligible participants to the IRS via the Interstate Connection Network (ICON); and,
- development and installation of necessary data management systems.

10. <u>Availability of NEG Funds to Assist States</u>. NEG funds are available to assist states in establishing or modifying the infrastructure needed to meet the responsibilities specified above. An initial amount of $50,000 is available to states to offset the additional costs of establishing or modifying the systems to comply with the state responsibilities noted above. Additions to this base level will be made as determined by documentation submitted to support a higher level.

Once the systems and procedures are in place and the state is receiving and processing HCTC requests, the state may submit a modification to the grant award to cover ongoing operational costs for these activities that exceed the amount of the initial system building grant award.

States that previously were awarded HCTC infrastructure funds for the purpose of establishing the requisite systems are limited to requesting funding to reprogram the new eligibility definitions into the current system.

11. <u>Use of NEG Funds</u>. NEG funds provided under section 173(f) of WIA may be used to provide assistance and support services, including qualifying health insurance coverage, transportation, child care, dependent care and income assistance, to eligible individuals. For both health insurance and income support assistance, the assistance cannot supplant other Federal, state or local assistance for which the individual is eligible.

In order to promote consistency with, and a transition to, the advance payment tax credit, and to conserve NEG resources in a manner that will allow broad participation by the states and eligible individuals, these NEG funds may be used to pay no more than 80 percent of the amount paid by an eligible individual for qualified health insurance coverage of the eligible individual and qualifying family members. This is the same level of assistance provided under the tax credit mechanism and is intended to fulfill the objective of providing a bridge to the advance payment tax credit mechanism.

In addition, the Department would generally expect the assistance provided under the NEG would be for prospective coverage; that is, for payments for coverage for months after the state has determined that the individual is eligible for HCTC. In extraordinary cases, as demonstrated by the applicant, the Department will consider the use of NEG funds to reimburse for qualified health insurance coverage premium payments that were made by an individual for the period before the state made an eligibility determination, but reimbursements cannot be for any period before **January 1, 2009 (the first date for coverage of monthly premiums under TGAAA)**. Furthermore, to qualify for such reimbursement, the individual would have to be determined to have met the eligibility requirements at the time such prior premiums were paid. As described below, NEG funds may be used for bridge and gap filler payments as well as to cover infrastructure costs related to the administration of the HCTC program. Individuals may apply for reimbursement regardless of whether the state has received NEG funds for bridge or gap filler payments.

<u>Infrastructure</u>: As outlined in section 10, NEG funds are available to assist states in establishing the infrastructure needed to meet the responsibilities specified in section 9 of this TEGL entitled, "State Responsibilities." To administer the HCTC, the Trade Act of 2002 anticipates that the Governors will establish adequate procedures and systems to ensure eligibility of individuals for assistance, proper referral to and enrollment of eligible individuals in qualified coverage, and effective verification of benefit payments.

Regarding the advanced tax credit, states will be asked to certify individuals' potential eligibility for the tax credit, issue certificates that these individuals may submit to insurers to seek the credit on an advance basis, and provide information electronically to the IRS about eligible individuals. Specific requirements for administration of the advance health insurance tax credit have been developed by the IRS. States are also asked to issue IRS Form 8887, showing the months for which eligibility requirements were met, to eligible individuals at the end of each tax year for which the credit is available. NEG funds are available to cover administrative costs for activities related to this health insurance tax credit.

Bridge Payments: States that have not yet developed the necessary infrastructure to administer the HCTC program may apply for HCTC NEG funds to help pay the cost of health insurance coverage and other authorized support services for eligible individuals while the state is developing and linking their system to the IRS system that will allow for the issuance of health insurance coverage assistance through the advanced payment tax credit mechanism.

Gap filler Payments: States may request HCTC NEG funds to cover up to three months of gap payments to support 80 percent of the qualified premium for eligible individuals. The gap period is defined as the period after the state determines a candidate's eligibility for HCTC until the IRS enrolls, processes, and pays a candidate's first payment under the HCTC program. This period is usually one month, but depending on the timing and other factors can take up to three months, and sometimes slightly longer in rare instances. NEG funding for gap periods is predicated on the fact that the individual remains eligible for the HCTC for all "gap" months.

12. Availability of Funds. Section 1899K of Division B of the Recovery Act amends section 174(c)(1)(A) of the WIA by authorizing and appropriating $150,000,000 for HCTC NEGs. Section 174(c)(1)(A) of the WIA is a "no-year" appropriation making these funds available for Federal obligation during the pendency of any outstanding claim.

13. Coordination of Available Funds. The Department strongly encourages efforts by the state to coordinate the provision of assistance under this NEG among the appropriate state agencies, such as the state insurance commission, the state health licensing and regulatory board or entity, and other departments or entities involved in the provision of health insurance coverage. A description of such coordination must be included in the narrative section of the NEG application.

14. Dislocated Worker Formula Funds Usage. Due to the purpose of HCTC NEGs, the provision of health coverage assistance rather than traditional employment and training services, the traditional Dislocated Worker formula funds usage requirements that apply to other types of NEGs do not pertain to HCTC NEGs.

15. Application Requirements. All HCTC NEG applications are to be submitted through the NEG Electronic Application System. If an entity does not have a NEG Electronic Application System password and Personal Identification Number (PIN), please send an e-mail to NEGesystem@dol.gov to request a password and PIN.

- Grantee organizations, administrative entities and service providers are subject to the WIA statute, regulations, grant application instructions, the terms and conditions of the grant and any subsequent modifications, and to all other applicable Federal laws (including provisions in Federal Appropriations law).

- Administrative Costs - Administrative cost limitations apply to all NEG awards. A 10 percent limit will apply to all NEG projects. Any costs associated with administering a system of health insurance coverage payments must be separately identified in the application budget and justified in the narrative.

  Although administrative cost limits on NEG projects are subject to negotiation, the Department expects that most projects will be able to be implemented within the above-cited limits. Any request for a higher limit will have to be clearly and fully justified in terms of unusual project operating circumstances. Applicants should recognize that any such request will have to be negotiated and will delay the timing of the funding action.

- Indirect Costs - If an indirect cost rate is applied in calculating administrative costs, the applicant must include information from the most recent approval document that identifies the approved indirect cost rate and base, the cognizant approval agency, and the date of the approval.

- Allowable Activities and Services - Funds may be used for the services described in WIA section 173(f) and (g).

- Project Design and Service Operations - Provision of services in addition to health insurance coverage assistance should be consistent with the established policies and procedures of the state in which the project is to operate.

When submitting a NEG application to provide health insurance coverage assistance via the NEG Electronic Application System, the application consists of the following OMB-approved forms:

- SF 424 – Application for Federal Assistance (OMB 4040-0004). This form is the required application for requesting Federal funds. The authorized signatory for the state must use the PIN which has been assigned to the state. The entry of this PIN on the SF 424 will constitute the authorized signature.

- Project Synopsis (ETA 9106) (OMB 1205-0439). This form summarizes key aspects of the proposed project such as project type, planned number of participants, and contact information.

  For gap filler payments, states must consider the following factors:

  - The total eligible population equals prospective TAA and ATAA participants and the PBGC population (ages 55 to 65). Upon request by a State Workforce Agency (SWA), the PBGC will provide the number of potentially eligible PBGC pension recipients in a state. The PBGC is also able to provide other information to assist the SWA in publicizing the availability of NEG funds for gap filler payments. To obtain this information from the PBGC, the SWA should send its request to the PBGC Disclosure Officer. The fax number is (202) 326-4042.

  - The percentage of the population expected to enroll in the HCTC program. This percentage will depend heavily on the state's efforts to promote the availability

of NEG funds for gap filler payments, but more than likely will not exceed 50 percent of the eligible population. Enrollment will be less in states that do not have a state-qualified health plan.

- The amount to cover 80 percent of the average monthly health insurance premium for a qualified plan in the state. The state insurance department should be contacted for this information. A recommended monthly estimate is $600 per person.

- The average number of months that someone will need the gap filler payments – approximately two months.

HCTC NEG applications should include the funding needed for the State to administer the gap filler payments. Other costs critical to the effectiveness of the gap filler program, including outreach and other informational activities, should also be included. These costs will generally be limited to 10 percent of the total funds requested. It is very important that states continue to provide information on the HCTC program and the availability of the NEG funds to support the costs of the premiums for qualified health insurance coverage pending the receipt of the first payment from the IRS.

- Planning Form (ETA 9103) (OMB 1205-0439). This form provides cumulative quarterly estimates on project scope (i.e. number of participants, exits), design (i.e. mix of enrollments in activities), and budget (i.e. costs by type of activity, administrative costs).

- Narrative Statement. A narrative explanation must be provided in cases where one or more of the following are reflected in the project plan:

    1. Indirect costs are included in the budget, which requires identifying the following: cognizant approval agency, approved cost rate and base, and date of approval.

    2. "Other" costs are included in the budget, which requires identifying the specific cost items and amounts.

    3. Administrative costs related to processing payments for qualified health insurance coverage and/or supportive services that are included in the budget, which requires explaining how the administrative cost estimate was derived (i.e. based on the number of check payment and check processing costs).

16. Existing HCTC Grants. Current HCTC gap filler grantees are required to submit a grant modification request in the following circumstances:

1. To expand the approved target group within the original scope of the grant.

2. To increase the number of participants receiving healthcare premiums and/or the amount of expenditures for health insurance premiums.

3. To extend the grant period.

4. To change the performance period of the project.

5. To adjust when actual end-of-project expenditures will be less than the amount awarded for project objectives.

6. When the amount to be realigned is at least 10 percent of the total grant amount.

For financial modifications, or to change the original scope of the grant, existing HCTC NEG grantees will have to submit a new HCTC NEG application. There are specific guidelines and requirements associated with the use and reporting of Recovery Act funds, as outlined in TEGL No. 17-08 and OMB guidance (OMB# M-09-21), so separate grants are necessary to ensure that the use of these funds will be captured and reported separately from previous funding.

17. Funding Approach. Applications for HCTC NEG funds can be funded in whole or in part at the Secretary's discretion. Applicants may request full or partial funding; however, in order to ensure the effective use of NEG resources, requests for HCTC NEG funds, when approved, will generally be funded on an incremental basis. Where the grant award reflects an incremental funding action, the grantee will be required to submit, at a later date, supplemental information to request the balance of funds. This information will be specified in the grant award documents but will include, at a minimum, current information on actual participant levels, performance outcomes, and expenditures.

18. Reporting. Accountability guidelines for the Recovery Act emphasize data quality, streamlining data collection, and collection of information that shows measurable program outputs. They also emphasize transparency and frequent communication with the American public about the nature of Recovery Act investments. Information on specific HCTC NEGs, such as award amount and State will be provided by the Department to OMB for posting on www.recovery.gov.

HCTC NEG grantees are not subject to the performance reporting outlined for other Recovery Act NEGs in TEGL No. 24-08, due to the unique nature of HCTC NEGs: the provision of health coverage assistance rather than traditional employment and training services. However, Recovery Act-funded HCTC NEG grantees will be required to comply with the reporting requirements under Section 1512 of the Recovery Act, as outlined in TEGL No. 1-09, Changes 1 and 2.

Recovery Act-funded HCTC NEG grantees will also continue to submit a Quarterly Progress Report and a Financial Status Report to the Department each quarter. A summary of these existing HCTC NEG reporting requirements is provided below.

Quarterly Progress Reports (ETA 9104) (OMB 1205-0439) - Grantees must submit a Quarterly Progress Report until all participants have exited NEG-funded services. The Quarterly Progress Report provides a detailed account of activities undertaken that quarter, including the number of participants receiving health coverage payments, expenditures on health coverage payments, and expenditures for processing payments. The report serves as a regular communication vehicle between the grantee and the Department regarding the progress of the project towards meeting the specific results and deliverables outlined in the NEG application.

Quarterly Financial Reports (ETA 9130) (OMB 1205-0461) - Grantees must submit a Financial Status Report quarterly until the grant's period of performance has expired. Financial Status Reports track the cumulative amount of grant funds that have been expended.

19. Project Oversight. Pursuant to WIA regulations 20 CFR 667.410, each state recipient and sub-recipient of Recovery Act funds must conduct regular oversight and monitoring of its WIA activities in order to determine that expenditures have been made against cost categories and within cost limitations and to otherwise monitor compliance. Oversight and monitoring should determine whether or not there is compliance with programmatic, accountability, and transparency requirements of the Recovery Act, as well as the WIA, and the regulations and approach in the use of the Secretary's discretionary NEG resources. However, the Department is responsible for monitoring and oversight of the use of public funds and will conduct its normal Regional Office monitoring of these resources. The Department will also work with NEG grantees to ensure that necessary and appropriate systems and safeguards are in place to protect public funds, taking into account the unique needs of each situation.

20. Paperwork Reduction Act Statement. This TEGL does not change collections of information currently approved under OMB Control Nos. 1205-0439, 1205-0461, and 1545-1842.

21. Action Requested. Recovery Act-funded HCTC NEG applications must be submitted in accordance with these policies and appropriate NEG Application Guidelines. State Administrators are asked to provide this information to appropriate staff.

22. Inquiries. Questions regarding this notice should be directed to Erica Cantor, Administrator, Office of National Response at (202) 693-3500, or to the appropriate Regional Administrator. SWAs can also contact the HCTC Customer Contact Center at (866) 628-HCTC for help in determining the HCTC-eligible population. A caller should identify herself/himself as a representative of the SWA and allow for time to receive a final call.

23. Attachment.

Sections 201, 202, and 203 of the Trade Act of 2002

TRADE ACT OF 2002

TITLE II—CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS

SEC. 201. CREDIT FOR HEALTH INSURANCE COSTS OF INDIVIDUALS RECEIVING A TRADE READJUSTMENT ALLOWANCE OR A BENEFIT FROM THE PENSION BENEFIT GUARANTY CORPORATION.

(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 inserting after section 34 the following new section:

''SEC. 35. HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A an amount equal to 65 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

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

''(1) IN GENERAL.—The term 'eligible coverage month' means any month if—

''(A) as of the first day of such month, the taxpayer—

''(i) is an eligible individual,

''(ii) is covered by qualified health insurance, the premium for which is paid by the taxpayer,

''(iii) does not have other specified coverage, and

''(iv) is not imprisoned under Federal, State, or local authority, and ''(B) such month begins more than 90 days after the date of the enactment of the Trade Act of 2002.

''(2) JOINT RETURNS.—In the case of a joint return, the requirements of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirements.

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

''(1) IN GENERAL.—The term 'eligible individual' means—

''(A) an eligible TAA recipient,

''(B) an eligible alternative TAA recipient, and

''(C) an eligible PBGC pension recipient.

''(2) ELIGIBLE TAA RECIPIENT.—The term 'eligible TAA recipient' means, with respect to any month,any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. An individual shall continue to be treated as an eligible TAA

recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

‘‘(3) ELIGIBLE ALTERNATIVE TAA RECIPIENT.— The term ‘eligible alternative TAA recipient’ means, with respect to any month, any individual who—

‘‘(A) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and

‘‘(B) is receiving a benefit for such month under section 246(a)(2) of such Act. An individual shall continue to be treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible alternative TAA recipient by reason of the preceding sentence.

‘‘(4) ELIGIBLE PBGC PENSION RECIPIENT.—The term ‘eligible PBGC pension recipient’ means, with respect to any month, any individual who—

‘‘(A) has attained age 55 as of the first day of such month, and

‘‘(B) is receiving a benefit for such month any portion of which is paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974.

‘‘(d) QUALIFYING FAMILY MEMBER.—For purposes of this section—

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

‘‘(A) the taxpayer’s spouse, and

‘‘(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c). Such term does not include any individual who has other specified coverage.

‘‘(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If paragraph (2) or (4) of section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (within the meaning of section 152(e)(1)) and not with respect to the noncustodial parent.

‘‘(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

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

‘‘(A) Coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

‘‘(B) State-based continuation coverage provided by the State under a State law that requires such coverage.

‘‘(C) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

‘‘(D) Coverage under a health insurance program offered for State employees.

‘‘(E) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

‘‘(F) Coverage through an arrangement entered into by a State and—

''(i) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

''(ii) an issuer of health insurance coverage,

''(iii) an administrator, or

''(iv) an employer.

''(G) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

''(H) Coverage under a State-operated health plan that does not receive any Federal financial participation.

''(I) Coverage under a group health plan that is available through the employment of the eligible individual's spouse.

''(J) In the case of any eligible individual and such individual's qualifying family members, coverage under individual health insurance if the eligible individual was covered under individual health insurance during the entire 30-day period that ends on the date that such individual became separated from the employment which qualified such individual for—

''(i) in the case of an eligible TAA recipient, the allowance described in subsection (c)(2),

''(ii) in the case of an eligible alternative TAA recipient, the benefit described in subsection (c)(3)(B), or

''(iii) in the case of any eligible PBGC pension recipient, the benefit described in subsection (c)(4)(B). For purposes of this subparagraph, the term 'individual health insurance' means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

''(2) REQUIREMENTS FOR STATE-BASED COVERAGE.—

''(A) IN GENERAL.—The term 'qualified health insurance' does not include any coverage described in subparagraphs (B) through (H) of paragraph (1) unless the State involved has elected to have such coverage treated as qualified health insurance under this section and such coverage meets the following requirements:

''(i) GUARANTEED ISSUE.—Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 and pays the remainder of such premium.

''(ii) NO IMPOSITION OF PREEXISTING CONDITION EXCLUSION.—No pre-existing condition limitations are imposed with respect to any qualifying individual.

''(iii) NONDISCRIMINATORY PREMIUM.—The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

''(iv) SAME BENEFITS.—Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

''(B) QUALIFYING INDIVIDUAL.—For purposes of this paragraph, the term 'qualifying individual' means—

‘‘(i) an eligible individual for whom, as of the date on which the individual seeks to enroll in the coverage described in subparagraphs (B) through (H) of paragraph (1), the aggregate of the periods of creditable coverage (as defined in section 9801(c)) is 3 months or longer and who, with respect to 1any month, meets the requirements of clauses (iii) and (iv) of subsection (b)(1)(A); and

‘‘(ii) the qualifying family members of such eligible individual.

‘‘(3) EXCEPTION.—The term ‘qualified health insurance’ shall not include—

‘‘(A) a flexible spending or similar arrangement, and

‘‘(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

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

‘‘(1) SUBSIDIZED COVERAGE.—

‘‘(A) IN GENERAL.—Such individual is covered under any insurance which constitutes medical care (except insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c)) under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer’s spouse and at least 50 percent of the cost of such coverage (determined under section 4980B) is paid or incurred by the employer.

‘‘(B) ELIGIBLE ALTERNATIVE TAA RECIPIENTS.—In the case of an eligible alternative TAA recipient, such individual is either—

‘‘(i) eligible for coverage under any qualified health insurance (other than insurance described in subparagraph (A), (B), or (F) of subsection (e)(1)) under which at least 50 percent of the cost of coverage (determined under section 4980B(f)(4)) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse, or

‘‘(ii) covered under any such qualified health insurance under which any portion of the cost of coverage (as so determined) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse.

‘‘(C) TREATMENT OF CAFETERIA PLANS.— For purposes of subparagraphs (A) and (B), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

‘‘(2) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

‘‘(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

‘‘(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

‘‘(3) CERTAIN OTHER COVERAGE.—Such individual—

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

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

‘‘(g) SPECIAL RULES.—

‘‘(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527 for months beginning in such taxable year.

‘‘(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213.

‘‘(3) MSA DISTRIBUTIONS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) shall not be taken into account under subsection (a).

‘‘(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) BOTH SPOUSES ELIGIBLE INDIVIDUALS.— The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

‘‘(A) the taxpayer is married at the close of the taxable year,

‘‘(B) the taxpayer and the taxpayer’s spouse are both eligible individuals during the taxable year, and

‘‘(C) the taxpayer files a separate return for the taxable year.

‘‘(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

‘‘(7) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

‘‘(8) TREATMENT OF PAYMENTS.—For purposes of this section—

‘‘(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals) shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

‘‘(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

‘‘(9) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050T, and section 7527.’’.

(b) PROMOTION OF STATE HIGH RISK POOLS.—Title 5 *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 (c)(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—

''(A) restricts premiums charged under the pool to no more than 150 percent of the premium for applicable standard risk rates;

''(B) offers a choice of two or more coverage options through the pool; and

''(C) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State after the end of fiscal year 2004 in connection with operation of the pool; the Secretary shall provide, from the funds appropriated under subsection (c)(2) and allotted to the State under paragraph (2), a grant of up to 50 percent of the losses incurred by the State in connection with the operation of the pool.

''(2) ALLOTMENT.—The amounts appropriated under subsection (c)(2) for a fiscal year shall be made available to the States in accordance with a formula that is based upon the number of uninsured individuals in the States.

''(c) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are authorized and appropriated—

''(1) $20,000,000 for fiscal year 2003 to carry out subsection (a); and

''(2) $40,000,000 for each of fiscal years 2003 and 2004 to carry out subsection (b). Funds appropriated under this subsection for a fiscal year shall remain available for obligation through the end of the following fiscal year. Nothing in this section shall be construed as providing a State with an entitlement to a grant under this section.

''(d) QUALIFIED HIGH RISK POOL AND STATE DEFINED.—For purposes of this section, the term 'qualified high risk pool' has the meaning given such term in section 2744(c)(2) and the term 'State' means any of the 50 States and the District of Columbia.''.

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

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

''Sec. 35. Health insurance costs of eligible individuals.

''Sec. 36. Overpayments of tax.''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2001.

(2) STATE HIGH RISK POOLS.—The amendment made by subsection (b) shall take effect on the date of the enactment of this Act.

SEC. 202. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

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

''SEC. 7527. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

''(a) GENERAL RULE.—Not later than August 1, 2003, the Secretary shall establish a program for making payments on behalf of certified individuals to providers of qualified health insurance (as defined in section 35(e)) for such individuals.

''(b) LIMITATION ON ADVANCE PAYMENTS DURING ANY TAXABLE YEAR.—The Secretary may make payments under subsection (a) only to the extent that the total amount of such payments made on behalf of any individual during the taxable year does not exceed 65 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

''(c) CERTIFIED INDIVIDUAL.—For purposes of this section, the term 'certified individual' means any individual for whom a qualified health insurance costs credit eligibility certificate is in effect.

''(d) QUALIFIED HEALTH INSURANCE COSTS CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, the term 'qualified health insurance costs credit eligibility certificate' means any written statement that an individual is an eligible individual (as defined in section 35(c)) if such statement provides such information as the Secretary may require for purposes of this section and—

''(1) in the case of an eligible TAA recipient (as defined in section 35(c)(2)) or an eligible alternative TAA recipient (as defined in section 35(c)(3)), is certified by the Secretary of Labor (or by any other person or entity designated by the Secretary), or

''(2) in the case of an eligible PBGC pension recipient (as defined in section 35(c)(4)), is certified by the Pension Benefit Guaranty Corporation (or by any other person or entity designated by the Secretary).''.

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Subsection (l) of section 6103 of such Code (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(18) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—The Secretary may disclose to providers of health insurance for any certified individual (as defined in section 7527(c)) return information with respect to such certified individual only to the extent necessary to carry out the program established by section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals).''.

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p) of such section is amended—

(A) in paragraph (3)(A) by striking ''or (17)'' and inserting ''(17), or (18)'', and (B) in paragraph (4) by inserting ''or (17)'' after ''any other person described in subsection (l)(16)'' each place it appears.

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

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

''SEC. 6050T. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.

''(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals) with respect to any certified individual (as defined in section 7527(c)) shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

''(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 number of months for which amounts were entitled to be received with respect to such individual under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals),

''(C) the amount entitled to be received for each such month, 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.''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) 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 credit for health insurance costs of eligible individuals),''.

(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 credit for health insurance costs of eligible individuals).''.

(d) CLERICAL AMENDMENTS.—

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

''Sec. 7527. Advance payment of credit for health insurance costs of eligible individuals.''.

(2) INFORMATION REPORTING.—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 credit for health insurance costs of eligible individuals.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 203. HEALTH INSURANCE ASSISTANCE FOR ELIGIBLE INDIVIDUALS.

(a) ELIGIBILITY FOR GRANTS.—Section 173(a) of the Workforce Investment Act of 1998 (29 U.S.C. 2918(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(4) from funds appropriated under section 174(c)—

''(A) to a State or entity (as defined in section 173(c)(1)(B)) to carry out subsection (f), including providing assistance to eligible individuals; and

''(B) to a State or entity (as so defined) to carry out subsection (g), including providing assistance to eligible individuals.''.

(b) USE OF FUNDS FOR HEALTH INSURANCE COVERAGE.—Section 173 of the Workforce Investment Act of 1998 (29 U.S.C. 2918) is amended by adding at the end the following:

''(f) HEALTH INSURANCE COVERAGE ASSISTANCE FOR ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—Funds made available to a State or entity under paragraph (4)(A) of subsection (a) may be used by the State or entity for the following:

''(A) HEALTH INSURANCE COVERAGE.—To assist an eligible individual and such individual's qualifying family members in enrolling in qualified health insurance.

‘‘(B) ADMINISTRATIVE AND START-UP EXPENSES.—To pay the administrative expenses related to the enrollment of eligible individuals and such individuals’ qualifying family members in qualified health insurance, including—

‘‘(i) eligibility verification activities;

‘‘(ii) the notification of eligible individuals of available qualified health insurance options;

‘‘(iii) processing qualified health insurance costs credit eligibility certificates provided for under section 7527 of the Internal Revenue Code of 1986;

‘‘(iv) providing assistance to eligible individuals in enrolling in qualified health insurance;

‘‘(v) the development or installation of necessary data management systems; and

‘‘(vi) any other expenses determined appropriate by the Secretary, including start-up costs and on going administrative expenses to carry out clauses (iv) through (ix) of paragraph (2)(A).

‘‘(2) QUALIFIED HEALTH INSURANCE.—For purposes of this subsection and subsection (g)—

‘‘(A) IN GENERAL.—The term ‘qualified health insurance’ means any of the following:

‘‘(i) Coverage under a COBRA continuation provision (as defined in section 733(d)(1) of the Employee Retirement Income Security Act of 1974).

‘‘(ii) State-based continuation coverage provided by the State under a State law that requires such coverage.

‘‘(iii) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

‘‘(iv) Coverage under a health insurance program offered for State employees.

‘‘(v) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

‘‘(vi) Coverage through an arrangement entered into by a State and

‘‘(I) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

‘‘(II) an issuer of health insurance coverage,

‘‘(III) an administrator, or

‘‘(IV) an employer.

‘‘(vii) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

‘‘(viii) Coverage under a State-operated health plan that does not receive any Federal financial participation.

‘‘(ix) Coverage under a group health plan that is available through the employment of the eligible individual’s spouse.

‘‘(x) In the case of any eligible individual and such individual’s qualifying family members, coverage under individual health insurance if the eligible individual was covered under individual health insurance during the entire 30-day period that ends on the date that such individual became separated from the employment which qualified such individual for—

‘‘(I) in the case of an eligible TAA recipient, the allowance described in section 35(c)(2) of the Internal Revenue Code of 1986,

‘‘(II) in the case of an eligible alternative TAA recipient, the benefit described in section 35(c)(3)(B) of such Code, or

‘‘(III) in the case of any eligible PBGC pension recipient, the benefit described in section 35(c)(4)(B) of such Code.

For purposes of this clause, the term ‘individual health insurance’ means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

‘‘(B) REQUIREMENTS FOR STATE-BASED COVERAGE.—

‘‘(i) IN GENERAL.—The term ‘qualified health insurance’ does not include any coverage described in clauses (ii) through (viii) of subparagraph (A) unless the State involved has elected to have such coverage treated as qualified health insurance under this paragraph and such coverage meets the following requirements:

‘‘(I) GUARANTEED ISSUE.—Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 of the Internal Revenue Code of 1986 and pays the remainder of such premium.

‘‘(II) NO IMPOSITION OF PREEXISTING CONDITION EXCLUSION.—No pre-existing condition limitations are imposed with respect to any qualifying individual.

‘‘(III) NONDISCRIMINATORY PREMIUM.—The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

‘‘(IV) SAME BENEFITS.—Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

‘‘(ii) QUALIFYING INDIVIDUAL.—For purposes of this subparagraph, the term ‘qualifying individual’ means—

‘‘(I) an eligible individual for whom, as of the date on which the individual seeks to enroll in clauses (ii) through (viii) of subparagraph (A), the aggregate of the periods of creditable coverage (as defined in section 9801(c) of the Internal Revenue Code of 1986) is 3 months or longer and who, with respect to any month, meets the requirements of clauses (iii) and (iv) of section 35(b)(1)(A) of such Code; and ‘‘(II) the qualifying family members of such eligible individual.

‘‘(C) EXCEPTION.—The term ‘qualified health insurance’ shall not include—

‘‘(i) a flexible spending or similar arrangement, and

‘‘(ii) any insurance if substantially all of its coverage is of excepted benefits described in section 733(c) of the Employee Retirement Income Security Act of 1974.

‘‘(3) AVAILABILITY OF FUNDS.—

‘‘(A) EXPEDITED PROCEDURES.—With respect to applications submitted by States or entities for grants under this subsection, the Secretary shall—

‘‘(i) not later than 15 days after the date on which the Secretary receives a completed application from a State or entity, notify the State or entity of the determination of the Secretary with respect to the approval or disapproval of such application;

‘‘(ii) in the case of an application of a State or other entity that is disapproved by the Secretary, provide technical assistance, at the request of the State or entity, in a timely manner to enable the State or entity to submit an approved application; and

‘‘(iii) develop procedures to expedite the provision of funds to States and entities with approved applications.

‘‘(B) AVAILABILITY AND DISTRIBUTION OF FUNDS.—The Secretary shall ensure that funds made available under section 174(c)(1)(A) to carry out subsection (a)(4)(A) are available to States and entities throughout the period described in section 174(c)(2)(A).

‘‘(4) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subsection and subsection (g), the term ‘eligible individual’ means—

‘‘(A) an eligible TAA recipient (as defined in section 35(c)(2) of the Internal Revenue Code of 1986),

‘‘(B) an eligible alternative TAA recipient (as defined in section 35(c)(3) of the Internal Revenue Code of 1986), and

‘‘(C) an eligible PBGC pension recipient (as defined in section 35(c)(4) of the Internal Revenue Code of 1986), who, as of the first day of the month, does not have other specified coverage and is not imprisoned under Federal, State, or local authority.

‘‘(5) QUALIFYING FAMILY MEMBER DEFINED.— For purposes of this subsection and subsection (g)—

‘‘(A) IN GENERAL.—The term ‘qualifying family member’ means—

‘‘(i) the eligible individual’s spouse, and

‘‘(ii) any dependent of the eligible individual with respect to whom the individual is entitled to a deduction under section 151(c) of the Internal Revenue Code of 1986.

Such term does not include any individual who has other specified coverage.

‘‘(B) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If paragraph (2) or (4) of section 152(e) of such Code applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in subparagraph (A)(ii) with respect to the custodial parent (within the meaning of section 152(e)(1) of such Code) and not with respect to the noncustodial parent.

‘‘(6) STATE.—For purposes of this subsection and subsection (g), the term ‘State’ includes an entity as defined in subsection (c)(1)(B).

‘‘(7) OTHER SPECIFIED COVERAGE.—For purposes of this subsection, an individual has other specified coverage for any month if, as of the first day of such month—

‘‘(A) SUBSIDIZED COVERAGE.—

‘‘(i) IN GENERAL.—Such individual is covered under any insurance which constitutes medical care (except insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c) of the Internal Revenue Code of 1986) under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer’s spouse and at least 50 percent of the cost of such coverage (determined under section 4980B of such Code) is paid or incurred by the employer.

‘‘(ii) ELIGIBLE ALTERNATIVE TAA RECIPIENTS.—In the case of an eligible alternative TAA recipient (as defined in section 35(c)(3) of the Internal Revenue Code of 1986), such individual is either—

‘‘(I) eligible for coverage under any qualified health insurance (other than insurance described in clause (i), (ii), or (vi) of paragraph (2)(A)) under which at least 50 percent of the cost of coverage (determined under section 4980B(f)(4) of such Code) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse, or

‘‘(II) covered under any such qualified health insurance under which any portion of the cost of coverage (as so determined) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer’s spouse.

‘‘(iii) TREATMENT OF CAFETERIA PLANS.—For purposes of clauses (i) and (ii), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d) of the Internal Revenue Code of 1986).

‘‘(B) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

‘‘(i) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

‘‘(ii) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

‘‘(C) CERTAIN OTHER COVERAGE.—Such individual—

‘‘(i) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

‘‘(ii) is entitled to receive benefits under chapter 55 of title 10, United States Code.

‘‘(g) INTERIM HEALTH INSURANCE COVERAGE AND OTHER ASSISTANCE.—

‘‘(1) IN GENERAL.—Funds made available to a State or entity under paragraph (4)(B) of subsection (a) may be used by the State or entity to provide assistance and support services to eligible individuals, including health care coverage to the extent provided under subsection (f)(1)(A), transportation, child care, dependent care, and income assistance.

‘‘(2) INCOME SUPPORT.—With respect to any income assistance provided to an eligible individual with such funds, such assistance shall supplement and not supplant other income support or assistance provided under chapter 2 of title II of the Trade Act of 1974 (19 U.S.C. 2271 et seq.) (as in effect on the day before the effective date of the Trade Act of 2002) or the unemployment compensation laws of the State where the eligible individual resides.

‘‘(3) HEALTH INSURANCE COVERAGE.—With respect to any assistance provided to an eligible individual with such funds in enrolling in qualified health insurance, the following rules shall apply:

‘‘(A) The State or entity may provide assistance in obtaining such coverage to the eligible individual and to such individual’s qualifying family members.

‘‘(B) Such assistance shall supplement and may not supplant any other State or local funds used to provide health care coverage and may not be included in determining the amount of non-Federal contributions required under any program.

‘‘(4) AVAILABILITY OF FUNDS.—

‘‘(A) EXPEDITED PROCEDURES.—With respect to applications submitted by States or entities for grants under this subsection, the Secretary shall—

‘‘(i) not later than 15 days after the date on which the Secretary receives a completed application from a State or entity, notify the State or entity of the determination of the Secretary with respect to the approval or disapproval of such application;

‘‘(ii) in the case of an application of a State or entity that is disapproved by the Secretary, provide technical assistance, at the request of the State or entity, in a timely manner to enable the State or entity to submit an approved application; and

‘‘(iii) develop procedures to expedite the provision of funds to States and entities with approved applications.

‘‘(B) AVAILABILITY AND DISTRIBUTION OF FUNDS.—The Secretary shall ensure that funds made available under section 174(c)(1)(B) to carry out subsection (a)(4)(B) are available to States and entities throughout the period described in section 174(c)(2)(B).

‘‘(5) INCLUSION OF CERTAIN INDIVIDUALS AS ELIGIBLE INDIVIDUALS.—For purposes of this subsection, the term ‘eligible individual’ includes an individual who is a member of a group of workers certified after April 1, 2002, under chapter 2 of title II of the Trade Act of 1974 (as in effect on the day before the effective date of the Trade Act of 2002) and is participating in the trade readjustment allowance program under such chapter (as so in effect) or who would be determined to be participating in such program under such chapter (as so in effect) if such chapter were applied without regard to section 231(a)(3)(B) of the Trade Act of 1974 (as so in effect).’’.

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 174 of the Workforce Investment Act of 1998 (29 U.S.C. 2919) is amended by adding at the end the following:

‘‘(c) ASSISTANCE FOR ELIGIBLE WORKERS.—

‘‘(1) AUTHORIZATION AND APPROPRIATION FOR FISCAL YEAR 2002.—There are authorized to be appropriated and appropriated—

‘‘(A) to carry out subsection (a)(4)(A) of section 173, $10,000,000 for fiscal year 2002; and

‘‘(B) to carry out subsection (a)(4)(B) of section 173, $50,000,000 for fiscal year 2002.

‘‘(2) AUTHORIZATION OF APPROPRIATIONS FOR SUBSEQUENT FISCAL YEARS.—There are authorized to be appropriated—

‘‘(A) to carry out subsection (a)(4)(A) of section 173, $60,000,000 for each of fiscal years 2003 through 2007; and

‘‘(B) to carry out subsection (a)(4)(B) of section 173—

‘‘(i) $100,000,000 for fiscal year 2003; and

‘‘(ii) $50,000,000 for fiscal year 2004.

‘‘(3) AVAILABILITY OF FUNDS.—Funds appropriated pursuant to—

‘‘(A) paragraphs (1)(A) and (2)(A) for each fiscal year shall, notwithstanding section 189(g), remain available for obligation during the pendency of any outstanding claim under the Trade Act of 1974, as amended by the Trade Act of 2002; and

‘‘(B) paragraph (1)(B) and (2)(B), for each fiscal year shall, notwithstanding section 189(g), remain available during the period that begins on the date of enactment of the Trade Act of 2002 and ends on September 30, 2004.’’.

(d) CONFORMING AMENDMENT.—Section 132(a)(2)(A) of the Workforce Investment Act of 1998 (29 U.S.C. 2862(a)(2)(A)) is amended by inserting ‘‘, other than under subsection (a)(4), (f), and (g)’’ after ‘‘grants’’.

(e) TEMPORARY EXTENSION OF COBRA ELECTION PERIOD FOR CERTAIN INDIVIDUALS.—

(1) ERISA AMENDMENTS.—Section 605 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165) is amended—

(A) by inserting ‘‘(a) IN GENERAL.—’’ before ‘‘For purposes of this part’’; and

(B) by adding at the end the following:

‘‘(b) TEMPORARY EXTENSION OF COBRA ELECTION PERIOD FOR CERTAIN INDIVIDUALS.—

‘‘(1) IN GENERAL.—In the case of a nonelecting TAA-eligible individual and notwithstanding subsection (a), such individual may elect continuation coverage under this part during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

‘‘(2) COMMENCEMENT OF COVERAGE; NO REACHBACK.—Any continuation coverage elected by a TAA-eligible individual under paragraph (1) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

‘‘(3) PREEXISTING CONDITIONS.—With respect to an individual who elects continuation coverage pursuant to paragraph (1), the period—

‘‘(A) beginning on the date of the TAA-related loss of coverage, and

‘‘(B) ending on the first day of the 60-day election period described in paragraph (1), shall be disregarded for purposes of determining the 63-day periods referred to in section 701(c)(2), section 2701(c)(2) of the Public Health Service Act, and section 9801(c)(2) of the Internal Revenue Code of 1986.

‘‘(4) DEFINITIONS.—For purposes of this subsection:

‘‘(A) NONELECTING TAA-ELIGIBLE INDIVIDUAL.—The term ‘nonelecting TAA-eligible individual’ means a TAA-eligible individual who—

‘‘(i) has a TAA-related loss of coverage; and

‘‘(ii) did not elect continuation coverage under this part during the TAA-related election period.

‘‘(B) TAA-ELIGIBLE INDIVIDUAL.—The term ‘TAA-eligible individual’ means—

‘‘(i) an eligible TAA recipient (as defined in paragraph (2) of section 35(c) of the Internal Revenue Code of 1986), and

‘‘(ii) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

‘‘(C) TAA-RELATED ELECTION PERIOD.— The term ‘TAA-related election period’ means,with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.

‘‘(D) TAA-RELATED LOSS OF COVERAGE.— The term ‘TAA-related loss of coverage’ means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.’’.

(2) PHSA AMENDMENTS.—Section 2205 of the Public Health Service Act (42 U.S.C. 300bb–5) is amended—

(A) by inserting ‘‘(a) IN GENERAL.—’’ before ‘‘For purposes of this title’’; and

(B) by adding at the end the following:

‘‘(b) TEMPORARY EXTENSION OF COBRA ELECTION PERIOD FOR CERTAIN INDIVIDUALS.—

‘‘(1) IN GENERAL.—In the case of a nonelecting TAA-eligible individual and notwithstanding subsection (a), such individual may elect continuation coverage under this title during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

‘‘(2) COMMENCEMENT OF COVERAGE; NO REACHBACK.—Any continuation coverage elected by a TAA eligible individual under paragraph (1) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

‘‘(3) PREEXISTING CONDITIONS.—With respect to an individual who elects continuation coverage pursuant to paragraph (1), the period—

‘‘(A) beginning on the date of the TAA-related loss of coverage, and

‘‘(B) ending on the first day of the 60-day election period described in paragraph (1), shall be disregarded for purposes of determining the 63-day periods referred to in section 2701(c)(2), section 701(c)(2) of the Employee Retirement Income Security Act of 1974, and section 9801(c)(2) of the In- ternal Revenue Code of 1986.

‘‘(4) DEFINITIONS.—For purposes of this subsection:

‘‘(A) NONELECTING TAA-ELIGIBLE INDIVIDUAL.—The term ‘nonelecting TAA-eligible individual’ means a TAA-eligible individual who—

‘‘(i) has a TAA-related loss of coverage; and

‘‘(ii) did not elect continuation coverage under this part during the TAA-related election period.

‘‘(B) TAA-ELIGIBLE INDIVIDUAL.—The term ‘TAA-eligible individual’ means—

‘‘(i) an eligible TAA recipient (as defined in paragraph (2) of section 35(c) of the Internal Revenue Code of 1986), and

‘‘(ii) an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

‘‘(C) TAA-RELATED ELECTION PERIOD.— The term ‘TAA-related election period’ means, with respect to a TAA-related loss of coverage, the 60-day election period under this part which is a direct consequence of such loss.

‘‘(D) TAA-RELATED LOSS OF COVERAGE.— The term ‘TAA-related loss of coverage’ means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.’’.

(3) IRC AMENDMENTS.—Paragraph (5) of section 4980B(f) of the Internal Revenue Code of 1986 (relating to election) is amended by adding at the end the following:

‘‘(C) TEMPORARY EXTENSION OF COBRA ELECTION PERIOD FOR CERTAIN INDIVIDUALS.—

‘‘(i) IN GENERAL.—In the case of a nonelecting TAA-eligible individual and notwithstanding subparagraph (A), such individual may elect continuation coverage under this subsection during the 60-day period that begins on the first day of the month in which the individual becomes a TAA-eligible individual, but only if such election is made not later than 6 months after the date of the TAA-related loss of coverage.

‘‘(ii) COMMENCEMENT OF COVERAGE; NO REACH-BACK.—Any continuation coverage elected by a TAA-eligible individual under clause (i) shall commence at the beginning of the 60-day election period described in such paragraph and shall not include any period prior to such 60-day election period.

‘‘(iii) PREEXISTING CONDITIONS.— With respect to an individual who elects continuation coverage pursuant to clause (i), the period—

‘‘(I) beginning on the date of the TAA-related loss of coverage, and

‘‘(II) ending on the first day of the 60-day election period described in clause (i), shall be disregarded for purposes of determining the 63-day periods referred to in section 9801(c)(2), section 701(c)(2) of the Employee Retirement Income Security Act of 1974, and section 2701(c)(2) of the Public Health Service Act.

‘‘(iv) DEFINITIONS.—For purposes of this subsection:

‘‘(I) NONELECTING TAA-ELIGIBLE INDIVIDUAL.—The term ‘nonelecting TAA-eligible individual’ means a TAA- eligible individual who has a TAA-related loss of coverage and did not elect continuation coverage under this subsection during the TAA-related election period.

‘‘(II) TAA-ELIGIBLE INDIVIDUAL.—The term ‘TAA-eligible individual’ means an eligible TAA recipient (as defined in paragraph (2) of section 35(c)) and an eligible alternative TAA recipient (as defined in paragraph (3) of such section).

‘‘(III) TAA-RELATED ELECTION PERIOD.—The term ‘TAA-related election period’ means, with respect to a TAA-related loss of coverage, the 60 day election period under this subsection which is a direct consequence of such loss.

‘‘(IV) TAA-RELATED LOSS OF COVERAGE.—The term ‘TAA-related loss of coverage’ means, with respect to an individual whose separation from employment gives rise to being an TAA-eligible individual, the loss of health benefits coverage associated with such separation.’’.

(f) RULE OF CONSTRUCTION.—Nothing in this title (or the amendments made by this title), other than provisions relating to COBRA continuation coverage and reporting requirements, shall be construed as creating any new mandate on any party regarding health insurance coverage.