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111TH CONGRESS
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REPT. 111–299
Part 3

AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

R E P O R T

OF THE

COMMITTEE ON EDUCATION AND LABOR

ON

H.R. 3200

together with

MINORITY AND SUPPLEMENTAL VIEWS

OCTOBER 14, 2009.—Ordered to be printed

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AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

OCTOBER 14, 2009.—Committed to the Committee of the Whole House on the State of the Union, and ordered to be printed.

Mr. GEORGE MILLER of California, from the Committee on Education and Labor, submitted the following

R E P O R T

together with

MINORITY AND SUPPLEMENTAL VIEWS

[To accompany H.R. 3200]

The Committee on Education and Labor, to whom was referred the bill (H.R. 3200) to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause (other than sections 161 through 163, 322, and 323 and title IV of division A, division B, section 2002 and titles I through IV of division C, and subtitles A, B, C, and E of title V of division C) and insert the following:

SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES, AND SUBTITLES.

(a) TABLE OF DIVISIONS, TITLES, AND SUBTITLES.—This Act is divided into divisions, titles, and subtitles as follows:

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS
Subtitle A—General Standards
Subtitle B—Standards Guaranteeing Access to Affordable Coverage
Subtitle C—Standards Guaranteeing Access to Essential Benefits
Subtitle D—Additional Consumer Protections
Subtitle E—Governance
Subtitle F—Relation to other requirements; Miscellaneous
Subtitle G—Early Investments
TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS
Subtitle A—Health Insurance Exchange
Subtitle B—Public health insurance option
Subtitle C—Individual Affordability Credits
Subtitle D—State innovation
TITLE III—SHARED RESPONSIBILITY

89–006

Subtitle A—Individual responsibility
Subtitle B—Employer Responsibility

[FOR DIVISION B—SEE TEXT OF INTRODUCED BILL]

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

[For titles I through IV of division C, see text of introduced bill.]
TITLE V—OTHER PROVISIONS
[For subtitles A , B, and C of title V, see text of introduced bill.]
Subtitle D—Grants for comprehensive programs to provide education to nurses and create a pipeline to nursing
[For subtitle E of title V, see text of introduced bill.]
Subtitle F—Standards for accessibility to medical equipment for individuals with disabilities.
Subtitle G—Other grant programs
Subtitle H—Long-term care and family caregiver support
Subtitle I—Online resources

(b) SHORT TITLE.—This Act may be cited as the "America's Affordable Health Choices Act of 2009".

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.

(a) PURPOSE.—

(1) IN GENERAL.—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;

(C) includes sliding scale affordability credits; and

(D) initiates shared responsibility among workers, employers, and the government;

so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

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

Sec. 100. Purpose; table of contents of division; general definitions.

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

Sec. 101. Requirements reforming health insurance marketplace.
Sec. 102. Protecting the choice to keep current coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting pre-existing condition exclusions.
Sec. 112. Guaranteed issue and renewal for insured plans.
Sec. 113. Insurance rating rules.
Sec. 114. Nondiscrimination in benefits; parity in mental health and substance abuse disorder benefits.
Sec. 115. Ensuring adequacy of provider networks.
Sec. 116. Ensuring value and lower premiums.
Sec. 117. Consistency of costs and coverage under qualified health benefits plans during plan year.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 121. Coverage of essential benefits package.
Sec. 122. Essential benefits package defined.
Sec. 123. Health Benefits Advisory Committee.
Sec. 124. Process for adoption of recommendations; adoption of benefit standards.
Sec. 125. Prohibition of discrimination in health care services based on religious or spiritual content.

Subtitle D—Additional Consumer Protections

Sec. 131. Requiring fair marketing practices by health insurers.
Sec. 132. Requiring fair grievance and appeals mechanisms.
Sec. 133. Requiring information transparency and plan disclosure.
Sec. 134. Application to qualified health benefits plans not offered through the Health Insurance Exchange.
Sec. 135. Timely payment of claims.
Sec. 136. Standardized rules for coordination and subrogation of benefits.
Sec. 137. Application of administrative simplification.
Sec. 138. Records relative to prescription information.

Subtitle E—Governance

Sec. 141. Health Choices Administration; Health Choices Commissioner.
Sec. 142. Duties and authority of Commissioner.
Sec. 143. Consultation and coordination.
Sec. 144. Health Insurance Ombudsman.

Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 151. Relation to other requirements.
Sec. 152. Prohibiting discrimination in health care.
Sec. 153. Whistleblower protection.
Sec. 154. Construction regarding collective bargaining.
Sec. 155. Severability.
Sec. 156. Rule of construction regarding Hawaii Prepaid Health Care Act.
Sec. 157. Increasing meaningful use of electronic health records.
Sec. 158. Private right of contract with health care providers.

Subtitle G—Early Investments

[For sections 161-163. See text of introduced bill.]
Sec. 164. Reinsurance program for retirees.
Sec. 165. Prohibition against post-retirement reductions of retiree health benefits by group health plans.
Sec. 166. Limitations on preexisting condition exclusions in group health plans in advance of applicability of new prohibition of preexisting condition exclusions.
Sec. 167. Extension of COBRA continuation coverage.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

Sec. 201. Establishment of Health Insurance Exchange; outline of duties; definitions.
Sec. 202. Exchange-eligible individuals and employers.
Sec. 203. Benefits package levels.
Sec. 204. Contracts for the offering of Exchange-participating health benefits plans.
Sec. 205. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.
Sec. 206. Other functions.
Sec. 207. Health Insurance Exchange Trust Fund.
Sec. 208. Optional operation of State-based health insurance exchanges.
Sec. 209. Participation of small employer benefit arrangements.

Subtitle B—Public Health Insurance Option

Sec. 221. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan.
Sec. 222. Premiums and financing.
Sec. 223. Payment rates for items and services.
Sec. 224. Modernized payment initiatives and delivery system reform.
Sec. 225. Provider participation.
Sec. 226. Application of fraud and abuse provisions.
Sec. 227. Sense of the House regarding enrollment of Members in the public option.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability through Health Insurance Exchange.
Sec. 242. Affordable credit eligible individual.
Sec. 243. Affordable premium credit.
Sec. 244. Affordability cost-sharing credit.
Sec. 245. Income determinations.
Sec. 246. No Federal payment for undocumented aliens.

Subtitle D—State Innovation

Sec. 251. Waiver of ERISA limitation; application instead of state single payer system.
Sec. 252. Requirements.
Sec. 253. Definitions.

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Sec. 301. Individual responsibility.

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

Sec. 311. Health coverage participation requirements.
Sec. 312. Employer responsibility to contribute towards employee and dependent coverage.
Sec. 313. Employer contributions in lieu of coverage.
Sec. 314. Authority related to improper steering.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

Sec. 321. Satisfaction of health coverage participation requirements under the Employee Retirement Income Security Act of 1974.
Sec. 324. Additional rules relating to health coverage participation requirements.

[FOR TITLE IV, SEE TEXT OF INTRODUCED BILL.]

(c) GENERAL DEFINITIONS.—Except as otherwise provided, in this division:

(1) ACCEPTABLE COVERAGE.—The term "acceptable coverage" has the meaning given such term in section 202(d)(2).

(2) BASIC PLAN.—The term "basic plan" has the meaning given such term in section 203(c).

(3) COMMISSIONER.—The term "Commissioner" means the Health Choices Commissioner established under section 141.

(4) COST-SHARING.—The term "cost-sharing" includes deductibles, coinsurance, copayments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.

(5) DEPENDENT.—The term "dependent" has the meaning given such term by the Commissioner and includes a spouse.

(6) EMPLOYMENT-BASED HEALTH PLAN.—The term "employment-based health plan"—

(A) means a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974);

(B) includes such a plan that is the following:

(i) FEDERAL, STATE, AND TRIBAL GOVERNMENTAL PLANS.—A governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), including a health benefits plan offered under chapter 89 of title 5, United States Code; or

(ii) CHURCH PLANS.—A church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974); and

(C) excludes coverage described in section 202(d)(2)(E) (relating to TRICARE).

(7) ENHANCED PLAN.—The term "enhanced plan" has the meaning given such term in section 203(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term "essential benefits package" is defined in section 122(a).

(9) FAMILY.—The term "family" means an individual and includes the individual's dependents.

(10) FEDERAL POVERTY LEVEL; FPL.—The terms "Federal poverty level" and "FPL" have the meaning given the term "poverty line" in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(11) HEALTH BENEFITS PLAN.—The terms "health benefits plan" means health insurance coverage and an employment-based health plan and includes the public health insurance option.

(12) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms in section 2791 of the Public Health Service Act.

(13) HEALTH INSURANCE EXCHANGE.—The term "Health Insurance Exchange" means the Health Insurance Exchange established under section 201.

(14) MEDICAID.—The term "Medicaid" means a State plan under title XIX of the Social Security Act (whether or not the plan is operating under a waiver under section 1115 of such Act).

(15) MEDICARE.—The term "Medicare" means the health insurance programs under title XVIII of the Social Security Act.

(16) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(17) PLAN YEAR.—The term "plan year" means—

(A) with respect to an employment-based health plan, a plan year as specified under such plan; or

(B) with respect to a health benefits plan other than an employment-based health plan, a 12-month period as specified by the Commissioner.

(18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms "premium plan" and "premium-plus plan" have the meanings given such terms in section 203(c).

(19) QHBP OFFERING ENTITY.—The terms "QHBP offering entity" means, with respect to a health benefits plan that is—

(A) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, except that, in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such term means such employer;

(B) health insurance coverage, the health insurance issuer offering the coverage;

(C) the public health insurance option, the Secretary of Health and Human Services;

(D) a non-Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the State or political subdivision of a State (or agency or instrumentality of such State or subdivision) which establishes or maintains such plan; or

(E) a Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the appropriate Federal official.

(20) QUALIFIED HEALTH BENEFITS PLAN.—The term "qualified health benefits plan" means a health benefits plan that meets the requirements for such a plan under title I and includes the public health insurance option.

(21) PUBLIC HEALTH INSURANCE OPTION.—The term "public health insurance option" means the public health insurance option as provided under subtitle B of title II.

(22) SERVICE AREA; PREMIUM RATING AREA.—The terms "service area" and "premium rating area" mean with respect to health insurance coverage—

(A) offered other than through the Health Insurance Exchange, such an area as established by the QHBP offering entity of such coverage in accordance with applicable State law; and

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

(23) STATE.—The term "State" means the 50 States and the District of Columbia.

(24) STATE MEDICAID AGENCY.—The term "State Medicaid agency" means, with respect to a Medicaid plan, the single State agency responsible for administering such plan under title XIX of the Social Security Act.

(25) Y1, Y2, ETC..—The terms "Y1" , "Y2", "Y3", "Y4", "Y5", and similar subsequently numbered terms, mean 2013 and subsequent years, respectively.

(26) EMPLOYEE PREMIUM.—The term "employee premium" does not include a collectively bargained premium in the case of a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974) that is a multiemployer plan (as defined in section 3(37) of such Act).

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

(a) PURPOSE.—The purpose of this title is to establish standards to ensure that new health insurance coverage and employment-based health plans that are offered meet standards guaranteeing access to affordable coverage, essential benefits, and other consumer protections.

(b) REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS.—On or after the first day of Y1, a health benefits plan shall not be a qualified health benefits plan under this division unless the plan meets the applicable requirements of the following subtitles for the type of plan and plan year involved:

(1) Subtitle B (relating to affordable coverage).

(2) Subtitle C (relating to essential benefits).

(3) Subtitle D (relating to consumer protection).

(c) TERMINOLOGY.—In this division:

(1) ENROLLMENT IN EMPLOYMENT-BASED HEALTH PLANS.—An individual shall be treated as being "enrolled" in an employment-based health plan if the individual is a participant or beneficiary (as such terms are defined in section 3(7) and 3(8), respectively, of the Employee Retirement Income Security Act of 1974) in such plan.

(2) INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.—The terms "individual health insurance coverage" and "group health insurance coverage" mean health insurance coverage offered in the individual market or large or small group market, respectively, as defined in section 2791 of the Public Health Service Act.

(d) SENSE OF CONGRESS ON HEALTH CARE NEEDS OF UNITED STATES TERRITORIES.—It is the sense of the Congress that the reforms made by H.R. 3200, as introduced, must be strengthened to meaningfully address the health care needs of residents of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands and Congress is committed to working with the representatives of these territories to ensure that residents of these territories have access to high-quality and affordable health care in such a way that best serves their unique needs.

SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) GRANDFATHERED HEALTH INSURANCE COVERAGE DEFINED.—Subject to the succeeding provisions of this section, for purposes of establishing acceptable coverage under this division, the term "grandfathered health insurance coverage" means individual health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT.—

(A) IN GENERAL.—Except as provided in this paragraph, the individual health insurance issuer offering such coverage does not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y1.

(B) DEPENDENT COVERAGE PERMITTED.—Subparagraph (A) shall not affect the subsequent enrollment of a dependent of an individual who is covered as of such first day.

(2) LIMITATION ON CHANGES IN TERMS OR CONDITIONS.—Subject to paragraph (3) and except as required by law, the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1.

(3) RESTRICTIONS ON PREMIUM INCREASES.—The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

(b) GRACE PERIOD FOR CURRENT EMPLOYMENT-BASED HEALTH PLANS.—

(1) GRACE PERIOD.—

(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 101, including the essential benefit package requirement under section 121.

(B) EXCEPTION FOR LIMITED BENEFITS PLANS.—Subparagraph (A) shall not apply to an employment-based health plan in which the coverage consists only of one or more of the following:

(i) Any coverage described in section 3001(a)(1)(B)(ii)(IV) of division B of the American Recovery and Reinvestment Act of 2009 (PL 111–5).

(ii) Excepted benefits (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974), including coverage under a specified disease or illness policy described in paragraph (3)(A) of such section.

(iii) Such other limited benefits as the Commissioner may specify.

In no case shall an employment-based health plan in which the coverage consists only of one or more of the coverage or benefits described in clauses (i) through (iii) be treated as acceptable coverage under this division

(2) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE.—During the grace period specified in paragraph (1)(A), an employment-based health plan that is described in such paragraph shall be treated as acceptable coverage under this division.

(3) EXCEPTION FOR CONSUMER-DIRECTED HEALTH PLANS AND ARRANGEMENTS.—In the case of a group health plan which consists of a consumer-directed health plan or arrangement (including a high deductible health plan, within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986), such group health plan shall be treated as acceptable coverage under a current group health plan for purposes of this division.

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may only be offered on or after the first day of Y1 as an Exchange-participating health benefits plan.

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Excepted benefits (as defined in section 2791(c) of the Public Health Service Act) are not included within the definition of health insurance coverage. Nothing in paragraph (1) shall prevent the offering, other than through the Health Insurance Exchange, of excepted benefits so long as it is offered and priced separately from health insurance coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any pre-existing condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any health status-related factors (as defined in section 2791(d)(9) of the Public Health Service Act) in relation to the individual or dependent.

SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS.

The requirements of sections 2711 (other than subsections (c) and (e)) and 2712 (other than paragraphs (3), and (6) of subsection (b) and subsection (e)) of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such section 2712(b)(1) shall apply only if, before nonrenewal or discontinuation of coverage, the issuer has provided the enrollee with notice of non-payment of premiums and there is a grace period during which the enrollees has an opportunity to correct such nonpayment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in sections 2712(b)(2) of such Act.

SEC. 113. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for an insured qualified health benefits plan may not vary except as follows:

(1) LIMITED AGE VARIATION PERMITTED.—By age (within such age categories as the Commissioner shall specify) so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1.

(2) BY AREA.—By premium rating area (as permitted by State insurance regulators or, in the case of Exchange-participating health benefits plans, as specified by the Commissioner in consultation with such regulators).

(3) BY FAMILY ENROLLMENT.—By family enrollment (such as variations within categories and compositions of families) so long as the ratio of the premium for family enrollment (or enrollments) to the premium for individual enrollment is uniform, as specified under State law and consistent with rules of the Commissioner.

(b) STUDY AND REPORTS.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large group insured and self-insured employer health care markets. Such study shall examine the following:

(A) The types of employers by key characteristics, including size, that purchase insured products versus those that self-insure.

(B) The similarities and differences between typical insured and self-insured health plans.

(C) The financial solvency and capital reserve levels of employers that self-insure by employer size.

(D) The risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent.

(E) The extent to which rating rules are likely to cause adverse selection in the large group market or to encourage small and mid size employers to self-insure

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations the Commissioner deems appropriate to ensure that the law does not provide incentives for small and mid-size employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. Not later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations.

SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

(a) NONDISCRIMINATION IN BENEFITS.—A qualified health benefits plan shall comply with standards established by the Commissioner to prohibit discrimination in health benefits or benefit structures for qualified health benefits plans, building from sections 702 of Employee Retirement Income Security Act of 1974, 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.

(b) PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.—To the extent such provisions are not superceded by or inconsistent with subtitle C, the provisions of section 2705 (other than subsections (a)(1), (a)(2), and (c)) of section 2705 of the Public Health Service Act shall apply to a qualified health benefits plan, regardless of whether it is offered in the individual or group market, in the same manner as such provisions apply to health insurance coverage offered in the large group market.

SEC. 115. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) IN GENERAL.—A qualified health benefits plan that uses a provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such networks in ensuring enrollee access to such items and services and transparency in the cost-sharing differentials between in-network coverage and out-of-network coverage.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a current listing of all providers in its network on its website and such data shall be available on the Health Insurance Exchange website as a 'click through' from the basic information on that plan. The Commissioner shall also establish an on-line system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) PROVIDER NETWORK DEFINED.—In this division, the term "provider network" means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.

The QHBP offering entity shall provide that for any plan year in which a qualified health benefits plan that the entity offers has a medical loss ratio (expressed as a percentage) that is less than a percentage (not less than 85 percent) specified by the Commissioner, the QHBP offering entity offering such plan shall provide for rebates to enrollees of payment sufficient to meet such loss ratio. The Commissioner shall establish a uniform definition of medical loss ratio and methodology for determining how to calculate the medical loss ratio. Such methodology shall be designed to take into account the special circumstances of smaller and newer plans.

SEC. 117. CONSISTENCY OF COSTS AND COVERAGE UNDER QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

In the case of health insurance coverage offered under a qualified health benefits plan, the coverage and cost of coverage may not be changed during the course of a plan year except to increase coverage to the enrollee or to lower costs to the enrollee.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

(a) IN GENERAL.—A qualified health benefits plan shall provide coverage that at least meets the benefit standards adopted under section 124 for the essential benefits package described in section 122 for the plan year involved.

(b) CHOICE OF COVERAGE.—

(1) NON-EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of a qualified health benefits plan that is not an Exchange-participating health benefits plan, such plan may offer such coverage in addition to the essential benefits package as the QHBP offering entity may specify.

(2) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of an Exchange-participating health benefits plan, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium-plus level of benefits, provide additional benefits.

(3) CONTINUATION OF OFFERING OF SEPARATE EXCEPTED BENEFITS COVERAGE.—Nothing in this division shall be construed as affecting the offering of health benefits in the form of excepted benefits (described in section

102(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

(c) NO RESTRICTIONS ON COVERAGE UNRELATED TO CLINICAL APPROPRIATENESS.—A qualified health benefits plan may not impose any restriction (other than cost-sharing) unrelated to clinical appropriateness on the coverage of the health care items and services.

SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term "essential benefits package" means health benefits coverage, consistent with standards adopted under section 124 to ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;

(4) complies with section 115(a) (relating to network adequacy); and

(5) is equivalent, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage.

(b) MINIMUM SERVICES TO BE COVERED.—The items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and including mental health and substance abuse services recommended by the Task Force on Clinical Preventive Services and those mental health and substance abuse services with compelling research or evidence, including Screening, Brief Intervention and Referral to Treatment (SBIRT), and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well baby and well child care and early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act) at least for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for preventive items and services (as specified under the benefit standards), including well baby and well child care.

(2) ANNUAL LIMITATION.—

(A) ANNUAL LIMITATION.—The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).

(B) APPLICABLE LEVEL.—The applicable level specified in this subparagraph for Y1 is $5,000 for an individual and $10,000 for a family. Such levels shall be increased (rounded to the nearest $100) for each subsequent year by the annual percentage increase in the Consumer Price Index (United States city average) applicable to such year.

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the

full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

(2) CHAIR.—The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee.

(3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) 9 members who are not Federal employees or officers and who are appointed by the President.

(B) 9 members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint.

The membership of the Committee shall include one or more experts in scientific evidence and clinical practice of integrative health care services. Such initial appointments shall be made not later than 60 days after the date of the enactment of this Act.

(4) TERMS.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term on the Committee, except that the terms of the initial members shall be adjusted in order to provide for a staggered term of appointment for all such members.

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, employers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in care for those with disabilities, representatives of relevant governmental agencies. and at least one practicing physician or other health professional and an expert on children's health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee. The membership of the Committee shall also include educated patients, consumer advocates, or both, who shall include persons who represent individuals affected by a specific disease or medical condition, are knowledgeable about the health care system, and have received training regarding health, medical, and scientific matters.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") benefit standards (as defined in paragraph (4)), and periodic updates to such standards. In developing such recommendations, the Committee shall—

(A) take into account innovation in health care,

(B) consider how such standards could reduce health disparities,

(C) take into account integrative health care services, and

(D) take into account typical multiemployer plan benefit structures and the impact of the essential benefit package on such plans.

(2) DEADLINE.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(3) STATE INPUT.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act. The Health Benefits Advisory Committee shall also seek input from the States and consider recommendations on how to ensure that the quality of health coverage does not decline in any State.

(4) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this subsection.

(5) BENEFIT STANDARDS DEFINED.—In this subtitle, the term "benefit standards" means standards respecting—

(A) the essential benefits package described in section 122, including categories of covered treatments, items and services within benefit classes, and cost-sharing; and

(B) the cost-sharing levels for enhanced plans and premium plans (as provided under section 203(c)) consistent with paragraph (5).

(6) LEVELS OF COST-SHARING FOR ENHANCED AND PREMIUM PLANS.—

(A) ENHANCED PLAN.—The level of cost-sharing for enhanced plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 85 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(B) PREMIUM PLAN.—The level of cost-sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(7) RECOMMENDATIONS OF INTEGRATIVE HEALTH CARE SERVICES TASK FORCE.—

(A) INCLUSION IN COMMITTEE'S RECOMMENDATIONS.—The Health Benefits Advisory Committee shall include in its recommendations under paragraph (1) the recommendations made by the Integrative Health Care Services Task Force established under subparagraph (B).

(B) ESTABLISHMENT OF TASK FORCE.—The Health Benefits Advisory Committee shall establish an Integrative Health Care Services Task Force. Such Task Force shall consist of 5 experts with expertise in research in, and practice of, integrative health care. Such experts shall be appointed by the Committee from among experts nominated by the Secretary, in consultation with the National Center for Complementary and Alternative Medicine at the National Institutes of Health. The duty of the Task Force shall be to make recommendations to the Committee on evidence-based, clinically effective, and safe integrative care services.

(c) OPERATIONS.—

(1) PER DIEM PAY.—Each member of the Health Benefits Advisory Committee shall receive travel expenses, including per diem in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code, and shall otherwise serve without additional pay.

(2) MEMBERS NOT TREATED AS FEDERAL EMPLOYEES.—Members of the Health Benefits Advisory Committee shall not be considered employees of the Federal government solely by reason of any service on the Committee.

(3) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the Health Benefits Advisory Committee.

(d) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

(1) REVIEW OF RECOMMENDED STANDARDS.—Not later than 45 days after the date of receipt of benefit standards recommended under section 123 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

(2) DETERMINATION TO ADOPT STANDARDS.—If the Secretary determines—

(A) to propose adoption of benefit standards so recommended as a package, the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption such standards; or

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) CONTINGENCY.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of initial benefit standards by such deadline.

(4) PUBLICATION.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under this subsection.

(b) ADOPTION OF STANDARDS.—

(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall, through the rulemaking process consistent with subsection (a), adopt an initial set of benefit standards.

(2) PERIODIC UPDATING STANDARDS.—Under subsection (a), the Secretary shall provide for the periodic updating of the benefit standards previously adopted under this section.

(3) REQUIREMENT.—The Secretary may not adopt any benefit standards for an essential benefits package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 122 and 123(b)(5).

SEC. 125 PROHIBITION OF DISCRIMINATION IN HEALTH CARE SERVICES BASED ON RELIGIOUS OR SPIRITUAL CONTENT.

Neither the Commissioner nor any health insurance issuer offering health insurance coverage through the Exchange shall discriminate in approving or covering a health care service on the basis of its religious or spiritual content if expenditures for such a health care service are allowable as a deduction under 213(d) of the Internal Revenue Code of 1986, as in effect on January 1, 2009.

Subtitle D—Additional Consumer Protections

SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

The Commissioner shall establish uniform marketing standards that all insured QHBP offering entities shall meet.

SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

(a) IN GENERAL.—A QHBP offering entity shall provide for timely grievance and appeals mechanisms that the Commissioner shall establish.

(b) INTERNAL CLAIMS AND APPEALS PROCESS.—Under a qualified health benefits plan the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update such process in accordance with any standards that the Commissioner may establish.

(c) EXTERNAL REVIEW PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent, and de novo review of denied claims under this division.

(2) REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.—A determination made, with respect to a qualified health benefits plan offered by a QHBP offering entity, under the external review process established under this subsection shall be binding on the plan and the entity.

(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the availability of judicial review under State law for adverse decisions under subsection (b) or (c), subject to section 151.

SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) IN GENERAL.—A qualified health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner. The Commissioner shall require that such disclosure be provided in plain language.

(2) PLAIN LANGUAGE.—In this subsection, the term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clean, concise, well-organized, and follows other best practices of plain language writing.

(3) GUIDANCE.—The Commissioner shall develop and issue guidance on best practices of plain language writing.

(b) CONTRACTING REIMBURSEMENT.—A qualified health benefits plan shall comply with standards established by the Commissioner to ensure transparency to each health care provider relating to reimbursement arrangements between such plan and such provider.

(c) ADVANCE NOTICE OF PLAN CHANGES.—A change in a qualified health benefits plan shall not be made without such reasonable and timely advance notice to enrollees of such change.

(d) IDENTIFICATION OF PROVIDERS TRAINED AND ACCREDITED IN INTEGRATIVE MEDICINE.—A qualified health benefit plan shall include in the disclosure required under subsection (a) identification to enrollees of any providers of services under the plan that are trained and accredited in integrative health medicine.

SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS PLANS NOT OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

The requirements of the previous provisions of this subtitle shall apply to qualified health benefits plans that are not being offered through the Health Insurance Exchange only to the extent specified by the Commissioner.

SEC. 135. TIMELY PAYMENT OF CLAIMS.

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to a qualified health benefits plan it offers in the same manner an Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 136. STANDARDIZED RULES FOR COORDINATION AND SUBROGATION OF BENEFITS.

The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.

SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

A QHBP offering entity is required to comply with standards for electronic financial and administrative transactions under section 1173A of the Social Security Act, added by section 163(a).

SEC. 138. RECORDS RELATIVE TO PRESCRIPTION INFORMATION.

(a) IN GENERAL.—A qualified health benefits plan shall ensure that its records relative to prescription information containing patient identifiable and prescriber-identifiable data are maintained in accordance with this section."

(b) REQUIREMENTS.—

(1) IN GENERAL.—Records described in subsection (a) may not be licensed, transferred, used, or sold by any pharmacy benefits manager, insurance company, electronic transmission intermediary, retail, mail order, or Internet pharmacy or other similar entity, for any commercial purpose, except for the limited purposes of—

(A) pharmacy reimbursement;

(B) formulary compliance;

(C) care management;

(D) utilization review by a health care provider, the patient's insurance provider or the agent of either;

(E) health care research; or

(F) as otherwise provided by law.

(2) COMMERCIAL PURPOSE.—For purposes of paragraph (1), the term "commercial purpose" includes, but is not limited to, advertising, marketing, promotion, or any activity that could be used to influence sales or market share of a pharmaceutical product, influence or evaluate the prescribing behavior of an individual health care professional, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(c) CONSTRUCTION.—

(1) PERMITTED PRACTICES.—Nothing in this section shall prohibit—

(A) the dispensing of prescription medications to a patient or to the patient's authorized representative;

(B) the transmission of prescription information between an authorized prescriber and a licensed pharmacy;

(C) the transfer of prescription information between licensed pharmacies;

(D) the transfer of prescription records that may occur in the event a pharmacy ownership is changed or transferred;

(E) care management educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy, or other information about the drug being dispensed, treatment options, or clinical trials.

(2) DE-IDENTIFIED DATA.—Nothing in this section shall prohibit the collection, use, transfer, or sale of patient and prescriber de-identified data by zip code, geographic region, or medical specialty for commercial purposes.

Subtitle E—Governance

SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH CHOICES COMMISSIONER.

(a) IN GENERAL.—There is hereby established, as an independent agency in the executive branch of the Government, a Health Choices Administration (in this division referred to as the "Administration").

(b) COMMISSIONER.—

(1) IN GENERAL.—The Administration shall be headed by a Health Choices Commissioner (in this division referred to as the "Commissioner") who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) COMPENSATION; ETC.—The provisions of paragraphs (2), (5) and (7) of subsection (a) (relating to compensation, terms, general powers, rulemaking, and delegation) of section 702 of the Social Security Act (42 U.S.C. 902) shall apply to the Commissioner and the Administration in the same manner as such provisions apply to the Commissioner of Social Security and the Social Security Administration.

SEC. 142. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) DUTIES.—The Commissioner is responsible for carrying out the following functions under this division:

(1) QUALIFIED PLAN STANDARDS.—The establishment of qualified health benefits plan standards under this title, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH INSURANCE EXCHANGE.—The establishment and operation of a Health Insurance Exchange under subtitle A of title II.

(3) INDIVIDUAL AFFORDABILITY CREDITS.—The administration of individual affordability credits under subtitle C of title II, including determination of eligibility for such credits.

(4) ADDITIONAL FUNCTIONS.—Such additional functions as may be specified in this division.

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(A) IN GENERAL.—The commissioner shall, in coordination with States, conduct audits of qualified health benefits plan compliance with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected non-compliance.

(B) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities.

(c) DATA COLLECTION.—The Commissioner shall collect data for purposes of carrying out the Commissioner's duties, including for purposes of promoting quality and value, protecting consumers, and addressing disparities in health and health care and may share such data with the Secretary of Health and Human Services.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—In the case that the Commissioner determines that a QHBP offering entity violates a requirement of this title, the Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph, with respect to a qualified health benefits plan offered by a QHBP offering entity, are—

(A) civil money penalties of not more than the amount that would be applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act;

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the entity under the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner notifies the

entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the requirements of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 208 and 241(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 143. CONSULTATION AND COORDINATION.

(a) CONSULTATION.—In carrying out the Commissioner's duties under this division, the Commissioner, as appropriate, shall consult with at least with the following:

(1) The National Association of Insurance Commissioners, State attorneys general, and State insurance regulators, including concerning the standards for insured qualified health benefits plans under this title and enforcement of such standards.

(2) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of title II and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(3) Other appropriate Federal agencies.

(4) Indian tribes and tribal organizations.

(5) The National Association of Insurance Commissioners for purposes of using model guidelines established by such association for purposes of subtitles B and D.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner, in coordination with such entities, shall seek to achieve uniform standards that adequately protect consumers in a manner that does not unreasonably affect employers and insurers.

SEC. 144. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Qualified Health Benefits Plan Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals.

(b) DUTIES.—The Qualified Health Benefits Plan Ombudsman shall, in a linguistically appropriate manner—

(1) receive complaints, grievances, and requests for information submitted by individuals;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant information needed to seek an appeal of a decision or determination;

(B) assistance to such individuals with any problems arising from disenrollment from such a plan;

(C) assistance to such individuals in choosing a qualified health benefits plan in which to enroll; and

(D) assistance to such individuals in presenting information under subtitle C (relating to affordability credits);

(3) consult with educated patients and consumer advocates (described in section 123(a)(5)); and

(4) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any in-

creases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 151. RELATION TO OTHER REQUIREMENTS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan), and in the case of employment-based health plans, the requirements of this title do not supercede any requirements applicable under titles XXII and XXVII of the Public Health Service Act, parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange—

(A) the requirements of this title do not supercede any requirements (including requirements relating to genetic information nondiscrimination and mental health) applicable under title XXVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

(B) individual rights and remedies under State laws shall apply.

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws with respect to any requirement referred to in paragraph (1)(A).

SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services.

(b) IMPLEMENTATION.—To implement the requirement set forth in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including insurance coverage and public health activities) covered by this Act are provided (whether directly or through contractual, licensing, or other arrangements) without regard to personal characteristics extraneous to the provision of high quality health care or related services.

SEC. 153. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or any person acting pursuant to a request of the employee)—

(1) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of any provision of this Act or any order, rule, or regulation promulgated under this Act;

(2) testified or is about to testify in a proceeding concerning such violation;

(3) assisted or participated or is about to assist or participate in such a proceeding; or

(4) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act.

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of subsection (a) may bring an action gov-

erned by the rules, procedures, legal burdens of proof, and remedies set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(c) EMPLOYER DEFINED.—As used in this section, the term "employer" means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

(d) RULE OF CONSTRUCTION.—The rule of construction set forth in section 20109(h) of title 49, United States Code, shall also apply to this section.

SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

Nothing in this division shall be construed to alter or supercede any statutory or other obligation to engage in collective bargaining over the terms and conditions of employment related to health care.

SEC. 155. SEVERABILITY.

If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, the remainder of the provisions of this Act and the application of the provision to any other person or circumstance shall not be affected.

SEC. 156. RULE OF CONSTRUCTION REGARDING HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)), and such exemption shall also apply with respect to the provisions of this division, and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate officials of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 157. INCREASING MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS.

(a) STUDY.—The Commissioner shall conduct a study on methods that QHBP offering entities can use to encourage increased meaningful use of electronic health records by health care providers, including—

(1) qualified health benefits plans offering higher reimbursement rates for such meaningful use; and

(2) promoting the use by health care providers of low-cost available electronic health record software packages, such as software made available to health care providers by the Veterans Administration.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commissioner shall submit to the Congress a report containing—

(1) the results of the study under subsection (a); and

(2) recommendations concerning whether qualified health benefits plans should increase reimbursement rates to health care providers to increase meaningful use of electronic health records by such providers.

(c) REQUIREMENTS.—

(1) IN GENERAL.—Not later than one year after the date the report is submitted to the Congress under subsection (b), if, under subsection (b)(2), the Commissioner recommends increased reimbursement rates, the Commissioner shall require that qualified health benefits plans increase reimbursement rates for health care providers that show meaningful use of electronic health records.

(2) COST LIMITATION.—An increase in rates under paragraph (1) shall not result in any increase in affordability premium or cost-sharing credits under subtitle C of title II of this division.

SEC. 158. PRIVATE RIGHT OF CONTRACT WITH HEALTH CARE PROVIDERS.

Nothing in this Act shall be construed to preclude any participant or beneficiary in a group health plan from entering into any contract or arrangement for health care with any health care provider.

Subtitle G—Early Investments

SEC. 161-163. [*For sections 161 through 163, see the text of H.R.3200, as introduced.***]**

SEC. 164. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a temporary reinsurance program (in this section referred to as the "reinsurance program") to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

(2) DEFINITIONS.—For purposes of this section:

(A) The term "eligible employment-based plan" means a group health benefits plan that—

(i) is maintained by one or more employers, former employers or employee associations, or a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan, and

(ii) provides health benefits to retirees.

(B) The term "health benefits" means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded or delivered through the purchase of insurance or otherwise.

(C) The term "participating employment-based plan" means an eligible employment-based plan that is participating in the reinsurance program.

(D) The term "retiree" means, with respect to a participating employment-benefit plan, an individual who—

(i) is 55 years of age or older;

(ii) is not eligible for coverage under title XVIII of the Social Security Act; and

(iii) is not an active employee of an employer maintaining the plan or of any employer that makes or has made substantial contributions to fund such plan.

(E) The term "Secretary" means Secretary of Health and Human Services.

(b) PARTICIPATION.—To be eligible to participate in the reinsurance program, an eligible employment-based plan shall submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—Under the reinsurance program, a participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) BASIS FOR CLAIMS.—Each claim submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the appropriate employment based health benefits provided to a retiree or to the spouse, surviving spouse, or dependent of a retiree. In determining the amount of any claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefits. For purposes of calculating the amount of any claim, the costs paid by the retiree or by the spouse, surviving spouse, or dependent of the retiree in the form of deductibles, co-payments, and co-insurance shall be included along with the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS AND LIMIT.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceeds $15,000, but is less than

$90,000. Such amounts shall be adjusted each year based on the percentage increase in the medical care component of the Consumer Price Index (rounded to the nearest multiple of $1,000) for the year involved.

(3) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower the costs borne directly by the participants and beneficiaries for health benefits provided under such plan in the form of premiums, co-payments, deductibles, co-insurance, or other out-of-pocket costs. Such payments shall not be used to reduce the costs of an employer maintaining the participating employment-based plan. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

(4) APPEALS AND PROGRAM PROTECTIONS.—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

(5) AUDITS.—The Secretary shall conduct annual audits of claims data submitted by participating employment-based plans under this section to ensure that they are in compliance with the requirements of this section.

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the "Retiree Reserve Trust Fund" (referred to in this section as the "Trust Fund"), that shall consist of such amounts as may be appropriated or credited to the Trust Fund as provided for in this subsection to enable the Secretary to carry out the reinsurance program. Such amounts shall remain available until expended.

(B) FUNDING.—There are hereby appropriated to the Trust Fund, out of any moneys in the Treasury not otherwise appropriated, an amount requested by the Secretary as necessary to carry out this section, except that the total of all such amounts requested shall not exceed $10,000,000,000.

(C) APPROPRIATIONS FROM THE TRUST FUND.—

(i) IN GENERAL.—Amounts in the Trust Fund are appropriated to provide funding to carry out the reinsurance program and shall be used to carry out such program.

(ii) BUDGETARY IMPLICATIONS.—Amounts appropriated under clause (i), and outlays flowing from such appropriations, shall not be taken into account for purposes of any budget enforcement procedures including allocations under section 302(a) and (b) of the Balanced Budget and Emergency Deficit Control Act and budget resolutions for fiscal years during which appropriations are made from the Trust Fund.

(iii) LIMITATION TO AVAILABLE FUNDS.—The Secretary has the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under the reinsurance program in order to ensure that expenditures under the reinsurance program do not exceed the funds available under this subsection.

SEC. 165. PROHIBITION AGAINST POST-RETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 714 the following new section:

"SEC. 715. PROTECTION AGAINST POST-RETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

"(a) IN GENERAL.—Every group health plan shall contain a provision which expressly bars the plan, or any fiduciary of the plan, from reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement unless such reduction is also made with respect to active participants.

"(b) NO REDUCTION.—Notwithstanding that a group health plan described in subsection (a) may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or his or her beneficiary under the terms of the plan if such reduction of benefits occurs after the date the participant retired for pur-

poses of the plan and reduces benefits that were provided to the participant, or his or her beneficiary, as of the date the participant retired unless such reduction is also made with respect to active participants.".

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 714 the following new item:

"Sec. 715. Protection against post-retirement reduction of retiree health benefits.".

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

SEC. 166. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS IN GROUP HEALTH PLANS IN ADVANCE OF APPLICABILITY OF NEW PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking "6-month period" and inserting "30-day period".

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 701(a)(2) of such Act (29 U.S.C. 1181(a)(2)) is amended by striking "12 months" and inserting "3 months", and by striking "18 months" and inserting "9 months".

(3) INAPPLICABILITY OF INTERIM LIMITATIONS UPON APPLICABILITY OF TOTAL PROHIBITION OF EXCLUSION.—Section 701 of such Act shall cease to be effective in the case of any group health plan as of the date on which such plan becomes subject to the requirements of section 111 of this Act (relating to prohibiting preexisting condition exclusions).

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by paragraphs (1) and (2) of subsection (a) shall apply with respect to group health plans for plan years beginning after the end of the 6th calendar month following the date of the enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by paragraphs (1) and (2) of subsection (a) shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) 3 years after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendments made by paragraphs (1) and (2) of subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 167. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) IN GENERAL.—In the case of any individual who is, under a COBRA continuation coverage provision, covered under COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated under the terms of such provision for any reason other than the expiration of a period of a specified number of months shall, notwithstanding such provision and subject to subsection (b), extend to the earlier of the date on which such individual becomes eligible for coverage under an employment-based health plan or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

(2) NOTICE.—As soon as practicable after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide or administer the COBRA continuation coverage involved, provide rules setting forth the form and manner in which prompt notice to individuals of the continued availability of COBRA continuation coverage to such individuals under paragraph (1).

(b) CONTINUED EFFECT OF OTHER TERMINATING EVENTS.—Notwithstanding subsection (a), any required period of COBRA continuation coverage which is extended

under such subsection shall terminate upon the occurrence, prior to the date of termination otherwise provided in such subsection, of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of a specified number of months.

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provision of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section solely by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired.

(d) DEFINITIONS.—For purposes of this section—

(1) COBRA CONTINUATION COVERAGE.—The term "COBRA continuation coverage" means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986.

(2) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means the provisions of law described in paragraph (1).

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE; OUTLINE OF DUTIES; DEFINITIONS.

(a) ESTABLISHMENT.—There is established within the Health Choices Administration and under the direction of the Commissioner a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 143(b), the Commissioner shall—

(1) under section 204 establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under section 203, and including with respect to oversight and enforcement;

(2) under section 205 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 202; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 206 and consumer protections under subtitle D of title I.

(c) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN DEFINED.—In this division, the term "Exchange-participating health benefits plan" means a qualified health benefits plan that is offered through the Health Insurance Exchange.

SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

(a) ACCESS TO COVERAGE.—In accordance with this section, all individuals are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Health Insurance Exchange unless such individuals are enrolled in another qualified health benefits plan or other acceptable coverage.

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term "Exchange-eligible individual" means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term "Exchange-eligible employer" means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms "employer", "employee", "full-time employee", and "part-time employee" have the meanings given such terms by the Commissioner for purposes of this division.

(c) TRANSITION.—Individuals and employers shall only be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following transition schedule:

(1) FIRST YEAR.—In Y1 (as defined in section 100(c))—

(A) individuals described in subsection (d)(1), including individuals described in paragraphs (3), (4), and (5) of subsection (d); and

(B) smallest employers described in subsection (e)(1).

(2) SECOND YEAR.—In Y2—

(A) individuals and employers described in paragraph (1); and

(B) smaller employers described in subsection (e)(2).

(3) THIRD YEAR.—In Y3—

(A) individuals and employers described in paragraph (2);

(B) larger employers described in subsection (e)(3); and

(C) largest employers as permitted by the Commissioner under subsection (e)(4).

(4) FOURTH AND SUBSEQUENT YEARS.—In Y4 and subsequent years—

(A) individuals and employers described in paragraph (3); and

(B) largest employers as permitted by the Commissioner under subsection (e)(4).

(d) INDIVIDUALS.—

(1) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who—

(A) is not enrolled in coverage described in subparagraphs (C) through (F) of paragraph (2); and

(B) is not enrolled in coverage as a full-time employee (or as a dependent of such an employee) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 312.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirements of section 312, such individual shall be deemed a full-time employee described in such subparagraph.

(2) ACCEPTABLE COVERAGE.—For purposes of this division, the term "acceptable coverage" means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102) or under a current group health plan (described in subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (z), or (aa) of section 1902 of such Act

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Commissioner in coordination with the Secretary of Treasury to be not less than a level specified by the Commissioner and Secretary of Veteran's Affairs, in coordination with the Secretary of Treasury, based on the individual's priority for services as provided under section 1705(a) of such title.

(G) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this paragraph.

The Commissioner shall make determinations under this paragraph in coordination with the Secretary of the Treasury.

(3) TREATMENT OF CERTAIN NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—An individual who is a non-traditional Medicaid eligible individual (as

defined in section 205(e)(4)(C)) in a State may be an Exchange-eligible individual if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the 6 months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual has chosen to enroll in an Exchange-participating health benefits plan, the individual is not also eligible for medical assistance under Medicaid.

(4) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under this subsection (including as an employee or dependent of an employee of an Exchange-eligible employer) and enrolls under an Exchange-participating health benefits plan through the Health Insurance Exchange, the individual shall continue to be treated as an Exchange-eligible individual until the individual is no longer enrolled with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to an individual once the individual becomes eligible for coverage—

(I) under part A of the Medicare program;

(II) under the Medicaid program as a Medicaid eligible individual, except as permitted under paragraph (3) or clause (ii); or

(III) in such other circumstances as the Commissioner may provide.

(ii) TRANSITION PERIOD.—In the case described in clause (i)(II), the Commissioner shall permit the individual to continue treatment under subparagraph (A) until such limited time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual's access to health care.

(5) ADVERSELY AFFECTED RETIREE HEALTH BENEFITS GROUP PARTICIPANTS AND BENEFICIARIES.—

(A) IN GENERAL.—Beginning in Y1, an individual who is a participant or beneficiary in an adversely affected retiree health benefits group who does not have coverage described in paragraph (2)(C) is an Exchange eligible individual, whether or not such an individual has other acceptable coverage.

(B) ADVERAGE AFFECTED RETIREE HEALTH BENEFIT GROUP DEFINED.—In this paragraph, the term "adversely affected retiree health benefits group" means the retired participants and their beneficiaries of a group health plan that cancelled or substantially reduced the amount, type, level, or form of health benefit or option provided prior January 1, 2008.

(e) EMPLOYERS.—

(1) SMALLEST EMPLOYERS.—Subject to paragraph (5), smallest employers described in this paragraph are employers with 15 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (5), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and that have 25 or fewer employees.

(3) LARGER EMPLOYERS.—Subject to paragraph (5), larger employers described in this paragraph are employers that are not smallest employers described in paragraph (1) or smaller employers described in paragraph (2) and that have 50 or fewer employees.

(4) LARGEST EMPLOYERS.—

(A) IN GENERAL.—Beginning with Y3, the Commissioner may permit employers not described in paragraphs (1) (2), or (3) to be Exchange-eligible employers.

(B) PHASE-IN.—In applying subparagraph (A), the Commissioner may phase-in the application of such subparagraph based on the number of full-time employees of an employer and such other considerations as the Commissioner deems appropriate.

(5) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement of section 311(a) through paragraph (1) of such section by offering a group health plan and not through offering Exchange-participating health benefits plan.

(6) EMPLOYER PARTICIPATION AND CONTRIBUTIONS.—

(A) SATISFACTION OF EMPLOYER RESPONSIBILITY.—For any year in which an employer is an Exchange-eligible employer, such employer may meet the requirements of section 312 with respect to employees of such employer by

offering such employees the option of enrolling with Exchange-participating health benefits plans through the Health Insurance Exchange consistent with the provisions of subtitle B of title III.

(B) EMPLOYEE CHOICE.—Any employee offered Exchange-participating health benefits plans by the employer of such employee under subparagraph (A) may choose coverage under any such plan. That choice includes, with respect to family coverage, coverage of the dependents of such employee.

(7) AFFILIATED GROUPS.—Any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated, for purposes of this subtitle, as a single employer.

(8) OTHER COUNTING RULES.—The Commissioner shall establish rules relating to how employees are counted for purposes of carrying out this subsection.

(9) TREATMENT OF MULTIEMPLOYER PLANS.—The plan sponsor of a group health plan (as defined in section 733(a) of the Employee Retirement Income Security Act of 1974) that is multiemployer plan (as defined in section 3(37) of such Act) may obtain health insurance coverage with respect to participants in the plan through the Exchange to the same extent as an employer not described in paragraph (1) or (2) is permitted by the Commissioner to obtain health insurance coverage through the Exchange as an Exchange-eligible employer

(f) SPECIAL SITUATION AUTHORITY.—The Commissioner shall have the authority to establish such rules as may be necessary to deal with special situations with regard to uninsured individuals and employers participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

(g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The Commissioner shall provide for periodic surveys of Exchange-eligible individuals and employers concerning satisfaction of such individuals and employers with the Health Insurance Exchange and Exchange-participating health benefits plans.

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

(2) ITEMS INCLUDED IN STUDY.—Such study also shall examine—

(A) the terms, conditions, and affordability of group health coverage offered by employers and QHBP offering entities outside of the Exchange compared to Exchange-participating health benefits plans; and

(B) the affordability-test standard for access of certain employed individuals to coverage in the Health Insurance Exchange.

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress on the study conducted under this subsection and shall include in such report recommendations regarding changes in standards for Exchange eligibility for for individuals and employers.

SEC. 203. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title I and this section.

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The Commissioner may not enter into a contract with a QHBP offering entity under section 204(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

(1) REQUIRED OFFERING OF BASIC PLAN.—The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF ENHANCED PLAN.—If and only if the entity offers a basic plan for such service area, the entity may offer one enhanced plan for such area.

(3) OPTIONAL OFFERING OF PREMIUM PLAN.—If and only if the entity offers an enhanced plan for such service area, the entity may offer one premium plan for such area.

(4) OPTIONAL OFFERING OF PREMIUM-PLUS PLANS.—If and only if the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area.

All such plans may be offered under a single contract with the Commissioner.

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

(1) IN GENERAL.—The Commissioner shall establish the following standards consistent with this subsection and title I:

(A) BASIC, ENHANCED, AND PREMIUM PLANS.—Standards for 3 levels of Exchange-participating health benefits plans: basic, enhanced, and premium (in this division referred to as a "basic plan", "enhanced plan", and "premium plan", respectively).

(B) PREMIUM-PLUS PLAN BENEFITS.—Standards for additional benefits that may be offered, consistent with this subsection and subtitle C of title I, under a premium plan (such a plan with additional benefits referred to in this division as a "premium-plus plan") .

(2) BASIC PLAN.—

(A) IN GENERAL.—A basic plan shall offer the essential benefits package required under title I for a qualified health benefits plan.

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS.—In the case of an affordable credit eligible individual (as defined in section 242(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are modified to provide for the reduced cost-sharing for the income tier applicable to the individual under section 244(c).

(3) ENHANCED PLAN.—A enhanced plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title I consistent with section 123(b)(5)(A).

(4) PREMIUM PLAN.—A premium plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title I consistent with section 123(b)(5)(B).

(5) PREMIUM-PLUS PLAN.—A premium-plus plan is a premium plan that also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits shall be separately specified.

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 122.

(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.

SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.

(a) CONTRACTING DUTIES.—In carrying out section 201(b)(1) and consistent with this subtitle:

(1) OFFERING ENTITY AND PLAN STANDARDS.—The Commissioner shall—

(A) establish standards necessary to implement the requirements of this title and title I for—

(i) QHBP offering entities for the offering of an Exchange-participating health benefits plan; and

(ii) for Exchange-participating health benefits plans; and

(B) certify QHBP offering entities and qualified health benefits plans as meeting such standards and requirements of this title and title I for purposes of this subtitle.

(2) SOLICITING AND NEGOTIATING BIDS; CONTRACTS.—The Commissioner shall—

(A) solicit bids from QHBP offering entities for the offering of Exchange-participating health benefits plans;

(B) based upon a review of such bids, negotiate with such entities for the offering of such plans; and

(C) enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this title) negotiated between the Commissioner and such entities.

(3) FAR NOT APPLICABLE.—The provisions of the Federal Acquisition Regulation shall not apply to contracts between the Commissioner and QHBP offering

entities for the offering of Exchange-participating health benefits plans under this title.

(b) STANDARDS FOR QHBP OFFERING ENTITIES TO OFFER EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—The standards established under subsection (a)(1)(A) shall require that, in order for a QHBP offering entity to offer an Exchange-participating health benefits plan, the entity must meet the following requirements:

(1) LICENSED.—The entity shall be licensed to offer health insurance coverage under State law for each State in which it is offering such coverage.

(2) DATA REPORTING.—The entity shall provide for the reporting of such information as the Commissioner may specify, including information necessary to administer the risk pooling mechanism described in section 206(b) and information to address disparities in health and health care.

(3) IMPLEMENTING AFFORDABILITY CREDITS.—The entity shall provide for implementation of the affordability credits provided for enrollees under subtitle C, including the reduction in cost-sharing under section 244(c).

(4) ENROLLMENT.—The entity shall accept all enrollments under this subtitle, subject to such exceptions (such as capacity limitations) in accordance with the requirements under title I for a qualified health benefits plan. The entity shall notify the Commissioner if the entity projects or anticipates reaching such a capacity limitation that would result in a limitation in enrollment.

(5) RISK POOLING PARTICIPATION.—The entity shall participate in such risk pooling mechanism as the Commissioner establishes under section 206(b).

(6) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall contract for outpatient services with covered entities (as defined in section 340B(a)(4) of the Public Health Service Act, as in effect as of July 1, 2009). The Commissioner shall specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act.

(7) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS.—The entity shall provide for culturally and linguistically appropriate communication and health services.

(8) ADDITIONAL REQUIREMENTS.—The entity shall comply with other applicable requirements of this title, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums and related grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

(c) CONTRACTS.—

(1) BID APPLICATION.—To be eligible to enter into a contract under this section, a QHBP offering entity shall submit to the Commissioner a bid at such time, in such manner, and containing such information as the Commissioner may require.

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(3) ENFORCEMENT OF NETWORK ADEQUACY.—In the case of a health benefits plan of a QHBP offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 115; and

(B) an individual enrolled in such plan receives an item or service from a provider that is not within such network;

then any cost-sharing for such item or service shall be equal to the amount of such cost-sharing that would be imposed if such item or service was furnished by a provider within such network.

(4) OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES.—The Commissioner shall establish processes, in coordination with State insurance regulators, to oversee, monitor, and enforce applicable requirements of this title with respect to QHBP offering entities offering Exchange-participating health benefits plans and such plans, including the marketing of such plans. Such processes shall include the following:

(A) GRIEVANCE AND COMPLAINT MECHANISMS.—The Commissioner shall establish, in coordination with State insurance regulators, a process under

which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 142(c).

(C) TERMINATION.—

(i) IN GENERAL.—The Commissioner may terminate a contract with a QHBP offering entity under this section for the offering of an Exchange-participating health benefits plan if such entity fails to comply with the applicable requirements of this title. Any determination by the Commissioner to terminate a contract shall be made in accordance with formal investigation and compliance procedures established by the Commissioner under which—

(I) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner's determination; and

(II) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(ii) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Clause (i) shall not apply if the Commissioner determines that a delay in termination, resulting from compliance with the procedures specified in such clause prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under the qualified health benefits plan of the QHBP offering entity.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of title I with respect to an entity for a violation of such a requirement.

SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(1) OUTREACH.—The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (4) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments.

(2) ELIGIBILITY.—The Commissioner shall make timely determinations of whether individuals and employers are Exchange-eligible individuals and employers (as defined in section 202).

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

(A) OPEN ENROLLMENT PERIOD.—The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll in an Exchange-participating health benefits plan for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be during September through November of each year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be less than 30 days.

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

(ii) experiences a change in marital or other dependent status;

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(C) ENROLLMENT INFORMATION.—The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(3) AUTOMATIC ENROLLMENT FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) SUBSIDIZED INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an Exchange-eligible individual who is either of the following:

(i) AFFORDABILITY CREDIT ELIGIBLE INDIVIDUALS.—The individual—

(I) has applied for, and been determined eligible for, affordability credits under subtitle C;

(II) has not opted out from receiving such affordability credit; and

(III) does not otherwise enroll in another Exchange-participating health benefits plan.

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) and who does not otherwise enroll in another Exchange-participating health benefits plan.

(4) DIRECT PAYMENT OF PREMIUMS TO PLANS.—Under the enrollment process, individuals enrolled in an Exchange-partcipating health benefits plan shall pay such plans directly, and not through the Commissioner or the Health Insurance Exchange.

(c) COVERAGE INFORMATION AND ASSISTANCE.—

(1) COVERAGE INFORMATION.—The Commissioner shall provide for the broad dissemination of information on Exchange-participating health benefits plans offered under this title. Such information shall be provided in a comparative manner, and shall include information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction.

(2) CONSUMER ASSISTANCE WITH CHOICE.—To provide assistance to Exchange-eligible individuals and employers, the Commissioner shall—

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet website through which individuals may obtain information on coverage under Exchange-participating health benefits plans and file complaints;

(B) develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities;

(C) assist Exchange-eligible individuals in selecting Exchange-participating health benefits plans and obtaining benefits through such plans; and

(D) ensure that the Internet website described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 133(a)(2)).

(3) USE OF OTHER ENTITIES.—In carrying out this subsection, the Commissioner may work with other appropriate entities to facilitate the dissemination of information under this subsection and to provide assistance as described in paragraph (2).

(d) SPECIAL DUTIES RELATED TO MEDICAID AND CHIP.—

(1) COVERAGE FOR CERTAIN NEWBORNS.—

(A) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, for the period of time beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

(i) to be a non-traditional Medicaid eligible individual (as defined in subsection (e)(5)) for purposes of this division and Medicaid; and

(ii) to have elected to enroll in Medicaid through the application of paragraph (3).

(B) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in subparagraph (A) who at the end of the period referred to in such subparagraph is not otherwise covered

under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(c)(1) of the Social Security Act) to be a traditional Medicaid eligible individual described in section 1902(l)(1)(B) of such Act.

(2) CHIP TRANSITION.—A child who, as of the day before the first day of Y1, is eligible for child health assistance under title XXI of the Social Security Act (including a child receiving coverage under an arrangement described in section 2101(a)(2) of such Act) is deemed as of such first day to be an Exchange-eligible individual unless the individual is a traditional Medicaid eligible individual as of such day.

(3) AUTOMATIC ENROLLMENT OF MEDICAID ELIGIBLE INDIVIDUALS INTO MEDICAID.—The Commissioner shall provide for a process under which an individual who is described in section 202(d)(3) and has not elected to enroll in an Exchange-participating health benefits plan is automatically enrolled under Medicaid.

(4) NOTIFICATIONS.—The Commissioner shall notify each State in Y1 and for purposes of section 1902(gg)(1) of the Social Security Act (as added by section 1703(a)) whether the Health Insurance Exchange can support enrollment of children described in paragraph (2) in such State in such year.

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—

(A) CHOICE FOR LIMITED EXCHANGE-ELIGIBLE INDIVIDUALS.—As part of the enrollment process under subsection (b), the Commissioner shall provide the option, in the case of an Exchange-eligible individual described in section 202(d)(3), for the individual to elect to enroll under Medicaid instead of under an Exchange-participating health benefits plan. Such an individual may change such election during an enrollment period under subsection (b)(2).

(B) MEDICAID ENROLLMENT OBLIGATION.—An Exchange eligible individual may apply, in the manner described in section 241(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4). In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(2) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—In the case of a non-traditional Medicaid eligible individual described in section 202(d)(3) who elects to enroll under Medicaid under paragraph (1)(A), the Commissioner shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4).

(3) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State (each in this division referred to as a "Medicaid memorandum of understanding") with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State's Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State Medicaid plan.

(4) MEDICAID ELIGIBLE INDIVIDUALS.—For purposes of this division:

(A) MEDICAID ELIGIBLE INDIVIDUAL.—The term "Medicaid eligible individual" means an individual who is eligible for medical assistance under Medicaid.

(B) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term "traditional Medicaid eligible individual" means a Medicaid eligible individual other than an individual who is—

(i) a Medicaid eligible individual by reason of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(ii) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(C) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term "non-traditional Medicaid eligible individual" means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

(f) EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

SEC. 206. OTHER FUNCTIONS.

(a) COORDINATION OF AFFORDABILITY CREDITS.—The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits under subtitle C to QHBP offering entities offering Exchange-participating health benefits plans.

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

(c) SPECIAL INSPECTOR GENERAL FOR THE HEALTH INSURANCE EXCHANGE.—

(1) ESTABLISHMENT; APPOINTMENT.—There is hereby established the Office of the Special Inspector General for the Health Insurance Exchange, to be headed by a Special Inspector General for the Health Insurance Exchange (in this subsection referred to as the "Special Inspector General") to be appointed by the President, by and with the advice and consent of the Senate. The nomination of an individual as Special Inspector General shall be made as soon as practicable after the establishment of the program under this subtitle.

(2) DUTIES.—The Special Inspector General shall—

(A) conduct, supervise, and coordinate audits, evaluations and investigations of the Health Insurance Exchange to protect the integrity of the Health Insurance Exchange, as well as the health and welfare of participants in the Exchange;

(B) report both to the Commissioner and to the Congress regarding program and management problems and recommendations to correct them;

(C) have other duties (described in paragraphs (2) and (3) of section 121 of division A of Public Law 110–343) in relation to the duties described in the previous subparagraphs; and

(D) have the authorities provided in section 6 of the Inspector General Act of 1978 in carrying out duties under this paragraph.

(3) APPLICATION OF OTHER SPECIAL INSPECTOR GENERAL PROVISIONS.—The provisions of subsections (b) (other than paragraphs (1) and (3)), (d) (other than paragraph (1)), and (e) of section 121 of division A of the Emergency Economic Stabilization Act of 2009 (Public Law 110–343) shall apply to the Special Inspector General under this subsection in the same manner as such provisions apply to the Special Inspector General under such section.

(4) REPORTS.—Not later than one year after the confirmation of the Special Inspector General, and annually thereafter, the Special Inspector General shall submit to the appropriate committees of Congress a report summarizing the activities of the Special Inspector General during the one year period ending on the date such report is submitted.

(5) TERMINATION.—The Office of the Special Inspector General shall terminate five years after the date of the enactment of this Act.

(d) ASSISTANCE FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—The Commissioner, in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers counseling and technical assistance with respect to the provision of health insurance to employees of such employers through the Health Insurance Exchange.

(2) DUTIES.—The program established under paragraph (1) shall include the following services:

(A) Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options.

(B) Distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health

Insurance Exchange, including standardized comparative information on the health plans available under the Health Insurance Exchange.

(C) Distribution of information to small employers with respect to available affordability credits or other financial assistance.

(D) Referrals to appropriate entities of complaints and questions relating to the Health Insurance Exchange.

(E) Enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange.

(F) Responses to questions relating to the Health Insurance Exchange and the program established under paragraph (1).

(3) AUTHORITY TO PROVIDE SERVICES DIRECTLY OR BY CONTRACT.—The Commissioner may provide services under paragraph (2) directly or by contract with nonprofit entities that the Commissioner determines capable of carrying out such services.

(4) SMALL EMPLOYER DEFINED.—In this subsection, the term "small employer" means an employer with less than 100 employees.

SEC. 207. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE TRUST FUND.—There is created within the Treasury of the United States a trust fund to be known as the "Health Insurance Exchange Trust Fund" (in this section referred to as the "Trust Fund"), consisting of such amounts as may be appropriated or credited to the Trust Fund under this section or any other provision of law.

(b) PAYMENTS FROM TRUST FUND.—The Commissioner shall pay from time to time from the Trust Fund such amounts as the Commissioner determines are necessary to make payments to operate the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(c) TRANSFERS TO TRUST FUND.—

(1) DEDICATED PAYMENTS.—There is hereby appropriated to the Trust Fund amounts equivalent to the following:

(A) TAXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals).

(B) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 3111(c) of the Internal Revenue Code of 1986 (relating to employers electing to not provide health benefits).

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b) plus such amounts as are necessary reduced by the amounts deposited under paragraph (1).

(d) APPLICATION OF CERTAIN RULES.—Rules similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange, then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange if it meets the requirements for approval under subsection (b).

(b) REQUIREMENTS FOR APPROVAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(1) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(A) negotiating and contracting with QHBP offering entities for the offering of Exchange-participating health benefits plan, which satisfy the standards and requirements of this title and title I;

(B) enrolling Exchange-eligible individuals and employers in such State in such plans;

(C) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(D) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Government which does exceed the cost to the Federal Government if this section did not apply; and

(E) enforcement activities consistent with federal requirements.

(2) There is no more than one Health Insurance Exchange operating with respect to any one State.

(3) The State provides assurances satisfactory to the Commissioner that approval of such an Exchange will not result in any net increase in expenditures to the Federal Government.

(4) The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Commissioner that it will vigorously enforce violations of applicable requirements.

(5) Such other requirements as the Commissioner may specify.

(c) CEASING OPERATION.—

(1) IN GENERAL.—A State-based Health Insurance Exchange may, at the option of each State involved, and only after providing timely and reasonable notice to the Commissioner, cease operation as such an Exchange, in which case the Health Insurance Exchange shall operate, instead of such State-based Health Insurance Exchange, with respect to such State (or States).

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Exchange under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such requirements of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

(3) EFFECTIVENESS.—The ceasing or termination of a State-based Health Insurance Exchange under this subsection shall be effective in such time and manner as the Commissioner shall specify.

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

(A) may not be performed by a State-based Health Insurance Exchange under this section; or

(B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(e) REFERENCES.—In the case of a State-based Health Insurance Exchange, except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be assistance provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 209. PARTICIPATION OF SMALL EMPLOYER BENEFIT ARRANGEMENTS.

(a) IN GENERAL.—The Commissioner may enter into contracts with small employer benefit arrangements to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an arrangement under Exchange participating health benefits plans.

(b) SMALL EMPLOYER BENEFIT ARRANGEMENT DEFINED.—In this section, the term "small employer benefit arrangement" means a not-for-profit agricultural or other cooperative that—

(1) consists solely of its members and is operated for the primary purpose of providing affordable employee benefits to its members;

(2) only has as members small employers in the same industry or line of business;

(3) has no member that has more than a 5 percent voting interest in the cooperative; and

(4) is governed by a board of directors elected by its members.

Subtitle B—Public Health Insurance Option

SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with Y1, the Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the "public health insurance option") that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without comprimising quality or access to care.

(b) OFFERING AS AN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—

(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

(A) shall offer basic, enhanced, and premium plans; and

(B) may offer premium-plus plans.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce disparities in health and health care based on race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation as determined appropriate by the Secretary, but only if the data collection is conducted on a voluntary basis and consistent with the standards, including privacy protections, established pursuant to section 1709 of the Public Health Service Act.

(f) TREATMENT OF PUBLIC HEALTH INSURANCE OPTION.—With respect to the public health insurance option, the Secretary shall be treated as a QHBP offering entity offering an Exchange-participating health benefits plan.

(g) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 222. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

(1) IN GENERAL.—The Secretary shall establish geographically-adjusted premium rates for the public health insurance option in a manner—

(A) that complies with the premium rules established by the Commissioner under section 113 for Exchange-participating health benefit plans; and

(B) at a level sufficient to fully finance the costs of—

(i) health benefits provided by the public health insurance option; and

(ii) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall include an appropriate amount for a contingency margin.

(b) ACCOUNT.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States an Account for the receipts and disbursements attributable to the operation of the public health insurance option, including the start-up funding under paragraph (2). Section 1854(g) of the Social Security Act shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

(2) START-UP FUNDING.—

(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under subparagraph (A) to the Treasury in an amortized manner over the 10-year period beginning with Y1.

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) RATES ESTABLISHED BY SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish payment rates for the public health insurance option for services and health care providers consistent with this section and may change such payment rates in accordance with section 224.

(2) INITIAL PAYMENT RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B) and subsection (b)(1), during Y1, Y2, and Y3, the Secretary shall base the payment rates under this section for services and providers described in paragraph (1) on the payment rates for similar services and providers under parts A and B of Medicare.

(B) EXCEPTIONS.—

(i) PRACTITIONERS' SERVICES.—Payment rates for practitioners' services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this paragraph shall be not less than 1 percent.

(ii) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this subtitle.

(3) FOR NEW SERVICES.—The Secretary shall modify payment rates described in paragraph (2) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(4) PRESCRIPTION DRUGS.—Payment rates under this section for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(1) INITIAL INCENTIVE PERIOD.—

(A) IN GENERAL.—The Secretary shall provide, in the case of services described in subparagraph (B) furnished during Y1, Y2, and Y3, for payment rates that are 5 percent greater than the rates established under subsection (a).

(B) SERVICES DESCRIBED.—The services described in this subparagraph are items and professional services, under the public health insurance option by a physician or other health care practitioner who participates in both Medicare and the public health insurance option.

(C) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subparagraph (A).

(2) SUBSEQUENT PERIODS.— Beginning with Y4 and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care consistent with section 221(a). Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subsection (a)(2) and paragraph (1) of this subsection were continued.

(3) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary.

(c) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this section but not to the specific methodology for establishing such rates or the calculation of such rates.

(d) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the provisions of section 221(a) and the amounts paid for similar health care providers and services under other Exchange-participating health benefits plans.

(e) CONSTRUCTION.—Nothing in this subtitle shall be construed as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services, such as the initiatives provided for under section 224.

(f) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 224.

SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(a) IN GENERAL.—For plan years beginning with Y1, the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.

(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficent and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

(2) promotes care that is integrated, patient-centered, quality, and efficient.

(c) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

(d) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

SEC. 225. PROVIDER PARTICIPATION.

(a) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

(b) LICENSURE OR CERTIFICATION.—The Secretary shall not allow a health care provider to participate in the public health insurance option unless such provider

is appropriately licensed, certified, or otherwise permitted to practice under State law.

(c) PAYMENT TERMS FOR PROVIDERS.—

(1) PHYSICIANS.—The Secretary shall provide for the annual participation of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment rate described in section 223 for such physicians) that exceed the ratio permitted under section 1848(g)(2)(C) of the Social Security Act.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(d) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from participation under the public health insurance option a health care provider that is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act).

SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

Provisions of law (other than criminal law provisions) identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as the False Claims Act (31 U.S.C. 3729 et seq.), shall also apply to the public health insurance option.

SEC. 227. SENSE OF THE HOUSE REGARDING ENROLLMENT OF MEMBERS IN THE PUBLIC OPTION.

It is the sense of the House of Representatives that Members who vote in favor of the establishment of a public, Federal Government run health insurance option, and senior members of the President's administration, are urged to forgo their right to participate in the Federal Employees Health Benefits Program (FEHBP) and agree to enroll under that public option.

Subtitle C—Individual Affordability Credits

SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, in the case of an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

(A) an affordability premium credit under section 243 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 244 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

(2) the Commissioner shall pay the QHBP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate amount of affordability credits for all affordable credit eligible individuals enrolled in such plan.

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle.The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that indi-

viduals with limited English proficiency are able to apply for affordability credits.

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding (as defined in section 205(c)(4))—

(A) the State Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination; and

(B) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(3) MEDICAID SCREEN AND ENROLL OBLIGATION.—In the case of an application made under paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(c) USE OF AFFORDABILITY CREDITS.—

(1) IN GENERAL.—In Y1 and Y2 an affordable credit eligible individual may use an affordability credit only with respect to a basic plan.

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability credit to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordable credit amount otherwise applicable if the individual had enrolled in a basic plan.

(d) ACCESS TO DATA.—In carrying out this subtitle, the Commissioner shall request from the Secretary of the Treasury consistent with section 6103 of the Internal Revenue Code of 1986 such information as may be required to carry out this subtitle.

(e) NO CASH REBATES.—In no case shall an affordable credit eligible individual receive any cash payment as a result of the application of this subtitle.

SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term "affordable credit eligible individual" means, subject to subsection (b), an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 312;

(B) with family income below 400 percent of the Federal poverty level for a family of the size involved; and

(C) who is not a Medicaid eligible individual, other than an individual described in section 202(d)(3) or an individual during a transition period under section 202(d)(4)(B)(ii).

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of the same family who are affordable credit eligible individuals shall be treated as a single affordable credit individual eligible for the applicable credit for such a family under this subtitle.

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the term "affordable credit eligible individual" does not include a full-time employee of an employer if the employer offers the employee coverage (for the employee and dependents) as a full-time employee under a group health plan if the coverage and employer contribution under the plan meet the requirements of section 312.

(2) EXCEPTIONS.—

(A) FOR CERTAIN FAMILY CIRCUMSTANCES.—The Commissioner shall establish such exceptions and special rules in the case described in paragraph (1) as may be appropriate in the case of a divorced or separated individual

or such a dependent of an employee who would otherwise be an affordable credit eligible individual.

(B) FOR UNAFFORDABLE EMPLOYER COVERAGE.—For years beginning with Y2, in the case of full-time employees for which the cost of the employee premium (plus, to the extent specified by the Commissioner, out-of-pocket cost-sharing for such year or the preceding year) for coverage under a group health plan would exceed 11 percent of current family income (determined by the Commissioner on the basis of verifiable documentation and without regard to section 245), paragraph (1) shall not apply.

(c) INCOME DEFINED.—

(1) IN GENERAL.—In this title, the term "income" means modified adjusted gross income (as defined in section 59B of the Internal Revenue Code of 1986).

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) CLARIFICATION OF TREATMENT OF AFFORDABILITY CREDITS.—Affordabilty credits under this subtitle shall not be treated, for purposes of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to be a benefit provided under section 403 of such title.

SEC. 243. AFFORDABLE PREMIUM CREDIT.

(a) IN GENERAL.—The affordability premium credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in an amount equal to the amount (if any) by which the premium for the plan (or, if less, the reference premium amount specified in subsection (c)), exceeds the affordable premium amount specified in subsection (b) for the individual.

(b) AFFORDABLE PREMIUM AMOUNT.—

(1) IN GENERAL.—The affordable premium amount specified in this subsection for an individual for monthly premium in a plan year shall be equal to 1/12 of the product of—

(A) the premium percentage limit specified in paragraph (2) for the individual based upon the individual's family income for the plan year; and

(B) the individual's family income for such plan year.

(2) PREMIUM PERCENTAGE LIMITS BASED ON TABLE.—The Commissioner shall establish premium percentage limits so that for individuals whose family income is within an income tier specified in the table in subsection (d) such percentage limits shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier.

(c) REFERENCE PREMIUM AMOUNT.—The reference premium amount specified in this subsection for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium levels. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) TABLE OF PREMIUM PERCENTAGE LIMITS AND ACTUARIAL VALUE PERCENTAGES BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subtitle, the table specified in this subsection is as follows:

In the case of family income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	The actuarial value percentage is—
133% through 150%	1.5%	3%	97%
150% through 200%	3%	5%	93%
200% through 250%	5%	7%	85%
250% through 300%	7%	9%	78%
300% through 350%	9%	10%	72%
350% through 400%	10%	11%	70%

(2) SPECIAL RULES.—For purposes of applying the table under paragraph (1)—

(A) FOR LOWEST LEVEL OF INCOME.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133% of FPL.

(B) APPLICATION OF HIGHER ACTUARIAL VALUE PERCENTAGE AT TIER TRANSITION POINTS.—If two actuarial value percentages may be determined with respect to an individual, the actuarial value percentage shall be the higher of such percentages.

SEC. 244. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's family income.

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing specified in section 122(c)(2)(B) under a basic plan for each income tier specified in the table under section 243(d), with respect to a year, in a manner so that, as estimated by the Commissioner, the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual cost-sharing limit) is equal to the actuarial value percentage (specified in the table under section 243(d) for the income tier involved) of the full actuarial value if there were no cost-sharing imposed under the plan.

(c) DETERMINATION AND PAYMENT OF COST-SHARING AFFORDABILITY CREDIT.—In the case of an affordable credit eligible individual in a tier enrolled in an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner shall provide for payment to the offering entity of an amount equivalent to the increased actuarial value of the benefits under the plan provided under section 203(c)(2)(B) resulting from the reduction in cost-sharing described in subsection (b).

SEC. 245. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be the income (as defined in section 242(c)) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty level applied shall be such level in effect as of the date of the application.

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

(1) PROGRAM INTEGRITY.—The Commissioner shall take such steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 242(b)) or upon an application for a change in the affordability credit based upon a significant change in family income described in subparagraph (A)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be permitted to verify the information contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(B) ALTERNATIVE PROCEDURES.—The Commissioner shall establish procedures for the verification of income for purposes of this subtitle if no income tax return is available for the most recent completed tax year.

(c) SPECIAL RULES.—

(1) CHANGES IN INCOME AS A PERCENT OF FPL.—In the case that an individual's income (expressed as a percentage of the Federal poverty level for a family of the size involved) for a plan year is expected (in a manner specified by the Commissioner) to be significantly different from the income (as so expressed) used under subsection (a), the Commissioner shall establish rules requiring an individual to report, consistent with the mechanism established under paragraph (2), significant changes in such income (including a significant change in family composition) to the Commissioner and requiring the substitution of such income for the income otherwise applicable.

(2) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner when there is a significant change in the family income of the individual (expressed as a percentage of the FPL for a family of the size involved) and of the information regarding such change. Such mechanism shall provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the family income of the individual,the Commissioner shall provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

(3) TRANSITION FOR CHIP.—In the case of a child described in section 202(d)(2), the Commissioner shall establish rules under which the family income of the child is deemed to be no greater than the family income of the child

as most recently determined before Y1 by the State under title XXI of the Social Security Act.

(4) STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.—The Commissioner shall examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Commissioner determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) PENALTIES FOR MISREPRESENTATION.—In the case of an individual intentionally misrepresents family income or the individual fails (without regard to intent) to disclose to the Commissioner a significant change in family income under subsection (c) in a manner that results in the individual becoming an affordable credit eligible individual when the individual is not or in the amount of the affordability credit exceeding the correct amount—

(1) the individual is liable for repayment of the amount of the improper affordability credit; ;and

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States.

Subtitle D—State Innovation

SEC. 251. WAIVER OF ERISA LIMITATION; APPLICATION INSTEAD OF STATE SINGLE PAYER SYSTEM.

(a) IN GENERAL.—A State may request from the Secretary, and the Secretary must grant except under extraordinary circumstances, a waiver of application of section 514 of the Employee Retirement Income Security Act of 1974 with respect to a state single payer system enacted into law by such State that would be structured and operate in a manner consistent with this subtitle. The Secretary shall provide for the revocation of any waiver granted under this section upon a determination made by the Secretary that the requirements of the preceding sentence are no longer being met.

(b) EFFECT OF WAIVER.—During any period for which a waiver under subsection (a) is in effect—

(1) the provisions of section 514 of the Employee Retirement Income Security Act of 1974 shall not apply with respect to the State single payer system; and

(2) the State single payer system shall operate in the State instead of the public health insurance option or the National Health Exchange.

(c) CONSTRUCTION.—Nothing in this subtitle shall be construed to limit or otherwise affect the transfer and allocation under this Act of funds to States with single payer systems.

SEC. 252. REQUIREMENTS.

A State single payer system shall—

(1)) provide benefits that meet or exceed the standards of coverage and quality of care set forth in this Act; and

(2) ensure that the cost to the Federal Government resulting from the waiver granted under section 261 is neither substantially greater nor substantially less than would have been the case in the absence of such waiver, except that:

(A) the State may seek and benefit from planning and start-up funds with respect to the system; and

(B) nothing in this paragraph shall be construed to preclude allowance for normal variations in population demographics, health status, and other factors exogenous to the health care system that may affect differences in costs.

SEC. 253. DEFINITIONS.

(a) STATE SINGLE PAYER SYSTEM.—The term "State single payer system" means, in connection with a State, a non-profit program of the State for providing health care—

(1) in which a single agency of the State is responsible for financing health care benefits for all residents of the State and for the administration or supervision of the administration of the program;

(2) under which private insurance duplicating the benefits provided in the single payer program is prohibited;

(3) which provides comprehensive health benefits to all residents of the State, and provides measures to assure free choice of providers for covered services, to promote quality, and to help resolve complaints and disputes between consumers and providers; and

(4) under which participation by health maintenance organizations is limited to non-profit health maintenance organizations that own their own delivery facilities and employ physicians on salary, and funding is limited to services that the health maintenance organizations actually deliver; and

(5) which may be maintained by such State together one or more other States in a geographic region.

(b) SECRETARY.—The term "Secretary" means the Secretary of Labor, acting in consultation with the Secretary of Health and Human Services.

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 301. INDIVIDUAL RESPONSIBILITY.

For an individual's responsibility to obtain acceptable coverage, see section 59B of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—An employer meets the requirements of this section if such employer does all of the following:

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 102(b))) in accordance with section 312.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 312.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2, if an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 313.

(b) HARDSHIP EXEMPTION.—Notwithstanding any other provision of this part, an employer may, in a form and manner which shall be prescribed by the Secretary, apply to the Secretary for a waiver from the health coverage participation requirements of this part for any 2-year period. The Secretary shall grant the waiver within 30 days after submission of the application if the application reasonably demonstrates to the Secretary that meeting the requirements of this part would result in job losses that would negatively impact the employer or the community in which the employer is located.

SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARDS EMPLOYEE AND DEPENDENT COVERAGE.

(a) IN GENERAL.—An employer meets the requirements of this section with respect to an employee if the following requirements are met:

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 311(1) either through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer timely pays to the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

(3) PROVISION OF INFORMATION.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section.

(4) AUTOENROLLMENT OF EMPLOYEES.—The employer provides for autoenrollment of the employee in accordance with subsection (c).

(b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH MINIMUM EMPLOYER CONTRIBUTION.—

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986) under a qualified health benefits plan (or current employment-based health plan) is equal to—

(A) in case of individual coverage, not less than 72.5 percent of the applicable premium (as defined in section 4980B(f)(4) of such Code, subject to paragraph (2)) of the lowest cost plan offered by the employer that is a qualified health benefits plan (or is such current employment-based health plan); and

(B) in the case of family coverage which includes coverage of such spouse and children, not less 65 percent of such applicable premium of such lowest cost plan.

(2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 243(c) for individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution under this subsection with respect to a full-time employee that reflects the proportion of—

(A) the average weekly hours of employment of the employee by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

(4) SALARY REDUCTIONS NOT TREATED AS EMPLOYER CONTRIBUTIONS.—For purposes of this section, any contribution on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer.

(c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPONSORED HEALTH BENEFITS.—

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll suchs employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

(2) OPT-OUT.—In no case may an employer automatically enroll an employee in a plan under paragraph (1) if such employee makes an affirmative election to opt out of such plan or to elect coverage under an employment-based health benefits plan offered by such employer. An employer shall provide an employee with a 30-day period to make such an affirmative election before the employer may automatically enroll the employee in such a plan.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—Each employer described in paragraph (1) who automatically enrolls an employee into a plan as described in such paragraph shall provide the employees, within a reasonable period before the beginning of each plan year (or, in the case of new employees, within a reasonable period before the end of the enrollment period for such a new employee), written notice of the employees' rights and obligations relating to the automatic enrollment requirement under such paragraph. Such notice must be comprehensive and understood by the average employee to whom the automatic enrollment requirement applies.

(B) INCLUSION OF SPECIFIC INFORMATION.—The written notice under subparagraph (A) must explain an employee's right to opt out of being automatically enrolled in a plan and in the case that more than one level of benefits or employee premium level is offered by the employer involved, the notice must explain which level of benefits and employee premium level the employee will be automatically enrolled in the absence of an affirmative election by the employee.

SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

(a) IN GENERAL.—A contribution is made in accordance with this section with respect to an employee if such contribution is equal to an amount equal to 8 percent of the average wages paid by the employer during the period of enrollment (determined by taking into account all employees of the employer and in such manner as the Commissioner provides, including rules providing for the appropriate aggregation of related employers). Any such contribution—

(1) shall be paid to the Health Choices Commissioner for deposit into the Health Insurance Exchange Trust Fund, and

(2) shall not be applied against the premium of the employee under the Exchange-participating health benefits plan in which the employee is enrolled.

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—In the case of any employer who is a small employer for any calendar year, subsection (a) shall be applied by substituting the applicable percentage determined in accordance with the following table for "8 percent":

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $250,000	0 percent
Exceeds $250,000, but does not exceed $300,000	2 percent
Exceeds $300,000, but does not exceed $350,000	4 percent
Exceeds $350,000, but does not exceed $400,000	6 percent

(2) SMALL EMPLOYER.—For purposes of this subsection, the term "small employer" means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $400,000.

(3) ANNUAL PAYROLL.—For purposes of this paragraph, the term "annual payroll" means, with respect to any employer for any calendar year, the aggregate wages paid by the employer during such calendar year.

(4) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

SEC. 314. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plan (within the meaning of section 102(b)) offered by the employer and instead to enroll in an Exchange-participating health benefits plan. An employer violating such standards shall be treated as not meeting the requirements of this section.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"(a) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

"(b) TIME AND MANNER.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

"SEC. 802. TREATMENT OF COVERAGE RESULTING FROM ELECTION.

"(a) IN GENERAL.—If an employer makes an election to the Secretary under section 801—

"(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

"(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

"(b) PERIODIC INVESTIGATIONS TO DISCOVER NONCOMPLIANCE.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to such sampling of plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

"(c) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of the trade or business in which the employer is engaged, has engaged for the performance of labor or services.

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title III of division A of America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of such Act).

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

"(a) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election under section 801 shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

"(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

"(1) separate lines of business, and

"(2) full-time employees and employees who are not full-time employees.

"SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.

"The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

"SEC. 806. REGULATIONS.

"The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.".

(b) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "paragraph" and all that follows through "subsection (c)" and inserting "paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)"; and

(2) in subsection (c), by redesignating the second paragraph (10) as paragraph (12) and by inserting after the first paragraph (10) the following new paragraph:

"(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

"(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

"(B) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this paragraph, the term 'health coverage participation requirements' has the meaning provided in section 803.

"(C) LIMITATIONS ON AMOUNT OF PENALTY.—

"(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

"(I) such failure was due to reasonable cause and not to willful neglect, and

"(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under subparagraph (A) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

"(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding 1-year period for group health plans, or

"(II) $500,000.

"(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

"(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

"(F) DEPOSIT OF PENALTY COLLECTED.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous receipts in the Treasury of the United States.".

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 734 the following new items:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"Sec. 801. Election of employer to be subject to national health coverage participation requirements.
"Sec. 802. Treatment of coverage resulting from election.
"Sec. 803. Health coverage participation requirements.
"Sec. 804. Rules for applying requirements.
"Sec. 805. Termination of election in cases of substantial noncompliance.
"Sec. 806. Regulations.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

[For sections 322 and 323, see text of bill as introduced on June 14, 2009.]

SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

(1) regulations, rulings, and interpretations issued by such officers relating to the same matter over which two or more of such officers have responsibility under subpart B of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, section 4980H of the Internal Revenue Code of 1986, and section 2793 of the Public Health Service Act are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such officers in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(b) MULTIEMPLOYER PLANS.—In the case of a group health plan that is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the regulations prescribed in accordance with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing sponsors of such plan.

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

[For division B, see text of bill as introduced on July 14, 2009.]

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

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

Sec. 2001. Table of contents; references.
[For section 2002, see text of introduced bill.]

[FOR TEXT OF TITLES I THROUGH IV, SEE TEXT OF INTRODUCED BILL.]

TITLE V—OTHER PROVISIONS

[For Subtitles A, B, and C, See Text of Introduced Bill.]

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

[For Subtitle E, See Text of Introduced Bill.]

Sec. 2531. Establishment of grant program.

Subtitle F—Standards for Accessibility to Medical Equipment for Individuals With Disabilities.

Sec. 2541. Access for individuals with disabilities.

Subtitle G—Other Grant Programs

Sec. 2551. Reducing student-to-school nurse ratios.
Sec. 2552. Wellness program grants.
Sec. 2553. Health professions training for diversity programs.

Subtitle H—Long-term Care and Family Caregiver Support

Sec. 2561. Long-term care and family caregiver support.

Subtitle I—Online Resources

Sec. 2571. Web site on health care labor market and related educational and training opportunities.
Sec. 2572. Online health workforce training programs.

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

[For section 2002 and titles I through IV of division C, see text of bill as introduced on July 14, 2009.]

TITLE V—OTHER PROVISIONS

[For subtitles A through C of title V of division C, see text of bill as introduced on July 14, 2009.]

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

SEC. 2531. ESTABLISHMENT OF GRANT PROGRAM.

(a) PURPOSES.—It is the purpose of this section to authorize grants to—

(1) address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including Certified Nurse Assistants, Licensed Practical Nurses, Licensed Vocational Nurses, and Registered Nurses) for incumbent ancillary health care workers;

(2) increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and

(3) provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.

(b) GRANTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (referred to in this section as the "Secretary") shall establish a partnership grant program to award grants to eligible entities to carry out comprehensive programs to provide education to nurses and create a pipeline to nursing for incumbent ancillary health care workers who wish to advance their careers, and to otherwise carry out the purposes of this section.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

(1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer and that carries out activities using labor management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)(6));

(2) an entity that operates a training program that is jointly administered by—

(A) one or more health care providers or facilities, or a trade association of health care providers; and

(B) one or more organizations which represent the interests of direct care health care workers or staff nurses and in which the direct care health care workers or staff nurses have direct input as to the leadership of the organization;

(3) a State training partnership program that consists of nonprofit organizations that include equal participation from industry, including public or private employers, and labor organizations including joint labor-management training programs, and which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing; or

(4) a school of nursing (as defined in section 801 of the Public Health Service Act (42 U.S.C. 296)).

(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible for a grant under this section, a health care employer described in subsection (c) shall demonstrate that it—

(1) has an established program within their facility to encourage the retention of existing nurses;

(2) provides wages and benefits to its nurses that are competitive for its market or that have been collectively bargained with a labor organization; and

(3) supports programs funded under this section through 1 or more of the following:

(A) The provision of paid leave time and continued health coverage to incumbent health care workers to allow their participation in nursing career ladder programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.

(B) Contributions to a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work full- or part-time in a faculty position.

(D) The provision of paid release time for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced nursing degrees, specialty training, or certification program.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(e) OTHER REQUIREMENTS.—

(1) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subparagraph (A) may be in cash or in kind (including paid release time), fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) REQUIRED COLLABORATION.—Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs or specialty training or certification programs.

(f) USE OF FUNDS.—Amounts awarded to an entity under a grant under this section shall be used for the following:

(1) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English -as-a-second language education, GED education, pre-college counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preference for dedicated cohort classes in community colleges, universities, accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs that assist newly graduated nurses in adjusting to working at the bedside to ensure their retention postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incumbent health care workers to participate in these programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that—

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually evaluate, and submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include—

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of nurse faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

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

[For subtitle E of title V of division C, see text of bill as introduced on July 14, 2009.]

Subtitle F—Standards for Accessibility to Medical Equipment for Individuals With Disabilities.

SEC. 2541. ACCESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

"SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

"(a) STANDARDS.—Not later than 9 months after the date of enactment of the America's Affordable Health Choices Act of 2009, the Architectural and Transportation Barriers Compliance Board shall issue guidelines setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that such equipment is accessible to, and usable by, individuals with disabilities, including provisions to ensure independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

"(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.

"(c) INTERIM STANDARDS.—Until the date on which final regulations are issued under subsection (d), purchases of examination tables, weight scales, and mammography equipment and used in (or in conjunction with) medical settings described in subsection (a), shall adhere to the following interim accessibility requirements:

"(1) Examination tables shall be height-adjustable between a range of at least 18 inches to 37 inches.

"(2) Weight scales shall be capable of weighing individuals who remain seated in a wheelchair or other personal mobility aid.

"(3) Mammography machines and equipment shall be capable of being used by individuals in a standing, seated, or recumbent position, including individuals who remain seated in a wheelchair or other personal mobility aid.

"(d) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

"(1) prescribe regulations in an accessible format as necessary to carry out the provisions of such Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

"(2) ensure that health care providers and health care plans covered by the America's Affordable Health Choices Act of 2009 meet the requirements of the Americans with Disabilities Act and section 504, including provisions ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

"(e) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (d).".

Subtitle G—Other Grant Programs

SEC. 2551. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education, in consultation with the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention, may make demonstration grants to eligible local education agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies that demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the agency, in part by providing information on current ratios of students to school nurses.

(3) MATCHING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(b) REPORT.—Not later than 24 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(c) DEFINITIONS.—For purposes of this section:

(1) The terms "elementary school", "local educational agency", and "secondary school" have the meanings given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term "eligible local educational agency" means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students to every school nurse.

(3) The term "high-need local educational agency" means a local educational agency—

(A) that serves not fewer than 10,000 children from families with incomes below the poverty line; or

(B) for which not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(4) The term "nurse" means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

SEC. 2552. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

(1) IN GENERAL.—For purposes of this section, the Secretary of Labor shall award wellness grants as determined under this section. Wellness program grants shall be awarded to qualified employers for any plan year in an amount equal to 50 percent of the costs paid or incurred by the employer in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(2) LIMITATION.—The amount of the grant allowed under paragraph (1) for any plan year shall not exceed the sum of—

(A) the product of $200 and the number of employees of the employer not in excess of 200 employees; plus

(B) the product of $100 and the number of employees of the employer in excess of 200 employees.

The wellness grants awarded to an employer under this section shall be for up to 3 years and shall not exceed $50,000.

(b) QUALIFIED WELLNESS PROGRAM.—For purposes of this section:

(1) QUALIFIED WELLNESS PROGRAM.—The term "qualified wellness program" means a program that —

(A) includes any 3 wellness components described in subsection (c); and

(B) is be certified by the Secretary of Labor, in coordination with the Health Choices Commissioner and the Director of the Center for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

(i) is newly established or in existence on the date of enactment of this Act but not yet meeting the requirements of this section;

(ii) is consistent with evidenced-based researched and best practices, as identified by persons with expertise in employer health promotion and wellness programs;

(iii) includes multiple, evidenced-based strategies which are based on the existing and emerging research and careful scientific reviews, including the Guide to Community Preventative Services, the Guide to Clinical Preventative Services, and the National Registry for Effective Programs, and

(iv) includes strategies which focus on prevention and support for employee populations at risk of poor health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretary of Labor, in consultation with other appropriate agencies shall establish procedures for periodic review, evaluation, and update of the programs under this subsection.

(3) HEALTH LITERACY/ACCESSIBILITY.—The Secretary of Labor shall, as part of the certification process: —

(A) ensure that employers make the programs culturally competent. physically and programmatically accessible (including for individuals with disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with low literacy skills, limited English and from under-served populations; and

(C) require the Secretary of Labor, in consultation with Secretary of Health and Human Services, to compile and disseminate to employer health plans info on model health literacy curricula, instructional programs, and effective intervention strategies.

(c) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow up measures.

(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for the active engagement of employees in worksite wellness programs through worksite assessments and program planning, onsite delivery, evaluation, and improvement efforts.

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which provides for altering employee lifestyles to encourage healthy living through counseling, seminars, on-line programs, or self-help materials which provide technical assistance and problem solving skills. such component may include programs relating to—

(A) tobacco use;
(B) obesity;
(C) stress management;
(D) physical fitness;
(E) nutrition;
(F) substance abuse;
(G) depression; and
(H) mental health promotion (including anxiety).

(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

(A) ON-SITE POLICIES.—Policies and services at the worksite which promote a healthy lifestyle, including policies relating to—

(i) tobacco use at the worksite;
(ii) the nutrition of food available at the worksite through cafeterias and vending options;
(iii) minimizing stress and promoting positive mental health in the workplace; and
(iv) the encouragement of physical activity before, during, and after work hours.

(d) PARTICIPATION REQUIREMENT.—No grant shall be allowed under subsection (a) unless the Secretary of Labor in consultation with other appropriate agencies, certifies, as a part of any certification described in subsection (b), that each wellness program component of the qualified wellness program—

(1) shall be available to all employees of the employer;
(2) shall not mandate participation by employees; and
(3) shall not require participation by individual employees as a condition to obtain a premium discount, rebate, deductible reduction, or other financial reward.

(e) PRIVACY PROTECTIONS.—Any employee health information collected through participation in an employer wellness program shall be confidential and available only to appropriately trained health professions as defined by the Secretary of Labor. Employers or employees of the employer sponsoring a wellness program shall have no access to employee health data. All entities offering employer-sponsored wellness programs shall be considered "business associates" pursuant to the American Reinvestment and Recovery Act and must comply with privacy protections restricting the release of personal medical information.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) QUALIFIED EMPLOYER.—The term "qualified employer" means an employer that offers a qualified health benefits plan to every employee (including each employee required to be offered coverage under a qualified health benefits plan under subtitle B of title III of division A), and meets the health coverage participation requirements as defined in section 312.

(2) CERTAIN COSTS NOT INCLUDED.—Costs paid or incurred by an employer for food or health insurance shall not be taken into account under subsection (a).

(g) OUTREACH.—

(1) IN GENERAL.—The Secretary of the Labor, in conjunction with other appropriate agencies and members of the business community, shall institute an outreach program to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs according to recognized and promising practices and on how to measure the success of implemented programs.

(h) EFFECTIVE DATE.—This section shall take effect on January 1, 2013.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2553. HEALTH PROFESSIONS TRAINING FOR DIVERSITY PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

"(f) HEALTH PROFESSIONS TRAINING FOR DIVERSITY PROGRAM.—

"(1) IN GENERAL.—The Secretary shall make available 20 grants of no more than $1,000,000 annually to nonprofit organizations for the purposes of providing workforce development training program for those who are currently employed in the health care workforce.

"(2) ELIGIBILITY.—For the purposes of providing assistance and services under the program established in this subsection, grants are to be awarded to Area Health Education Centers or similar nonprofit organizations involved in the development and implementation of health care workforce development programs and that—

"(A) have a formal affiliation with a hospital or community health center, and institution of higher education as defined by section 101 of the Higher Education Act of 1965;

"(B) have a history of providing program services to minority populations; and

"(C) provide workforce development programs to low-income persons, veterans, or urban and rural underserved communities.".

Subtitle H—Long-term Care and Family Caregiver Support

SEC. 2561. LONG-TERM CARE AND FAMILY CAREGIVER SUPPORT.

(a) AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965.—

(1) PROMOTION OF DIRECT CARE WORKFORCE.—Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by inserting before the semicolon the following: ", and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and assisting States in developing a comprehensive state workforce development plans with respect to such workforce including efforts to systematically assess, track, and report on workforce adequacy and capacity".

(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL.—Section 202 of such Act (42 U.S.C. 3012) is amended by adding at the end the following new subsection:

"(g)(1) The Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel and pilot program to improve working conditions and training for long term care workers, including home health aides, certified nurse aides, and personal care attendants.

"(2) The Panel shall include representatives from—

"(A) relevant health care agencies and facilities (including personal or home care agencies, home health care agencies, nursing homes and residential care facilities);

"(B) the disability community;

"(C) the nursing community;

"(D) direct care workers (which may include unions and national organizations);

"(E) older individuals and family caregivers;

"(F) State and federal health care entities; and

"(G) experts in workforce development and adult learning.

"(3) Within one year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary articulating core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources.

"(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 states to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

"(5) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to each House of the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.".

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1965.—Section 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking "$173,000,000" and all that follows through "2011", and inserting "and $250,000,000 for each of the fiscal years 2010, 2011, and 2012".

(c) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—There is authorized to be appropriated $10,000,000 for each of the fiscal years 2010, 2011, and 2012 for the operation of the National Clearinghouse for Long-Term Care Information established by the Secretary of Health and Human Services under section 6021(d) of Public Law 109-171.

Subtitle I—Online Resources

SEC. 2571. WEB SITE ON HEALTH CARE LABOR MARKET AND RELATED EDUCATIONAL AND TRAINING OPPORTUNITIES.

(a) IN GENERAL.—The Secretary of Labor, in consultation with the National Center for Health Workforce Analysis, shall establish and maintain a Web site to serve as a comprehensive source of information, searchable by workforce region, on the health care labor market and related educational and training opportunities.

(b) CONTENTS.—The Web site maintained under this section shall include the following:

(1) Information on the types of jobs that are currently or are projected to be in high demand in the health care field, including—

(A) salary information; and

(B) training requirements, such as requirements for educational credentials, licensure, or certification.

(2) Information on training and educational opportunities within each region for the type jobs described in paragraph (1), including by—

(A) type of provider or program (such as public, private nonprofit, or private for-profit);

(B) duration;

(C) cost (such as tuition, fees, books, laboratory expenses, and other mandatory costs);

(D) performance outcomes (such as graduation rates, job placement, average salary, job retention, and wage progression);

(E) Federal financial aid participation;

(F) average graduate loan debt;

(G) student loan default rates;

(H) average institutional grant aid provided;

(I) Federal and State accreditation information; and

(J) other information determined by the Secretary.

(3) A mechanism for searching and comparing training and educational options for specific health care occupations to facilitate informed career and education choices.

(4) Financial aid information, including with respect to loan forgiveness, loan cancellation, loan repayment, stipends, scholarships, and grants or other assistance authorized by this Act or other Federal or State programs.

(c) PUBLIC ACCESSIBILITY.—The Web site maintained under this section shall—

(1) be publicly accessible;

(2) be user friendly and convey information in a manner that is easily understandable; and

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2572. ONLINE HEALTH WORKFORCE TRAINING PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) (as amended by section 2553) is further amended by adding at the end the following:

"(g) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

"(1) GRANT PROGRAM.—

"(A) IN GENERAL.—The Secretary shall award National Health Workforce Online Training Grants on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grant with other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

"(B) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

"(i) an entity shall be an educational institution, community-based organization, non-profit organization, workforce investment board, or local or county government; and

"(ii) an entity shall provide online workforce training for individuals seeking to attain or advance in health care occupations, including nursing, nursing assistants, dentistry, pharmacy, health care management and administration, public health, health information systems analysis, medical assistants, and other health care practitioner and support occupations.

"(C) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

"(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

"(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

"(iii) conduct training for occupations with national or local shortages.

"(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

"(i) the number of participants;

"(ii) the services received by the participants;

"(iii) program completion rates;

"(iv) factors determined as significantly interfering with program participation or completion;

"(v) the rate of job placement; and

"(vi) other information as determined as needed by the Secretary.

"(E) OUTREACH.—Grantees under this paragraph shall conduct outreach activities to disseminate information about their program and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

"(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be used to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected to be achieved by the grantee on the indicators of performance.

"(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $50,000,000 for fiscal years 2011 through 2020.

"(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.—

"(A) DESCRIPTION OF GRANT.—The Secretary shall award one grant to an eligible postsecondary educational institution to provide the services described in this paragraph.

"(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

"(i) have demonstrated the ability to disseminate research on best practices for implementing workforce investment programs; and

"(ii) be a national leader in producing cutting-edge research on technology related to workforce investment systems under subtitle B.

"(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

"(i) to provide technical assistance to entities that receive grants under paragraph (1);

"(ii) to collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

"(iii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

"(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.".

I. PURPOSE

The U.S. health care system is on an unsustainable course. Between 1999 and 2008, health insurance premiums more than dou-

bled as wages largely stagnated.[1] Over the past two decades, the cost of the average family health insurance policy has steadily drained larger and larger portions of families' income. In the United States, at least 47 million individuals are uninsured and millions more are underinsured.[2] Even having insurance does not guarantee health care security, as families are forced to fight insurance companies that regularly deny coverage or delay treatment. In more than half of the medical bankruptcies filed, the household was insured.[3] Rising health care costs have had a negative impact on business, especially small employers.[4] Over just the last 15 years, the percentage of small businesses offering health insurance dropped from 61 percent to 38 percent.[5] The number of uninsured Americans is expected to hit 61 million by 2020.[6] In no uncertain terms, the U.S. health care system is in crisis and has been for some time. Reform is needed. Inaction is not an option.

H.R. 3200, America's Affordable Health Choices Act, adopts the health care reform principles outlined by President Barack Obama. Specifically, the bill preserves and strengthens the employer-based health care system, includes protections for small businesses, creates a health insurance marketplace where individuals can choose between private insurance and the public health insurance option, ensures low and middle income Americans have access to affordability credits to help offset the costs of insurance and saves over $500 billion in future health outlays of Medicare and Medicaid through reforms to the system.

Together, these critical reforms are fundamental to the long-term health and security of this country.

II. COMMITTEE ACTION INCLUDING LEGISLATIVE HISTORY AND VOTES IN COMMITTEE

LEGISLATIVE HISTORY

For more than 70 years, Congress and Presidents have attempted to reform the nation's health care system, most recently under President Clinton in 1993–94. The election of the Democratic majority in Congress in 2006 and President Obama in 2008 have led to renewed efforts toward national health care reform. The legislative history described in this report is limited to legislative action beginning in the 110th Congress.

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[1] Jacob Hacker, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Hacker)(Jun. 23, 2009) at 2.

[2] Alliance for Health Care Reform, "Health Care Coverage in America: Understanding the Issues and Proposed Solutions." (Mar. 2008).

[3] Id.

[4] U.S. Department of Health and Human Services, "Helping the Bottom Line: Health Reform and Small Business," Prepared by Meena Seshamani, Director of Policy Analysis, Office of Health Reform, available at: *http:www.healthreform.gov/reports/helpbottomline/helpbottomline.pdf.*

[5] National Small Business Association, "2008 NSBA Small & Mid-Sized Business Survey," Table at 14, available at: *http:www.nsba.biz/docs/2008bizsurvey.pdf.*

[6] The Commonwealth Fund Commission on a High Performance Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," Exhibit ES–2: Trend in the Number of Uninsured, 2009–2020 Under Current Law and Path Proposal, February 2009, available at: *http:www.commonwealthfund.org//media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237*1Commission1path1high1perform1US1hlt1sys1WEB1rev103052009.pdf.

110TH CONGRESS (2007–2008)

HEARINGS IN THE HOUSE OF REPRESENTATIVES

Committee on Education and Labor

On March 15, 2007, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Examining Innovative Approaches to Covering the Uninsured Through Employer-Provided Health Benefits." The panel included: Joan Alker, Deputy Executive Director, Center for Children and Families; Brian England, Owner, British American Auto Repair Columbia; Andrew Webber, President and Chief Executive Officer, National Business Coalition on Health; and Linda Blumberg, Ph.D., Economist and Principal Research Associate, Urban Institute.

On May 22, 2007, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives." The panel included: Congressman John Tierney (D–MA); Congressman Tom Price (R–GA); Congresswoman Tammy Baldwin (D–WI); Mila Kofman, J.D., Associate Research Professor, Health Policy Institute, Georgetown University; John Colmers, Secretary, State of Maryland Department of Health and Mental Hygiene; Steven Goldman, Commissioner, New Jersey Department of Banking and Insurance; John Morrison, Auditor and Commissioner, Montana Insurance and Securities; Amy Moore, Partner, Covington & Burling, LLP; and Kevin Covert, Board Member, American Benefits Council.

On September 25, 2008, the Committee on Education and Labor held a hearing entitled "Safeguarding Retiree Health Benefits." The panel included: C. William Jones, Chairman, ProtectSeniors.org; Bill Kadereit, President, National Retiree Legislative Network; David Lillie, Retiree, Raytheon Missile Systems; Scott Macey, Senior Vice President and Director of Government Affairs, Aon Consulting, Inc; Norman Stein, Douglas Arant Professor of Law, University of Alabama; and Dale Yamanoto, President and Founder, Red Quill Consulting.

Committee on Energy & Commerce

On September 18, 2008, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "America's Need for Health Reform." The panel included: Ronald E. Bachman, F.S.A., M.A.A.A., Senior Fellow, Center for Health Transformation; Governor Jon S. Corzine, State of New Jersey; Karen Davis, President, The Commonwealth Fund; Elizabeth Edwards, Senior Fellow, Center for American Progress; William J. Fox, F.S.A., M.A.A.A., Principal and Consulting Actuary, Milliman Inc.; E.J. "Ned" Holland, Jr., Senior Vice President, Human Resources and Communication, EMBARQ; Patricia Owen, President/Founder, FACES DaySpa; Stephen T. Parente, Ph.D., Director, Medical Industry Leadership Institute, and Associate Professor of Finance, Carlson School of Management, University of Minnesota; and Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University.

Committee on Ways and Means

On November 17, 2007, the Subcommittee on Income Security and Family Support in the Committee on Ways and Means held a hearing entitled "Impact of Gaps in Health Coverage on Income Security." The panel included: Sherena Johnson, former foster youth, Morrow, GA; Sara R. Collins, Ph.D., Assistant Vice President, Program on the Future of Health Insurance, Commonwealth Fund; Ron Pollack, Founding Executive Director, Families USA; Bruce Lesley, President, First Focus; and Brian J. Gottlob, Senior Fellow, Milton and Rose D. Friedman Foundation, Indianapolis, IN.

On April 15, 2008, the Subcommittee on Health in the Committee on Ways and Means held a two-panel hearing entitled "Instability of Health Coverage in America." The first panel included former Senator Dave Durenberger (R–MN). The second panel included: Diane Rowland, Sc.D., Executive Vice President, Kaiser Family Foundation; John Z. Ayanian, M.D., Professor of Medicine and Health Care Policy, Harvard Medical School; Michael O'Grady, Senior Fellow, National Opinion Research Center, University of Chicago; Stan Brock, Founder and Volunteer Director of Operations, Remote Area Medical, Knoxville, TN; and Stephen Finan, Associate Director of Policy, American Cancer Society.

On May 14, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "Health Savings Accounts and Consumer Driven Health Care: Cost Containment or Cost-Shift." The panel included: John F. Dicken, Health Care Director, U.S. Government Accountability Office (GAO); Michael E. Chernew, Ph.D., Professor of Health Care Policy, Harvard Medical School; Linda J. Blumberg, Ph.D., Principal Research Associate, Urban Institute; Judy Waxman, Vice President and Director of Health and Reproductive Rights, National Women's Law Center; and Wayne Sensor, CEO, Alegent Health.

On June 10, 2008, the Subcommittee on Health in the Committee on Ways and Means held a two-panel hearing entitled "Addressing Disparities in Health and Healthcare: Issues for Reform." The first panel included: Delegate Donna M. Christensen (D–USVI); former Congresswoman Hilda L. Solis (D–CA); Delegate Madeleine Z. Bordallo (D–GU); and Congressman Jerry Moran (R–KS). The second panel included: Marsha Little-Blanton, Dr.P.H., Senior Advisor on Race, Ethnicity and Healthcare, Kaiser Family Foundation; Mohammed Akhter, M.D., M.P.H., Executive Director, National Medical Association; Deena Jang, J.D., Policy Director, Asian and Pacific Islander American Health Forum; Anthony B. Iton, M.D., J.D., M.P.H., Director of Public Health and Health Officer, Alameda County, CA; Sally Satel, M.D., Resident Scholar, American Enterprise Institute; and Michael A. Rodriguez, M.D., M.P.H., Associate Professor and Vice Chair of Research, Department of Family Medicine, University of California, Los Angeles.

On September 11, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "Reforming Medicare's Physician Payment System." The panel included: Bruce C. Vladeck, Ph.D., Senior Health Policy Advisor and Executive Director of Health Sciences, Ernst & Young, LLP; Gail Wilensky, Ph.D., Senior Fellow, Project Hope; Nancy H. Nielsen, M.D., Ph.D., President, American Medical Association; and Donald M. Crane,

President and Chief Executive Officer, California Association of Physician Groups.

On September 23, 2008, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled the "Health of the Private Health Insurance Market." The panel included: Karen Davis, President, Commonwealth Fund; Bruce Bodaken, Chairman and Chief Executive Officer, Blue Shield of California; Roger Feldman, Ph.D., Blue Cross Professor of Health Insurance, University of Minnesota; and Mila Kofman, Superintendent of Insurance, Maine Bureau of Insurance.

HEARINGS IN THE SENATE

Committee on Health, Education, Labor and Pension

On January 10, 2007, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing entitled "Health Care Coverage and Access." The panel included: Peter Meade, Executive Vice President, Blue Cross Blue Shield of Massachusetts; John McDonough, Executive Director, Health Care for All; Karen Davis, President, Commonwealth Fund; Andy Stern, President, SEIU; Debra Ness, President, National Partnership for Women and Families; Larry Burton, Executive Vice President, Business Roundtable; Peter Harbage, New America Foundation; Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute; John Goodman, President, National Center for Policy Analysis; and Pat Vredevoogd Combs, National Association of Realtors, and owner, Coldwell-Banker-AJS Realty.

On February 12, 2008, the Senate HELP Committee held a hearing entitled "Addressing Healthcare Workforce Issues for the Future." The panel included: A. Bruce Steinwald, Director, Healthcare GAO; Kevin Grumbach, M.D., Director, Center for California Health Workforce Studies, University of California San Francisco, and Chair, Department of Family and Community Medicine; Roderick S. Hooker, Ph.D., P.A., Director of Research, Rheumatology Section, Medical Service Department of Veterans Affairs, Dallas VA Medical Center; Edward S. Salsberg, M.P.A., Director, Center for Workforce Studies, Association of American Medical Colleges; James Q. Swift, D.D.S., Board President, American Dental Education Association; Bruce Auerbach, M.D., President Elect, Massachusetts Medical Society, and Vice President and Chief of Emergency Medicine, Sturdy Memorial Hospital; Beth Landon, M.H.A., M.B.A., Director, Alaska Center for Rural Health, University of Alaska; Jennifer Laurent, M.S., FNP–BC, President, Vermont Nurse Practitioner Association; and John E. Maupin, Jr., D.D.S., M.B.A., President, Morehouse School of Medicine.

Committee on Finance

On March 14, 2007, the Senate Committee on Finance held a hearing entitled "Course for Health Care Reform: Moving Toward Universal Coverage." The panel included: James J. Mongan, M.D., President and Chief Executive Officer, Partners HealthCare; Stuart H. Altman, Ph.D., Dean, Sol C. Chaikin Professor of National Health Policy, The Heller School for Social Policy and Management, Brandeis University; John Sheils, Vice President, The Lewin

Group; and Richard G. Frank, Ph.D., Vice Chair, Citizens' Health Care Working Group.

On May 6, 2008, the Senate Committee on Finance held a hearing entitled "Seizing the New Opportunity for Health Reform." The panel included the Honorable Tommy Thompson and the Honorable Donna Shalala, both former Secretaries of Health and Human Services.

On June 3, 2008, the Senate Committee on Finance held a hearing entitled "Rising Costs, Low Quality in Health Care: The Necessity for Reform." The panel included: Paul B. Ginsburg, Ph.D., President, Center for Studying Health System Change; Elizabeth McGlynn, Ph.D., Associate Director, RAND Health, and Distinguished Chair in Health Quality; Arlene Holt Baker, Executive Vice President, AFL–CIO; and Felicia Fields, Group Vice President, Human Resources and Corporate Services, Ford Motor Company.

On June 10, 2008, the Senate Committee on Finance held a hearing entitled "47 Million and Counting: Why the Health Care Marketplace is Broken." The panel included: Lisa Kelly, cancer patient; Raymond Arth, President and CEO, Phoenix Faucets; Ron Williams, Chairman and Chief Executive Officer, Aetna, Inc.; and Mark Hall, Professor of Law and Public Health, Wake Forest University School of Law and School of Medicine.

On September 9, 2008, the Senate Committee on Finance held a hearing entitled "Improving Health Care Quality: An Integral Step Toward Health Reform." The panel included: Peter V. Lee, J.D., Executive Director of National Health Policy, Pacific Business Group on Health; Samuel Nussbaum, M.D., Executive Vice President for Clinical Health Policy and Chief Medical Officer, WellPoint, Inc.; Gregory Schoen, M.D., Regional Medical Director, Fairview Northland Health Services; Kevin B. Weiss, M.D., President and CEO, American Board of Medical Specialties; and William L. Roper, M.D., M.P.H., Dean, School of Medicine, University of North Carolina (UNC), and Vice Chancellor for Medical Affairs and CEO, UNC Health Care System.

On September 23, 2008, the Senate Committee on Finance held a hearing entitled "Covering the Uninsured: Making Health Insurance Markets Work." The panel included: John Bertko, F.S.A., M.A.A.A., Adjunct Staff, The RAND Corporation, and Former Chief Actuary, Humana, Inc., Flagstaff, AZ; Andrew Dreyfuss, Executive Vice President, Health Care Services, Blue Cross Blue Shield of Massachusetts; Pam MacEwan, Executive Vice President, Public Affairs and Governance, Group Health Cooperative; and Kim Holland, State of Oklahoma Insurance Commissioner.

On November 19, 2008, the Senate Committee on Finance held a hearing entitled "Health Care Reform: An Economic Perspective." The panel included: Ivan G. Seidenberg, Chairman and Chief Executive Officer, Verizon Communications, Inc.; Andy Stern, President, SEIU; Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University; and Amitabh Chandra, Ph.D., Assistant Professor of Public Policy, John F. Kennedy School of Government, Harvard University.

111TH CONGRESS (2009–2010)

HEARINGS IN THE HOUSE OF REPRESENTATIVES

Committee on Education and Labor

On March 10, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a panel entitled "Strengthening Employer-Based Health Care." The panel included: Mark Derbyshire, Small Business Owner; Bruce Pyenson, Principal and Consulting Actuary, Milliman, Inc.; John Sheridan, CEO, Cooper University Hospital; Kenneth Thorpe, Chair of the Health Policy and Management Department, Emory University; E. Neil Trautwein, Vice President, Employee Benefits Counsel, National Retail Federation; and Jim Winkler, Health Management Practice Leader, Hewitt Associates.

On April 23, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a panel entitled "Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families." The panel included: Karen Davenport, Director of Health Policy, Center for American Progress; David Himmelstein, Associate Professor of Medicine, Harvard University; Michael Langan, Principal, Towers Perrin; William Oemichan, President and CEO, Cooperative Network; Ron Pollack, Executive Director, FamiliesUSA; Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters; and William Vaughn, Senior Health Policy Analyst, Consumers Union.

On June 10, 2009, the Subcommittee on Health, Employment, Labor and Pensions of the Committee of Education and Labor held a hearing entitled "Examining the Single Payer Health Care Option." The panel included: Congressman John Conyers, Jr. (D–MI); Marcia Angell, M.D., Senior Lecturer in Social Medicine, Harvard Medical School; David Gratzer, Senior Fellow, Manhattan Institute; Geri Jenkins, R.N., Co-President, California Nurses Association/National Nurses Organizing Committee; and Walter Tsou M.D., M.P.H., National Board Advisor, Physicians for a National Health Program.

Committee on Energy & Commerce

On March 10, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Designing a High Performing Healthcare System." The panel included: Doug Elmendorf, Director, Congressional Budget Office; Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission; Jack C. Ebeler, Vice Chair, Committee on Health Insurance Status and Its Consequences, Institute of Medicine; Alan Levine, Secretary, Louisiana Department of Health and Hospitals; Atul Gawande, M.D., Associate Professor of Surgery, Harvard Medical School, and Associate Professor, Department of Health Policy and Management, Harvard School of Public Health; and M. Todd Williamson, M.D., President, Medical Association of Georgia Policy Studies.

On March 17, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Ensuring Affordable

Coverage." The panel included: Uwe E. Reinhardt, Ph.D., Professor of Political Economy, Economics and Public Affairs, Princeton University; Sally C. Pipes, B.A., President and Chief Executive Officer, Pacific Research Institute; Judy Feder, Ph.D., Senior Fellow, Center for American Progress Action Fund; Mila Kofman, J.D., Superintendent of Insurance, State of Maine Bureau of Insurance; Jon Kingsdale, Ph.D., Executive Director, Commonwealth Health Insurance Connector Authority, MA; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; and Edmund F. Haislmaier, B.A., Senior Research Fellow, Center for Health, Heritage Foundation.

On March 24, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Improving Access to Care." The panel included: Brian D. Smedley, Ph.D., Vice President and Director, Health Policy Institute, Joint Center for Political and Economic Studies; Michael John Kitchell, M.D., President-Elect, Iowa Medical Society, McFarland Clinic PC; Michael A. Sitorius, M.D., Professor and Chairman, Department of Family Medicine, University of Nebraska Medical Center; Risa Lavizzo-Mourey, M.D., M.B.A., President and CEO, Robert Wood Johnson Foundation; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, Professor of Pediatrics, George Washington University; Jeffrey P. Harris, M.D., F.A.C.P., President, American College of Physicians; James R. Bean, M.D., President, American Association of Neurological Surgeons; and Diane Rowland, Sc.D., Executive Director, Kaiser Commission on Medicaid and the Uninsured.

On March 27, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: The Role of Public Health." The panel included: E. Besser, M.D., Acting Director, CDC, and Acting Administrator, Agency for Toxic Substances and Disease Registry; Jonathan E. Fielding, M.D., M.P.H., Chair, Task Force on Community Preventive Services, and Director, L.A. County Department of Public Health and County Health Officer; Heather Howard, J.D., Commissioner, New Jersey Department of Health and Senior Services; David Satcher, M.D., Ph.D., Former U.S. Surgeon General, and Director, Satcher Health Leadership Institute, Morehouse School of Medicine; Barbara Spivak, M.D., President, Mt. Auburn Cambridge Independent Practice Association, Inc.; Devon Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis; and Jeffrey Levi, Ph.D., Executive Director, Trust for Americas Health.

On April 2, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Making Health Care Work for American Families: Saving Money, Saving Lives." The panel included: Jonathan Skinner, Ph.D., Professor of Economics, Dartmouth Institute for Health Policy and Clinical Practice; Christine K. Cassel, M.D., President and CEO, American Board of Internal Medicine and ABIM Foundation; John Goodman, Ph.D., President and CEO, National Center for Policy Analysis; Bruce Sigsbee, M.D., M.S., President Elect, American Academy of Neurology, and Medical Director, Pen Bay Physicians and Associates; Dennis Smith, M.P.A., Senior Research Fellow in Health Care Re-

form, Heritage Foundation; Jerry Avorn, M.D., Professor of Medicine, Harvard Medical School; Paul Ginsburg, Ph.D., President, Center for Studying Health System Change; Regina Herzlinger, Ph.D., Professor of Business Administration, Harvard Business School; Ronald Bachman, F.S.A., M.A.A.A., Senior Fellow, Center for Health Transformation; and Diane Archer, J.D., Director, Health Care Project, Institute for America's Future.

On June 16, 2009, the Subcommittee on Oversight and Investigation of the Committee on Energy and Commerce held a hearing entitled "Termination of Individual Health Policies by Insurance Companies." The panel included: Don Hamm, CEO, Assurant Health; Richard Collins, CEO, Golden Rule Insurance Company, UnitedHealth Group; Brian A. Sassi, President and CEO, Consumer Business, WellPoint, Inc.; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Robin Beaton, Policyholder; Wittney Horton, Policyholder; and Peggy Raddatz, Relative of Policyholder.

Committee on Ways & Means

On March 11, 2009, the Committee on Ways and Means held a hearing entitled "Expanding Coverage, Improving Quality and Controlling Costs." The panel included: John Z. Ayanian, M.D., M.P.P., on behalf of the Institute of Medicine Committee on Health Insurance Status and Its Consequences; Karen Davis, President, Commonwealth Fund; and John M. Pickering, Principal, Consulting Actuary, Milliman, Inc.

On March 17, 2009, the Subcommittee on Health in the Committee on Ways and Means held a hearing entitled "MedPAC's Annual March Report to the Congress on Medicare Payment Policy." The panel featured Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission.

On April 1, 2009, the Committee of Ways and Means held a hearing entitled "Reforming the Health Care Delivery System." The hearing consisted of two panels. The first panel included: Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission; Elliot S. Fisher, M.D., M.P.H., Director, Population Health and Policy, Dartmouth Institute for Health Policy and Clinical Practice, and Professor of Medicine and Community and Family Medicine, Dartmouth Medical School; and Robert A. Berenson, M.D., Senior Fellow, Urban Institute. The second panel included: Glenn D. Steele, Jr., M.D., Ph.D., President and CMO, Geisinger Health System; L. Allen Dobson, Jr., M.D., F.A.A.F.P., Vice President for Clinical Practice Development, Carolinas Health System; and Brent C. James, M.D., M.Stat., Chief Quality Officer and Chief Medical Officer, Institute for Health Care Delivery Research, Intermountain Healthcare.

On April 22, 2009, the Committee on Ways and Means held a hearing entitled "Insurance Market Reforms." The panel included: Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy and Professor of Economics and Public Affairs, Princeton University; William Vaughn, Senior Policy Analyst, Consumers Union; William D. Hobson, Jr., M.S., President and CEO, Watts Healthcare Corporation; David Borris, Owner, Hel's Kitchen Catering, Northbrook, Ill.; Kenneth L. Sperling, Global Health Management Leader, Hewitt Associates, on behalf of National Coalition on

Benefits; and Linda Blumberg, Ph.D., Principal Research Associate, Urban Institute.

On April 29, 2009, the Committee on Ways and Means held a hearing entitled "Employer Sponsored Insurance." The panel included: Elise Gould, Ph.D., M.P.Aff., Director of Health Policy Research, Economic Policy Institute; J. Randal MacDonald, Senior Vice President for Human Resources, IBM Corporation; Kelly Conklin, Owner, Foley-Waite Associates; Denny Dennis, Senior Research Fellow, NFIB Research Foundation; John Shells, Senior Vice President, Lewin Group; and Gerald Shea, Special Assistant to the President, AFL–CIO.

On May 6, 2009, the Committee on Ways and Means held a hearing on "Health Care Reform" with Kathleen Sebelius, the Secretary for Health and Human Services.

HEARINGS IN THE SENATE

Committee on Health, Education, Labor and Pensions

On January 29, 2009, the Senate HELP Committee held a hearing entitled "Crossing the Quality Chasm in Health Reform." The panel included: Nancy Davenport-Ennis, CEO, National Patient Advocate Foundation; Karen Davis, President, Commonwealth Fund; Rhonda Robinson-Beale, M.D., Chief Medical Officer, Optum Health Behavioral Solutions, Golden Valley, MN; Elizabeth Teisberg, Ph.D., Associate Professor, University of Virginia's Darden School of Business; and Christine K. Cassel, M.D., President, American Board of Internal Medicine.

On February 23, 2009, the Senate HELP Committee held a hearing entitled "Principles of Integrative Health: A Path to Health Care Reform." The panel included: Cathy Baase, M.D., Global Director Health Services, Dow Chemical Company; Robert M. Duggan, M.A., M.Ac., President, Tai Sophia Institute; James S. Gordon, M.D., Founder and Director, Center for Mind-Body Medicine; Wayne B. Jonas, M.D., President, Samueli Institute; Sister Charlotte Rose Kerr, R.S.M., R.N., B.S.N., M.P.H., M.Ac., Practitioner and Professor Emeritus, Tai Sophia Institute; Mary Jo Kreitzer, Ph.D., R.N., Founder and Director, University of Minnesota Center for Spirituality & Healing; Herbert Benson, M.D., Director Emeritus, Benson-Henry Institute for Mind Body Medicine, Massachusetts General Hospital; Brian M. Berman, M.D., Director, Center for Integrative Medicine, University of Maryland School of Medicine; Susan Hartnoll Berman, Executive Director, Institute for Integrative Health; Ron Z. Goetzel, Ph.D., Research Professor and Director, Institute for Health and Productivity Studies, Rollins School of Public Health, Emory University; Kathi J. Kemper, M.D., M.P.H., F.A.A.P., Caryl J. Guth Chair for Complementary and Integrative Medicine, Division of Health Sciences, Wake Forest University; and Simon Mills, Project Lead, United Kingdom Department of Health project: Integrated Self Care in Family Practice.

On February 24, 2009, the Senate HELP Committee held a hearing entitled "Addressing Underinsurance in National Health Reform." The panel included: Cathy Schoen, M.S., Senior Vice President, Commonwealth Fund; Gail Shearer, M.S., Director of Health Policy Analysis, Consumers Union; Diane Rowland, D.Sc., Execu-

tive Vice President, Henry J. Kaiser Family Foundation, and Executive Director, Kaiser Commission on Medicaid and the Uninsured; and Grace-Marie Turner, President, Galen Institute.

On March 24, 2009, the Senate HELP Committee held a hearing entitled "Addressing Insurance Market Reform in National Health Reform." The panel included: Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters; Ronald A. Williams, M.S., Chairman and Chief Executive Officer, Aetna, Inc.; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Karen Ignagni, M.B.A., President and CEO, America's Health Insurance Plans; Len Nichols, Ph.D., Director, Health Policy Program, New America Foundation; Katherine Baicker, Ph.D., Professor of Health Economics, Department of Health Policy and Management, Harvard School of Public Health; and Sandy Praeger, Health Insurance Commissioner, State of Kansas.

On April 28, 2009, the Senate HELP Committee held a hearing entitled "Learning from the States: Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform." The panel included: Jon Kingsdale, Ph.D., Executive Director, Commonwealth Health Insurance Connector Authority, MA; Susan Besio, Director, Office of Vermont Health Access, State of Vermont Human Services Agency; Harry Chen, M.D., Emergency Room Physician and Board Member, Vermont Program for Quality in Health Care; Brent James, Executive Director, IHC Institute for Health Care Delivery Research, Intermountain Health Care, Inc.; Honorable David Clark (R), Majority Leader, Utah House of Representatives; Ruth Liu, Senior Director for Health Policy, Legal and Government Relations, Kaiser Permanente; and Eileen McAnneny, Senior Vice-President of Government Affairs and Associate General Counsel, Associated Industries of Massachusetts.

On April 30, 2009, the Senate HELP Committee held a hearing entitled "Primary Health Care Access Reform: Community Health Centers and the National Health Service Corps." The panel included: Cynthia Bascetta, Director of Health Care, GAO; Dan Hawkins, Senior Vice President, National Association of Community Health Centers; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University School of Public Health; Caswell A. Evans, Jr., D.D.S, M.P.H., Associate Dean for Prevention and Public Health Sciences, University of Illinois at Chicago College of Dentistry; Yvonne Davis, Board Member, Community Health Center; John Matthew, M.D., Health Center, Plainfield, VT; and Lisa Nichols, Executive Director, Midtown Community Center, Ogden, UT.

On June 11, 2009, the Senate HELP Committee held a two-panel hearing entitled "Health Care Reform." The first panel included: Margaret Flowers, M.D., Maryland Co-Chair, Physicians for a National Health Program; Ron Williams, CEO, Aetna, Inc; Randel Johnson, Vice President for Labor, Immigration, and Employee Benefits, U.S. Chamber of Commerce; William Dennis, Senior Research Fellow, National Federation of Independent Business; Mary Andrus, Co-Chair of the Health Care Taskforce, Consortium for Citizens with Disabilities; Samantha Rosman, M.D., Board of Trustees, American Medical Association; Ray Scheppach, Ph.D., Executive Director, National Governors' Association; Gerald Shea,

Special Assistant to the President, AFL–CIO; Dennis Rivera, Chair, SEIU Healthcare; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; Jonathan Gruber, Ph.D., Associate Head, MIT Department of Economics; Janet Trautwein, Executive Vice-President and CEO, National Association of Health Underwriters; Sandy Praeger, Kansas Insurance Commissioner; Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute; and Steve Burd, President and CEO, Safeway, Inc. The second panel included: Gary Raskob, Ph.D., Dean, University of Oklahoma College of Public Health; Jeffrey Levi, Ph.D., Executive Director, Trust for America's Health; Fay Raines, Ph.D., President, American Association of Colleges of Nursing; Wayne Jonas, M.D., President and CEO, Samueli Institute; Delos Cosgrove, M.D., CEO, Cleveland Clinic; Brent James, M.D., M.Stat., Executive Director, Institute for Health Care Delivery Research, Intermountain Health Care, Inc.; Charles Kahn, M.P.H., President, Federation of American Hospitals; John Rother, J.D., Executive Vice President for Policy and Strategy, AARP; and Judith Palfrey, M.D., President-Elect, American Academy of Pediatric.

Committee on Finance

On February 25, 2009, the Senate Committee on Finance held a hearing entitled "Scoring Health Care Reform: CBO's Budget Options" with Douglas Elmendorf, Ph.D., Director of the Congressional Budget Office.

On March 12, 2009, the Senate Committee on Finance held a hearing entitled "Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future." The panel included: David C. Goodman, M.D., M.S., Director of the Center for Health Policy Research, Dartmouth College; Allan H. Goroll, M.D., M.A.C.P., Professor of Medicine, Harvard Medical School; Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University; and Steven A. Wartman, M.D., Ph.D., M.A.C.P., President and CEO, Association of Academic Health Centers.

On March 25, 2009, the Senate Committee on Finance held a hearing entitled "The Role of Long-Term Care in Health Reform." The panel included: Judy Feder, Ph.D., Senior Fellow, Center for American Progress Action Fund; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Dennis G. Smith, Senior Research Fellow in Health Care Reform, Heritage Foundation; and Joshua M. Wiener, Ph.D., Senior Fellow, RTI International.

On April 21, 2009, the Senate Committee on Finance held a hearing entitled "Reforming America's Health Care Delivery System." The panel included: Allan M. Korn, M.D., Senior Vice President, Chief Medical Officer, Office of Clinical Affairs, Blue Cross Blue Shield Association; Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission; Peter V. Lee, J.D., Executive Director of National Health Policy, Pacific Business Group on Health; Mark B. McClellan, M.D., Director, Engelberg Center for Health Care Reform, Brookings Institute; Lewis Morris, J.D., Chief Counsel to the Inspector General, Office of Counsel to the Inspector General; Mary D. Naylor, Ph.D., F.A.A.N., R.N., Marian S. Ware

Professor in Gerontology, University of Pennsylvania School of Nursing; Debra Ness, President, National Partnership for Women and Families; Frank G. Opelka, M.D., F.A.C.S., Vice Chancellor for Clinical Affairs and Professor of Surgery, Office of the Chancellor, Louisiana State University Health Science Center; Glenn Steele, Jr., M.D., Ph.D., President, Geisinger Health System; John Tooker, M.D., M.B.A., F.A.C.P., Executive Vice President and Chief Executive Officer, American College of Physicians; Richard J. Umbdenstock, F.A.C.H.E., President and CEO, American Hospital Association; Ron Williams, Chairman and CEO, Aetna, Inc.; and Paul J. Diaz, J.D., President and CEO, Kindred Healthcare, Inc.

On May 5, 2009, the Senate Committee on Finance held a hearing entitled "Expanding Health Care Coverage." The panel included: Stuart M. Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, Heritage Foundation; John Castellani, President, Business Roundtable; Gary Claxton, Vice President and Director, Health Care Marketplace Project, Henry J. Kaiser Family Foundation; Donald A. Danner, President and CEO, National Federation of Independent Business; Jennie Chin Hansen, R.N., M.S., F.A.A.N., President, AARP; Karen Ignagni, President and CEO, America's Health Insurance Plan; R. Bruce Josten, Executive Vice President, Government Affairs, U.S. Chamber of Commerce; Len Nichols, Ph.D., Director, Health Policy Program, New America Foundation; Ron Pollack, J.D., Executive Director, Families USA; Sandy Praeger, Chair, Health Insurance and Managed Care Committee, National Association of Insurance Commissioners; Sara Rosenbaum, J.D., Chair, Department of Health Policy, George Washington School of Public Health and Health Services; Diane Rowland, Sc.D., Executive Vice President, Henry J. Kaiser Family Foundation; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Scott Serota, President and Chief Executive Officer, Blue Cross and Blue Shield Association; and Andy Stern, President, SEIU.

On May 12, 2009, the Senate Committee on Finance held a hearing entitled "Financing Comprehensive Health Care Reform." The panel included: Stuart H. Altman, Ph.D., Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy and Management, Brandeis University; Joseph R. Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute; Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health; Leonard Burman, Ph.D., Director, Tax Policy Center, Urban Institute; Robert Greenstein, Ph.D., Executive Director, Center on Budget and Policy Priorities; Jonathan Gruber, Ph.D., Professor of Economics, Massachusetts Institute of Technology; Michael F. Jacobson, Ph.D., Executive Director, Center for Science in the Public Interest; James A. Klein, President, American Benefits Council; Edward Kleinbard, Chief of Staff, Joint Committee on Taxation; Gerald M. Shea, Special Assistant to the President, AFL–CIO; John Sheils, Senior Vice President, Lewin Group; Gail Wilensky, Ph.D., Senior Fellow, Project HOPE; and Steven Wojcik, Vice President of Public Policy, National Business Group on Health.

INTRODUCTION AND CONSIDERATION OF AMERICA'S AFFORDABLE HEALTH CHOICES ACT, H.R. 3200

On June 19, 2009, Congressman George Miller (D-CA), along with Congressmen Henry Waxman (D–CA), Charles Rangel (D–NY) and John Dingell (D–MI) released the Tri-Committee draft proposal for health care reform.

Committee on Education & Labor Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 23, 2009, the House Education and Labor Committee held a hearing to discuss the draft proposal for health care reform that was jointly developed by the House Ways and Means, Energy and Commerce, and Education and Labor Committees. The draft was designed to achieve President Obama's goals of controlling health care cost, preserving health care choices, and ensuring quality, affordable health care for all Americans. The hearing entitled "The Tri-Committee Draft Proposal for Health Care Reform" consisted of three panels. The first panel included: Christina Romer, Ph.D., Chair, Council of Economic Advisers, Office of the President; Ron Pollack, Founding Executive Director, Families USA; Gerald Shea, Special Assistant to the President, AFL–CIO; Paul J. Speranza, Senior Vice President, General Counsel and Secretary, Wegmans Food Markets, Inc.; Jacob Hacker, Ph.D., Professor and Co-Director, Berkeley Center on Health, Economic, and Family Security, University of California Berkeley; Michael J. Stapley, President and Chief Executive Officer, Deseret Mutual; John Arensmeyer, Chief Executive Officer, Small Business Majority; and Fran Visco, President, National Breast Cancer Coalition. The second panel included: Karen Pollitz, Research Professor and Project Director, Health Policy Institute, Georgetown University; Celia Wcislo, Assistant Division Director, SEIU; James A. Klein, President, American Benefits Council; William Vaughan, Senior Health Policy Analyst, Consumers Union; Robert E. Moffit, Ph.D., Director, Center for Health Policy Studies, Heritage Foundation; ReShonda Young, Small Business Owner, Alpha Express, Inc. on behalf of the Main Street Alliance; and Fitzhugh Mullan, M.D., Murdock Head Professor of Medicine and Health Policy, George Washington University.

Committee on Energy & Commerce Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 23, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled "Comprehensive Health Reform Discussion, Day 1." The panel included: Richard Kirsch, National Campaign Manager, Health Care for America Now; Ralph G. Neas, Chief Executive Officer, National Coalition on Health Care; Stephen T. Parente, Ph.D., Director, Medical Industry Leadership Institute; Marian Wright Edelman, President, Children's Defense Fund; Jennie Chin Hansen, President, AARP; David L. Shern, Ph.D., President and Chief Executive Officer, Mental Health America; Erik Novak, M.D., Orthopedic Surgeon, Patients United Now; Shona Robertson-Holmes, Patient at Mayo Clinic; Jeffrey Levi, Ph.D., Executive Director, Trust for America's Health; Brian D. Smedley, Ph.D., Vice President and Director, Health Pol-

icy Institute, Joint Center for Political and Economic Studies; and Mark Kestner, M.D., Chief Medical Officer, Alegent Health.

On June 24, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a three-panel hearing entitled "Comprehensive Health Reform Discussion, Day 2." The first panel on single-payer health care included: Sidney M. Wolfe, M.D., Director, Health Research Group at Public Citizen; Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Medical School, and Co-Founder, Physicians for a National Health Program; and John C. Goodman, Ph.D., President and CEO, National Center for Policy Analysis. The second panel on state, local and tribal views included: the Honorable Michael O. Leavitt, Former Secretary, U.S. Department of Health and Human Services; the Honorable Joseph Vitale (D), Chairman, Committee on Health, Human Services, and Senior Citizens, New Jersey State Senate; W. Ron Allen, Chairman, Jamestown S'Klallam Tribe; the Honorable Jay Webber (R), New Jersey State Assembly; Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association; Robert S. Freeman, Deputy Executive Director, CenCal Health, California Association of Health Insuring Organizations; and Ron Pollack, Executive Director, Families USA. The third panel on drug and device manufacturer views included: Thomas Miller, CEO, Workflow and Solutions Division, Siemens Medical Solutions, USA; Kathleen Buto, Vice President for Health Policy, Johnson & Johnson; William Vaughan, Senior Health Policy Analyst, Consumers Union; Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute; and A. Kelly, Senior Vice President, Government Affairs and Public Policy, National Association of Chain Drug Stores.

On June 25, 2009, the Subcommittee on Health of the Committee on Energy and Commerce held a four-panel hearing entitled "Comprehensive Health Reform Discussion, Day 3." The first panel on Medicare payment included Glenn M. Hackbarth, Chair of the Medicare Payment Advisory Commission, and the Honorable Daniel R. Levinson, Inspector General of the U.S. Department of Health and Human Services. The second panel on doctor, nurse, hospital, and other provider views included: Ted D. Epperly, M.D., President, American Academy of Family Physicians; M. Todd Williamson, M.D., President, Medical Association of Georgia; Karl J. Ulrich, M.D., Clinic President and CEO, Marshfield Clinic; Janet Wright, M.D., Vice President, Science and Quality, American College of Cardiology; Kathleen M. White, Ph.D., Chair, Congress on Nursing Practice and Economics, American Nurses Association; Patricia Gabow, M.D., Chief Executive Officer, Denver Health and Hospital Authority, National Association of Public Hospitals; Dan Hawkins, Senior Vice President, Public Policy and Research, National Association of Community Health Centers; Bruce T. Roberts, R.Ph., Executive Vice President and CEO, National Community Pharmacists Association; Bruce Yarwood, President and CEO, American Health Care Association; and Alissa Fox, Senior Vice President, Office of Policy and Representation, Blue Cross Blue Shield Association. The third panel on employer and employee views included: Kelly Conklin, Owner, Foley-Waite Custom Woodworking, Main Street Alliance; John Arensmeyer, Founder and CEO, Small Business Majority; Gerald M. Shea, Special Assistant to the President, AFL–CIO; Dennis Rivera, Health Care Chair,

SEIU; John Castellani, President, Business Roundtable Institute for Corporate Ethics; John Sheils, Senior Vice President, Lewin Group; and Martin Reiser, Manager of Government Policy, Xerox Corporation, National Coalition on Benefits. The fourth panel on insurers' views included: Howard A. Kahn, Chief Executive Officer, L.A. Care Health Plan; Karen Pollitz, M.P.P., Research Professor, Health Policy Institute, Georgetown University; Karen Ignagni, President and CEO, America's Health Insurance Plans; and Janet Trautwein, Executive Vice President and CEO, National Association of Health Underwriters.

Committee on Ways & Means Consideration of the Tri-Committee Draft Proposal for Health Care Reform

On June 24, 2009, the Committee on Ways and Means had a hearing entitled "Health Reform in the 21st Century: Proposals to Reform the Health System." The hearing consisted of three panels. The first panel included: Karen Pollitz, Policy Director, Health Policy Institute, Georgetown Public Policy Institute; John F. Holahan, Ph.D., Director, Health Policy Research Center, Urban Institute; and David Gratzer, M.D., Senior Fellow, Manhattan Institute for Policy Research. The second panel included: Richard Kirsch, National Campaign Manager, Health Care for America NOW; Mike Draper, Owner, SMASH; Peter V. Lee, Executive Director for National Health Policy, Pacific Business Group on Health; Gerald Shea, Special Assistant to the President, AFL-CIO; Jennie Chin Hansen, President, AARP; and Randel K. Johnson, Senior Vice President, Labor, Immigration and Employee Benefits, U.S. Chamber of Commerce. The third panel included: Dan Baxter, Medical Director, William F. Ryan Community Health Network, NY; Ted Epperly, M.D., President, American Academy of Family Physicians; Donna Policastro, Executive Director, Rhode Island State Nurses Association on behalf of the American Nurses Association; Chip Kahn, President, Federation of American Hospitals; Larry Minnix, President and CEO, American Association of Homes and Services for the Aging; Ronald Williams, Chairman and CEO, Aetna, Inc.; and Richard Warner, M.D., Member, Kansas Medical Society House of Delegates, AMA Alternate Delegate, and past President, Kansas Medical Society.

Introduction of America's Affordable Health Choices Act, H.R. 3200

On July 15, 2009, after taking into consideration comments on the discussion draft from a very wide range of voices, Chairmen George Miller, Henry Waxman, Charles Rangel, and Congressman John Dingell introduced America's Affordable Health Choices Act, H.R. 3200. The bill seeks to control rising health care costs, strengthen the employer-based health care system, and ensure that all Americans have access to quality and affordable health care coverage.

Committee on Education & Labor Mark-up of H.R. 3200

The Full Committee met on July 15–17, 2009 to mark up H.R. 3200. The Committee passed by voice vote an amendment in the nature of a substitute offered by Chairman George Miller (D–CA). There were 42 other amendments offered and debated. Of the

amendments offered, 20 passed, 17 failed, 4 were withdrawn, and one was ruled not germane.

America's Affordable Health Choices Act of 2009

H.R. 3200 was reported favorably to the House with an amendment in the nature of a substitute. By a vote of 26–22, the Committee authorized the Chairman to transmit the bill, with an amendment in the nature of a substitute, to the Committee on the Budget in compliance with section 310 of the Congressional Budget Act of 1974 as the first part of the Committee's recommendations, pursuant to the reconciliation instruction in S. Con Res. 13.

The Miller amendment in the nature of a substitute contains the following modifications to H.R. 3200:

Recognizes the unique structures of multi-employer plans and how they interact with the Health Insurance Exchange (HIE). In Section 100(26), the health care contributions of multiemployer plans are to be treated as employer contributions. Section 123(b)(1)(D) directs the Health Benefits Advisory Committee to take into consideration the unique nature of the multiemployer plans in recommending the essential benefits package. Lastly, Section 202(e)(8) makes clear that multiemployer plans shall be treated as large employers in regard to joining the HIE.

The Miller substitute also creates a new subsection (b) in Section 115 that requires qualified health benefits plans to make provider information available to consumers by publishing current listings of all providers within a plan network on their website. Amends the bill in Section 116 to provide that the medical loss ratio for qualified health benefits plans must be at least 85 percent.

Creates Section 117 to prohibit insurance companies from changing the coverage or costs of a health plan mid-year except if the costs are lowered and/or the coverage is increased.

Specifically includes in the essential benefits package "durable medical equipment, prosthetics, orthotics, and supplies." (DMEPOS) The Committee is aware that Section 122 (4) related to coverage of "services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in . . . patients' homes or places of residence" encompasses coverage of such devices and related services, but opted to clarify that these are considered essential benefits. By separately listing the category of DMEPOS as an essential benefit, the Committee intends to underscore the importance of coverage for these devices and related services.

Amends sections 122 and 133 to include three provisions related to integrative medicine: to require that the membership of the Health Benefits Advisory Committee include one or more integrative medicine providers; establish an Integrative Health Care Service Task Force that is to be comprised of five experts in integrative health care; and, ensure that HIE enrollees are provided with information to identify integrative medicine providers who are trained and accredited.

Establishes Section 138 to ban the sales of physician prescribing data to the pharmaceutical industry when the physician serves patients enrolled in a qualified health benefit plan.

Amends Section 202(d) to include that retirees who are participants or beneficiaries in an adversely affected health benefits

group and are not enrolled in Medicare, are to be considered Exchange eligible individuals and may enter into the HIE in 2013, the first year of operation. Also limits post-retirement reductions of retiree health benefits by group health plans in Section 165.

Creates a new provision, Section 209, to allow small employer benefit arrangements, which are defined as not-for-profit agricultural or other industry cooperatives, to work with the Commissioner to assist in the enrollment of small employers and their employees in the HIE. The small employer benefit arrangements are to operate for the primary purpose of providing affordable employee benefits to its members; that only consists of member employers that are in the same industry or line of business; ensure that no member has more than five percent voting interest in the cooperative, and are to be governed by a board of directors elected by its members.

Adds an additional condition for providers eligible to participate in the public health insurance option in Section 225(b) by permitting providers, such as Christian Science practitioners, who are "otherwise permitted to practice under state law" to also participate in the public health insurance option.

Amends the affordability standard for access to the HIE in Section 242(b)(2)(B) by giving the Commissioner the authority to permit individuals and families who have received an employer offer of health care coverage to qualify for the HIE in Y2 of operation if their premium and cost sharing is greater than 11 percent of family income.

Inserts language to protect against the misclassification of workers for purposes of the provisions within H.R. 3200. The language requires the Secretary of Labor to promulgate record-keeping requirements for both employees and certain individuals performing work for an employer but whom the employer has not treated as employees. The content and scope of these record-keeping requirements (both in terms of what data is needed and what non-employee individuals are covered) should be designed to assist the Secretary in the audits she performs to determine noncompliance with the bill's health coverage participation requirements.

Requires the development of standards for accessible equipment, and requires relevant agencies to ensure that all entities covered by the legislation meet the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The Committee recognizes that a critical component of providing health care to many individuals with disabilities is ensuring that diagnostic and treatment equipment is accessible to those with impairments which impede use of standard equipment. Inaccessible medical equipment often prevents people with disabilities from receiving the basic care others take for granted, such as getting weighed, preventative dental care, mammograms, pelvic exams, x-rays, physical examinations, colonoscopies, and vision screenings.

Subtitle F of Division C adds a new provision to reduce the student-to-school nurse ratio. Section 2551 makes available demonstration grants to eligible local education agencies with the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools with special consideration given to high-need local educational agencies who demonstrate the greatest

need for new or additional nursing services by providing information on the current ratios of students to school nurses.

The last modification within the Miller substitute recognizes the importance of preventive approaches to health and wellness. Section 2552 authorizes the Secretary of Labor to offer incentives to employers who establish qualified wellness programs for their employees. The Committee believes these small grants will assist in improving the health of our nation's workforce and will reduce employer healthcare costs. Participating employers must offer the programs to all employees and cannot mandate participation nor use participation as a condition to receive any financial incentive.

AMENDMENTS CONSIDERED IN COMMITTEE

The amendment offered by Representative Courtney (D–CT) amends Section 111 of the Miller substitute. The amendment reduces the pre-existing condition "look-back" period from six months to 30 days and shortens the amount of time during which a provider can exclude coverage for pre-existing conditions, during the period prior to the bill's effective date for the total prohibition on pre-existing condition exclusions. The amendment was passed by voice vote.

The Representative Kline (R–MN) amendment would have struck Titles I and II of Division A which would include striking the protections and standards for qualified health benefits plans and also the HIE. The Kline amendment would have also struck Sections 311, 312, 313, 314, 321 and 324 which include striking employer mandate requirements and requirements for employer health coverage participation under ERISA. The amendment was defeated by a roll call vote of 19–29.

The amendment offered by Representative Titus (D–NV) would increase the size of small businesses that can choose to enter the HIE. It specifies that in 2013 (Y1), the size of businesses eligible for the HIE would increase from 10 to 15; in 2014 (Y2), the size of businesses eligible for the HIE would increase from 20 to 25; and, in 2015 (Y3), the Commissioner must allow additional small businesses to enter the HIE and would set the minimum size for an eligible small business as one with 50 employees or less. The amendment passed by a roll call vote of 29–19.

The amendment offered by Representative Scott (D–VA) would add early periodic screening, diagnosis, and treatment (EPSDT) benefits to children up to age 21 to be included in the essential benefits package (Section 122(b)(10)). The amendment passed by a roll call vote of 32–17.

The amendment offered by Representative Thompson (R–PA) would have struck Subtitle A of Title II of Division A, i.e., the HIE. The amendment was defeated by a roll call vote of 19–29.

The amendment offered by Representative Roe (R–TN) would have struck Subtitle B of Title II of Division A, i.e., the public health insurance option. The amendment was defeated by a roll call vote of 19–29.

The amendment offered by Representative Davis (D–CA) would instruct the Health Benefits Advisory Committee to examine current state laws and to seek input from the states as it forms its recommendations for the federal benefits standards by inserting

the aforementioned after paragraph (2) in Section 123(b). The amendment was passed by voice vote.

The amendment offered by Representative Guthrie (R–KY) would have struck Sections 311, 312, 313, 314, 321 and 324, i.e., the employer mandate requirements and requirements for employer health coverage participation under ERISA. The amendment was defeated by a roll call vote of 19–28.

The second amendment offered by Representative Davis (D–CA) would end the current COBRA eligibility limit and allow those currently enrolled in COBRA to keep their insurance until they find another job offering coverage or until they become eligible to participate in the HIE. This amendment would be inserted after Subtitle G of Title I of Division A. The amendment was passed by voice vote.

The amendment offered by Representative Biggert (R–IL) and Representative Price (R–GA) would have struck Section 102(b) and inserted that any group health plan operating under ERISA would be treated as already meeting the requirements of a qualified health benefits plan as listed in Title I. The amendment was defeated by a roll call vote of 18–29.

The amendment offered by Representative Fudge (D–OH) and Representative Titus (D–NV) would help small employers select health plans. The amendment would require the Commissioner, in consultation with the Small Business Administration, to establish and carry out a program to provide health insurance counseling and technical assistance to small employers who provide their employees health care through the HIE. The amendment was passed by a roll call vote of 28–18.

The amendment offered by Representative Wilson (R–SC) would exclude TRICARE from the definition of employment-based health care. The amendment was passed by voice vote.

The amendment offered by Representative Hare (D–IL) would make a technical change in the Miller amendment regarding "small employer benefit associations." The amendment would strike "association(s)" and instead insert "arrangement(s)." The amendment was passed by voice vote.

The amendment offered by Representative Kline (R–MN) would have added to the end of Section 311 a provision to exempt employers from having to offer or maintain qualified health insurance coverage if an employer-initiated referendum calling for such an exemption was passed by a majority of employees. The amendment was defeated by a roll call vote of 18–28.

The amendment offered by Representative Hirono (D–HI) would maintain Hawaii's Prepaid Health Care Act exemption under ERISA, including with respect to the provisions of H.R. 3200, where such state statute ensures health care benefits equivalent to or greater than those benefits that would be guaranteed by H.R. 3200. The amendment was passed by voice vote.

The amendment offered by Representative Hoekstra (R–MI) would have suspended Sections 311, 312, 313, and 314, which pertain to H.R. 3200's employer mandate, in the event that the national unemployment rate as announced monthly by the Bureau of Labor Statistics at the Department of Labor equals or exceed eight percent for two consecutive months. The amendment was defeated by voice vote.

The amendment offered by Representative Kucinich (D–OH) would create an ERISA waiver to permit States to enact single payer laws. The Department of Labor would determine whether the State plan meets certain requirements to obtain the waiver. The amendment was passed by a roll call vote of 27–19 with one member passing on the vote.

The amendment offered by Representative Hunter (R–CA) would create a two-year employer hardship exemption that waives an employer's obligation to provide coverage or pay a penalty. The amendment was passed by voice vote.

The second amendment offered by Representative Kucinich (D–OH) would have limited the total compensation of insurance company executives to not exceed the compensation of the President of the United States. The amendment was withdrawn and no further action was taken on it.

The amendment offered by Mr. McClintock (R–CA) would have required that 30 days after H.R. 3200's enactment, the Director of the Office of Management and Budget submit a report to the House of Representatives determining whether Sections 311, 312, 313, 314, 321, and 324 are deficit neutral for the applicable period of ten fiscal years. The report would be annually conducted prior at the end of each fiscal year and if a section was found to not be deficit neutral, then it would be suspended for two years following that fiscal year. The amendment was defeated by a roll call vote of 19–28.

The en bloc amendment offered by Representative Holt (D–NJ), incorporating proposals by Representatives Loebsack, Wu, Courtney, Altmire, and Tonko, would add workforce development provisions for long-term care workers; add training for health care jobs for vulnerable populations; expand and clarify that mental health and substance abuse preventative services are covered in the essential benefits package; and create a health care labor market website and an online health professional training grant program. The amendment was passed by voice vote.

The amendment offered by Representative Biggert (R–IL) would have established an annual report on the average waiting period for minimum health services and if an increase of five percent or more was reported, then Sections 311, 312, 313, 314, 321, and 324 would not apply in the following year. The amendment was withdrawn and no further action was taken on it.

The amendment offered by Representative Polis (D–CO) would expand the characteristics outlined in Section 221(e) on data collection to include race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation as determined appropriate by the Secretary. The amendment was passed by voice vote.

The amendment offered by Representative McMorris Rodgers (R–WA) would have prohibited any tax increases to families with an income of $250,000 or less. The amendment was ruled not germane as outside the jurisdiction of the Committee.

The amendment offered by Representative Sablan (NMI), Representative Pierluisi (PR), and Representative Clarke (D–NY) would add to H.R. 3200 a Sense of Congress stating that the final

bill must meaningfully address the health care needs of the territories. The amendment was passed by voice vote.

The second amendment offered by Representative Kline (R–MN) would have prohibited any provision in H.R. 3200 from the application of state law remedies in connection to group health plans, maintaining that section 502 of ERISA will continue to supersede state law. The amendment was defeated by a roll call vote of 19–28.

The amendment offered by Representative Sestak (D–PA) would require the presence of patient representatives on the Health Benefits Advisory Committee. It is the intent of the Committee that such educated patients or consumer advocates be free of conflicts of interest with any provider, insurer, or other interest in the health sector. The amendment was passed by voice vote.

The amendment offered by Representative Price (R–GA) would have created a waiver that would exempt States from enacting Subtitle B in Title III if a State health plan was enacted into law by the legislature of that State. The amendment was defeated by a roll call vote of 19–28.

The amendment offered by Representative Wu (D–OR) and Representative Altmire (D–PA) would require the Health Choices Commissioner to study how to increase the meaningful use of electronic health records and then use the results of that study to potentially require higher reimbursement rates for providers that use health information technology. The amendment was passed by voice vote.

The amendment offered by Representative Souder (R–IN) would have prohibited any provision in H.R. 3200 from requiring a group health plan to provide coverage for abortion or access to an abortion. The amendment was defeated by roll call vote of 19–29.

The second amendment offered by Representative Souder (R–IN) would require that no funds appropriated under Titles I–III be used for abortion or to cover any part of the costs of any health benefits plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness. The amendment was defeated by a roll call vote of 19–29.

The second amendment offered by Representative Biggert (R–IL) would prohibit the Commissioner or any health insurance issuer offering health insurance coverage through the HIE from discriminating against approving or covering health care services based on religious or spiritual content if expenditures for such a health care service are allowable under 213(d) of the Internal Revenue Code of 1986. The amendment was passed by voice vote.

The second amendment offered by Representative Price (R–GA) would prohibit any provision in H.R. 3200 to be construed to preclude any participant or beneficiary in a group health plan from entering into any contract or arrangement for health care with any health care provider. The amendment was passed by voice vote.

The second amendment offered by Representative Hoekstra (R–MI) would have designated a "health care sharing ministry" as an "employer" and the members of such a ministry would be designated as "employees." The amendment was withdrawn and no further action was taken on it.

The amendment offered by Representative Petri (R–WI) would permit group consumer directed health plans and arrangements

(including a high deductible health plan with the meaning of section 223(c)(2) of the IRS Code) to be treated as acceptable coverage consistent with other employer group health plans subject to the grace period until Y5. The amendment was amended by unanimous consent to ensure that this exception was not permanent and passed by voice vote.

The amendment offered by Representative McKeon (R–CA) would have created a new title at the end of Division A titled Title IV—Small Business Health Fairness. This title would include rules governing association health plans; clarification of treatment of single employer arrangements; enforcement provisions related to association health plans; and other provisions related to association health plans. The amendment was defeated by a roll call vote of 21–27.

The amendment offered by Representative Castle (R–DE) would have allowed variation in cost-sharing and premiums charged by the qualified health benefits plans dependent upon participant participation in employer prevention and wellness programs. The amendment was withdrawn and no further action was taken on it.

The second amendment offered by Representative Wilson (R–SC) would add to H.R. 3200 a Sense of the House of Representatives that any members who vote in support of the public health insurance option are urged to forgo their right to participate in the FEHBP and enroll under the public option. The amendment was passed by voice vote.

The third amendment offered by Representative Price (R–GA) would have established provisions for defined contribution health plans. The amendment was defeated by a roll call vote of 19–29.

The fourth amendment offered by Representative Price (R–GA) would have struck the physician billing language in Section 225(c). The amendment was defeated by a roll call vote of 19–29.

The second amendment offered by Representative McMorris Rodgers (R–WA) would have exempted plans established and maintained by Indian tribal governments. The amendment was defeated by voice vote.

Committee on Ways & Means Mark-up of H.R. 3200

On July 16, 2009, the Committee on Ways and Means met to mark-up H.R. 3200, America's Affordable Health Choices Act and reported the bill as amended by a vote of 23–18.

Committee on Energy & Commerce Mark-up of H.R. 3200

Beginning on July 16, 2009, the Committee on Energy and Commerce met to mark-up H.R. 3200, America's Affordable Health Choices Act. In addition to July 16, 2009, the Committee considered H.R. 3200 on July 17, 20, 30 and 31. The Committee reported the bill as amended by a vote of 31–28.

SENATE CONSIDERATION OF THE AFFORDABLE HEALTH CHOICES ACT

Beginning on June 17, 2009 the HELP Committee met to mark-up the Affordable Health Choices Act. The Committee reported the bill as amended on July 15, 2009 by a vote of 13–10.

III. SUMMARY OF THE BILL

America's Affordable Health Choices Act makes critical reforms to this nation's broken health care system. It will lower costs, preserve choice, and expand access to quality, affordable care. To protect families struggling with health care costs and inadequate coverage, the bill ensures that health insurance companies can no longer compete based on risk selection. By prohibiting rate increases based on pre-existing conditions, gender and occupation, the bill requires that insurance companies instead compete based on quality and efficiency. In addition, H.R. 3200 will lower the cost of health care by eliminating co-pays and deductibles for preventive care, capping annual out-of-pocket expenses, prohibiting lifetime limits, and allowing the uninsured, part-time workers, and employees of some small businesses to obtain group rates by purchasing health care through the HIE.

H.R. 3200 will expand choice of health insurance, especially in many parts of the country where families have very limited choices because of the nature of the insurance market. The HIE will serve as an organized and transparent "marketplace for the purchase of health insurance"[7] where individuals and employees (phased-in over time) can shop and compare health insurance options. To participate in the HIE, insurers will be required to meet the insurance market reforms and consumer protections and offer the essential benefits package established by the new independent benefits advisory committee. Individuals and families under 400 percent of poverty who qualify for affordability credits will be able to use that money in the HIE to help offset the costs of their health care coverage.

One health insurance choice within the HIE will be the public health insurance option. The public option will be required to operate on the same level as private insurance companies, adhering to the same market reforms and consumer protections, and it will be required to be financed from its premiums. Rates will vary geographically just as private insurers do. The public plan option will be able to utilize payment rates similar to Medicare with provider rates at Medicare plus 5 percent. However, beginning in Y4 the Secretary will have the authority to use an administrative process to set rates (at levels that do not increase costs) in order to promote payment accuracy and the delivery of affordable and efficient care.

The inclusion of a public option in the HIE will help to rein in the costs of health insurance while preserving access. At all times, the Secretary retains the authority to utilize innovative payment mechanisms and policies to improve health outcomes, reduce health disparities, and promote quality and integrated care. Furthermore, the public option will represent choice in many communities where one insurer dominates the market. Consequently, the public health insurance option has the ability to increase competition and control costs. However, no one, including employers who put their employees into the HIE, can place or force anyone into the public option. The decision to enroll in a private plan or the

[7] Linda Blumberg and Karen Pollitz, Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals, the Urban Institute & Robert Wood Johnson Foundation (April 2009).

public option is always left to individuals and families to decide for themselves.

H.R. 3200 is built upon the premise of shared responsibility among individuals, employers and the government, so that everyone contributes and has access to affordable, quality health care. America's Affordable Health Choices Act gives employers the choice to either offer health insurance or pay a percentage of payroll for their employees to go into the HIE.

Beginning in 2013, employers "playing" will be required to offer health coverage to all of their full-time employees and contribute 72.5 percent of the premium for an individual and 65 percent for a family premium. For part-time workers, employers will have the choice to either offer health coverage on a pro rata basis or pay the required penalty. There will be no minimum benefit requirement for existing employer-sponsored health plans until the end of 2018. At that time, employers who "play" will be required to offer coverage that is no less than the minimum benefit level within the Exchange and must include the insurance market reforms.

Employers may also choose to "pay" instead of play. A "pay" employer would be required to make a contribution equal to 8 percent of their payroll to the HIE. However, recognizing the difficulties small businesses face, the bill includes a number of provisions to help small employers. For example, H.R. 3200 exempts employers with payrolls of $250,000 or less from the pay or play requirements. For employers with payroll between $250,000 and $400,000 the contribution amount phases-up from 2 to 8 percent so that only employers with payrolls greater than $400,000 will pay the full 8 percent.

Whether obtaining coverage through an employer, a spouse or the HIE, H.R. 3200 requires that individuals either enroll in health care coverage or pay 2.5 percent of their adjusted gross income capped at the total cost of the average cost premium offered in the HIE. Recognizing that high health care costs prevent many Americans from securing health care coverage, H.R. 3200 provides for affordability credits to help eligible low- and middle-income individuals and families purchase coverage in the HIE. In addition, for those who can demonstrate that they are unable to afford health insurance, the Health Choices Commissioner (Commissioner) retains the authority to develop and grant hardship waivers.

The affordability credits provided for under the bill will be available to individuals and families with incomes between 133 to 400 percent of the federal poverty level. Medicaid will be expanded so that anyone below 133 percent of poverty will be Medicaid eligible and that expansion will be fully federally financed. Employees who are offered health insurance through an employer will be unable to go into the HIE and receive affordability credits unless that employer coverage is deemed unaffordable. An unaffordable employer offer is one where the employees' share of the premium and cost sharing are more than 11 percent of family income.

Finally, as millions of Americans gain coverage, investments in the health care workforce are critical to ensuring all Americans have access to needed care. H.R. 3200 includes significant investments to help train more primary care and public health physicians as well as nurses. It puts into place incentives to encourage more people to become doctors and nurses (particularly in rural

areas). Some of the workforce provisions include: (1) increased funding for the National Health Service Corp.; (2) expanded scholarships and loans for health professionals who work in shortage professions and areas; (3) steps to increase physician training outside of the hospital and redistribute unfilled graduate medical education residency slots so that more primary care physicians can be trained; and (4) grants through the Department of Labor to help train and retain nurses.

IV. COMMITTEE VIEWS

The Committee on Education and Labor of the 111th Congress is committed to containing the cost of health care and ensuring that every American has access to affordable, quality health care coverage. H.R. 3200 includes critical reforms to the health care system that are needed to reduce surging premium and health care costs that families, businesses and governments are struggling to afford. The bill cuts over a half trillion dollars from the health care system, ensures that no one is ever one illness away from bankruptcy and creates a system where 97 percent of Americans will have health care coverage by 2015.

OVERVIEW

Health care reform is a critical issue in this country. There are 47 million people in the United States without health care coverage and almost nine million of them are children.[8] Meanwhile, health care costs are rising for nearly everyone. The United States spends over $2.4 trillion—more than 18 percent of GDP—on health care services and products—far more than other industrialized countries.[9] In addition, health care costs continue to grow faster than the economy as a whole, and individuals and families are burdened by the weight of these escalating expenses. Yet, for all this spending, the United States' scores are average or worse on many key indicators of health care quality. Health care reform is critical to restoring prosperity for our nation's families and H.R. 3200 will ensure that coverage is truly affordable and dependable for hard-working Americans.

The Uninsured

The number of uninsured persons in the United States continues to grow, from 44.8 million in 2005 to 47.0 million in 2006. The percentage of uninsured is also rising, from 15.3 percent of the total population in 2005 to 15.8 percent in 2006.[10]

More than two-thirds of the uninsured live in a household with one full-time worker. These increasing numbers can be attributed to the rising cost of health care, a decline in manufacturing jobs and an increase in workers employed in the service industries and small businesses, which are less likely to provide insurance.[11] Roughly two-thirds of Americans without health insurance have in-

[8] Supra note 2.

[9] National Coalition on Health Care, "Facts on the Cost of Health Insurance and Health Care," (2007), available at: *http:www.nchc.org/facts/cost.shtml*

[10] U.S. Census Bureau, "Health Insurance Coverage: 2006—Highlights." (Aug. 27, 2007), available at: *http:www.census.gov/hhes/www/hlthins/hlthin06/hlth06asc.html*

[11] Robert Pear. "Without Health Benefits, a Good Life Turns Fragile," N.Y. Times (Mar. 5, 2007).

comes 200 percent below the federal poverty level—or approximately $44,000 for a family of four.[12] Not surprisingly, those in households with annual incomes below $25,000 are even less likely to be insured. In 2006, twenty-five percent of these Americans were uninsured in comparison to 16 percent of the total population.[13]

Approximately 162 million non-elderly workers and their dependents received health coverage through their employment-based health plans.[14] However, millions of other working Americans are unable to participate in an employer-sponsored plan, either because the employer does not offer coverage or the employee is not eligible under the plan. In 2005, 20 percent of "wage and salary" workers had an employer that did not offer any coverage to their workers. And 18 percent were not eligible for the health plan that was offered by their employer.[15] For example, some firms do not offer coverage to part-time employees and some do not offer coverage to workers who have been employed for less than a specific amount of time.

While employer-sponsored plans still remain the dominant source of health coverage for most Americans, the percentage of people obtaining health coverage through these plans has been steadily shrinking. For example, 60 percent of employers offered benefits in 2007, compared with 69 percent in 2000. Most of this decline can be attributed to the decline in small businesses (less than 200 workers) offering coverage.[16] Among firms with less than 10 workers, the offer rate dropped from 57 percent in 2000 to 45 percent in 2007.[17] For employers who have stopped offering coverage, almost three out of four say that premiums are too expensive.[18]

Unaffordable Health Care Coverage

Employers and workers alike are increasingly concerned about the rising costs of health care and insurance. Premiums for employer-sponsored health coverage are rising much faster than workers' earnings and inflation. Between spring 2006 and spring 2007, premiums for coverage offered by employers across the United States increased by 6.1 percent—more than twice the growth in the Consumer Price Index (CPI). The average annual cost of employer-sponsored health insurance was nearing $13,000 in 2008. In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 12 percent more for their coverage in 2007 than in 2006. Premiums for a fam-

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[12] Kaiser Family Foundation, "The Uninsured: A Primer," (Oct. 2008). *http:www.kff.org/uninsured/upload/7451–04.pdf.*

[13] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006" Current Population Reports (2006) at 60–233. See also, U.S. Department of Commerce, Economics and Statistics Administration, August 2007.

[14] Elise Gould, "The Erosion of Employer-Sponsored Health Insurance," Economic Policy Institute (Oct. 8, 2008).

[15] Supra note 9.

[16] Kaiser Commission on Medicaid and the Uninsured, "2007 Employer Health Benefits Survey—Summary of Findings," (Sept. 2007) at 29, available at: *http:www.kff.org/insurance/7672/index.cfm*

[17] Paul Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey." Employee Benefit Research Institute, October 2007.

[18] Kaiser Family Foundation/HRET, "Employer Health Benefits 2007 Annual Survey." (Sept. 2007).

ily of four paid by workers increased by 10 percent from 2006 to 2007.[19]

These increases are of great concern, and more and more workers believe that they may not be able to afford their share of the cost of coverage. In a recent poll by the Pew Research Center,[20] forty-four percent of workers surveyed say that affording health insurance is difficult or very difficult. In addition, almost three out of four uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly. Workers also know that if they lose their job, they are likely to lose access to affordable health care coverage.

In addition, among those employers that offer benefits, a large percentage of firms report that in the next year not only are they very or somewhat likely to increase the amount workers contribute to premiums (45 percent), but they will also increase deductible amounts (37 percent), office visit cost sharing (42 percent) or the amount that employees have to pay for prescription drugs (41 percent).[21]

The problem of being "underinsured" has also become increasingly relevant. One recent study estimated that 29 percent of individuals who have insurance are "underinsured" and have coverage that is inadequate to secure them access to needed care or protect again catastrophic medical bills.[22]

The Commonwealth Fund found that 25 million adults who had health coverage in 2007 were underinsured[23]—a 60 percent increase from the 16 million Americans who were underinsured in 2003.[24] Another study found that while 16 percent of adults spent more than 10 percent of their family income on health care service in 1996. By 2003 the proportion of adults bearing these health-related "catastrophic financial burdens" had increased to 19 percent to about 49 million individuals.[25] Another study found that financial burdens had increased to the point that private health insurance coverage no longer provided adequate financial protection for low-income families.[26]

In addition, many families have little room within their family budgets for large or unexpected out-of-pocket health care expenses. In 2003, an estimated 77 million Americans—nearly two out of five adults—had difficulty paying medical bills.[27] Even working age adults who were continually insured had problems paying their medical bills and carried medical debt as a result. Nearly half of all bankruptcies in the United States are related, in part, to health

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[19] Id.

[20] Pew Research Center for the People and the Press poll, conducted January 9–13, 2008, available at: *http:people-press.org/reports/dispaly.php3?ReportID*= 395.

[21] Supra note 16.

[22] Consumer Reports, "Health Insurance: CR Investigates Health Care," September 2007, available at: *http:www.consumerreports.org/cro/health-fitness/health-care/health-insurance–9–07/overview/0709*[illegible]

[23] According to the Commonwealth Fund study, families are identified as underinsured if they had out-of-pocket medical spending that absorbed at least 10 percent of family income, or for low-income adults (200 percent below the federal poverty level), medical spending consumed at least 5 percent of family income.

[24] Cathy Schoen et al, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Health Affairs 27 no. 4 (2008).

[25] J. Banthin and D. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996 to 2003," JAMA (2006).

[26] J. Banthin, P. Cunningham and D. Bernard. "Financial Burdens of Health Care, 2001–2004," Health Affairs 27, no.1 (2008) at 188–195.

[27] Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," The Commonwealth Fund (Aug. 2005).

care expenses. And of those facing medical bankruptcies, roughly three-quarters had health insurance at the onset of their bankrupting illness.[28]

The risk of being underinsured or experiencing financial problems due to health spending varies not only by family income, but also by health status. According to Judy Feder, Senior Fellow at the Center for American Progress, "health care affordability is particularly elusive for individuals with chronic illness and other conditions that require on-going, often costly, medical care."[29] Individuals who are older and have chronic conditions such as diabetes, heart disease, or arthritis, or have experienced a stroke, are more likely to spend a high proportion of their income on health expenses. If these individuals do not have an employer-sponsored health plan, or if they lose this coverage, their ability to purchase coverage in the non-group market is limited at best. The non-group market systematically denies coverage, limits benefits, and charges excessive premiums to individuals with pre-existing conditions or those who are perceived to be at high-risk. Ironically, the people who are more likely to become sick—the very population that insurance is supposed to protect—are also more likely to be underinsured and face grave financial problems.

The Consequences of being Uninsured or Underinsured

Being uninsured makes it more likely that a person will not receive adequate medical care. Individuals without insurance often go without or delay care, and the care they do receive is likely to be lower quality than the care received by insured individuals. An estimated 18,000 to 22,000 Americans die each year because they do not have health coverage.[30] The length of time a person goes without health insurance also makes a difference—people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time.[31] Finally, lack of coverage and coverage stability is particularly burdensome on the seriously and chronically ill, whose care is often delayed or denied when they cannot pay.[32]

HEALTH CARE COSTS AND SPENDING: THE COST OF DOING NOTHING

H.R. 3200 ensures quality and affordable health care choices for all Americans while also controlling costs in a system in which costs have spiraled out of control. The United States spends over $2.4 trillion on health care each year.[33] As noted earlier, health care expenditures in the United States constitute approximately 18 percent of the current Gross Domestic Product (GDP).[34] If health care costs continue to grow at historical rates, the share of GDP

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[28] David Himmelstein, Elizabeth Warren, D. Thorne, and S. Woolhandler, "Illness and Injury as Contributors to Bankruptcy," Health Affairs (2005).

[29] Judy Feder, Testimony before the Committee on Energy and Commerce Committee (hereinafter Feder) (Mar. 17, 2009).

[30] "Insuring America's Health: Principles and Recommendations," Institute of Medicine (Jan. 14, 2004).

[31] Id.

[32] Institute of Medicine, "Care Without Coverage: Too Little, Too Late" (May 2002), available at: *http:www.iom.edu/Object.File/Master/4/160/Uninsured2FINAL.pdf*

[33] Supra note 9.

[34] Executive Office of the President, Council of Economic Advisors, "The Economic Case for Health Care Reform," available at *http:www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/ (June 2009).*

devoted to health care in the United States is projected to reach 34 percent by 2040.[35]

International Comparisons

The United States devotes a far larger share of GDP to health care spending more than two times per person on health care than any other OECD (Organization for Economic Co-operation and Development) country.[36] While health care expenditures in the United States are about 18 percent of GDP[37] the OECD reports that the next highest country was Switzerland—with 11.3 percent—and in most other high-income countries, the share was less than 10 percent.[38]

Despite outpacing other countries with investments in health care, the U.S. fails to produce better health outcomes in fundamental ways. OECD data shows that life expectancy in the United States is lower than in any other high-income country, as well as in many middle-income countries.[39] Similarly, the infant mortality rate in the United States is substantially higher than that of other developed countries. While many factors other than health care expenditures may affect life expectancy and infant mortality rates—for example, demographics, lifestyle behaviors, income inequality, non-health disparities, and measurement differences across countries[40]—the Council of Economic Advisors (CEA) has concluded that "the fact that the United States lags behind lower spending countries is strongly suggestive of substantial inefficiency in our current system."[41] Indeed, according to estimates by the CEA based on the spending and outcomes in other countries, efficiency improvements in the U.S. health care system potentially could free up resources equal to 5 percent of U.S. GDP.[42]

Analyzing health care spending over time, the CEA also notes that while health care spending has increased in other countries as well, the spending by the U.S. has not yielded the same outcomes as other countries. In 1970, the United States devoted only a moderately higher fraction of GDP to health care than other high-income countries, whereas in 2009 the United States spends dramatically more.[43] Yet, during that same period, life expectancy has actually risen less in the United States than in other countries.[44] This data suggests that much of the increased U.S. spending is inefficient.[45]

Cost of the Uninsured

While the U.S. health care system currently leaves 47 million Americans uninsured[46] and approximately 25 million under-

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[35] Id.
[36] Marcia Angell Testimony before the Committee on Education and Labor Committee (hereinafter Angell) (Jun. 10, 2009).
[37] Supra note 34.
[38] Id.
[39] Id.
[40] Robert Wood Johnson Foundation, Commission to Build a Healthier America, "Beyond Health Care: New Directions to a Healthier America" (Apr. 2009).
[41] Supra note 34.
[42] Id.
[43] Id.
[44] Garber, Alan M., and J. Skinner, "Is American Health Care Uniquely Inefficient?" Journal of Economic Perspectives (2008) at 27–50.
[45] Supra note 34.
[46] National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml (2009).*

insured,[47] the CEA projects that the number of uninsured could increase to 72 million by 2040.[48] Such increases in the numbers of uninsured people will create additional uncompensated care costs, which include costs incurred by hospitals and physicians for the charity care they provide to the uninsured as well as bad debt such as unpaid bills.[49] Both the federal government and state governments use tax revenues to pay health care providers for a portion of these costs through programs such as Disproportionate Share Hospital (DSH) payments and grants to Community Health Centers.[50] In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.[51] The CEA projects that if the U.S. does not slow the real growth rate of health spending and a subsequent rise in the uninsured, the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.[52]

Costs to Individuals and Families

As the cost of health care skyrockets, families and employers offering health insurance struggle to absorb the increased costs. In 2008, employer-based premiums increased by 5 percent. That growth was even greater for small firms. On average, they incurred a premium increase of 5.5 percent, and, for those with 24 or fewer workers, their respective increase was 6.8 percent.[53] Much of the increase in health care costs has been shifted onto workers. In 2008, the average annual premium for a family of four was $12,700, and workers contributed approximately $3,400 of that total which was 12 percent more than the year before. Workers are now paying $1,600 more for family coverage than they did 10 years ago.[54] Over the last decade, health care costs have risen on average four times faster than workers' earnings.[55]

These dramatic increases in health care costs have serious implications for American households. Some economists believe that, over the long run, workers pay for the rising cost of health insurance through lower wages.[56] To illustrate this relationship, the CEA has analyzed historical and projected average annual total compensation (measured in 2008 dollars), which includes wages as well as non-wage benefits such as health insurance.[57] Their analysis indicates that health insurance premiums are growing more rapidly than total compensation in percentage terms, and as a result, an increasing share of total compensation that a worker re-

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[47] "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," Commonwealth Fund (2008)

[48] Supra note 34.

[49] American Hospital Association, "Uncompensated Hospital Care Fact Sheet" (Nov. 2005), available at *http:www.aha.org/aha/content/2005/pdf/0511 UncompensatedCareFactSheet.pdf.*

[50] Hadley, Jack, J. Holahan, T. Coughlin, and D. Miller. "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," Health Affairs (2008).

[51] Id.

[52] Supra note 34.

[53] The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2008 Annual Survey, (Sept. 2008).

[54] Angell.

[55] See, National Coalition on Health Care, available at: *www.nchc.org/facts/cost.shtml* (2009).

[56] Pauly, Mark V., "Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance" (1998).

[57] Supra note 34 (relying on the 1996 to 2006 Medical Expenditure Panel Survey-Insurance Component).

ceives goes to cover health insurance premiums.[58] Moreover, the CEA notes that households with employer-sponsored health insurance could also be affected by rapid cost growth as employers shift to less generous plans with higher annual deductibles.[59] It is important to note, however, that the wage stagnation experienced by workers over recent decades cannot be attributed solely to rising health care costs. For example, low-wage workers have experienced real wage declines in recent years despite few such workers having access to or participating in employment-based health insurance coverage.[60] More economic dynamics are at work in the wage squeeze on workers, but rising health costs contribute to the downward pressure.

H.R. 3200 Will Increase Standards of Living and Create New Jobs

By slowing the growth in health care costs, standards of living will improve and resources will be freed to improve and expand the health care system. The CEA projects that slowing growth by 1.5 percentage points per year will save a family $2,600 by 2020.[61] By 2030 that savings would be increased to nearly $10,000.[62]

Furthermore, the CEA estimates that the coverage expansions that will result from health reform will produce a net benefit of approximately $100 billion a year, or about two-thirds of a percent of GDP.[63] According to its analysis, health care reform will lower the unemployment rate in the United States and could add as many as 500,000 jobs on an annual basis.[64] By producing a more healthy and productive workforce, health care reform will improve standards of living and help strengthen the U.S. economy.

Shared Responsibility & Employment-Based Health Care Insurance

In order to control costs and expand access to quality affordable health care, everyone must be covered and employers, individuals and the government must share in this responsibility. Consistent with the minimum wage and overtime laws, H.R. 3200 creates a fundamental right to a minimum level of health care contribution and/or coverage through an employer. As noted earlier, two-thirds of Americans receive health coverage through an employer, and H.R. 3200 builds upon the current employer-based system by implementing a 'pay or play' requirement.

The employer responsibility to provide and/or contribute to the health care of its workers will stabilize the employer-based health care system. Because the Employee Retirement Income Security Act of 1974 (ERISA) currently contains no requirement that an employer offer employee benefits, employers who do not offer health insurance to their workers gain an unfair economic advantage relative to those employers who do provide coverage, and millions of hard-working Americans and their families are left without health insurance. It is a vicious cycle because these uninsured workers turn to emergency rooms for health care which in turn increases

[58] Id.
[59] Id.
[60] Economic Policy Institute, "Increasing Health Costs Can't Explain Earnings Dip for Low-Wage Workers," Economic Snapshot (April 12, 2006).
[61] Supra note 34.
[62] Id.
[63] Id.
[64] Id.

costs for employers and families with health insurance. It is estimated that in 2008 premiums were about 8 percent or $1,100 higher due to this hidden cost shift.[65]

Strengthening the Employer-Based System

Millions of employers voluntarily decide to offer health benefits because it is in their economic interest. Employers are not taxed on their contributions to employees' health care, and these costs are deductible as a business expense.[66] In addition, large employers can offer health care coverage at a much lower cost because they can negotiate with insurers and have a larger pool of employees to spread the risk. Furthermore, employers recognize that investments in health care can produce gains in employee health which means fewer missed days, higher productivity and better overall job satisfaction.

Despite the incentives to offer health coverage, skyrocketing health care costs make it difficult for employers, particularly small businesses, to offer comprehensive health insurance. As noted earlier, while approximately 63 percent of the under–65 population and their dependents have insurance through employment,[67] the number of employers offering health care coverage has been declining over the last decade. The number of people getting health coverage through an employer dropped by 3 million between 2000 and 2007,[68] largely due to increasing costs. In addition, the Center for American Progress projects that as a result of layoffs, approximately 14,000 Americans lose their employer-sponsored coverage each day.[69] Overall, since 1999 premiums have increased 120 percent and at a rate that is on average four times faster than workers' earnings.[70]

However, even without an employer shared responsibility requirement, 86 percent of employers surveyed report that they will continue offering health care despite increasing costs.[71] Many of these employers are large ones who use health care benefits as a means to recruit and retain employees. Health care benefits are "highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage" even though they can currently do so.[72]

H.R. 3200 generally will not change what many employers are already doing. Beginning in 2013, the bill requires employers already offering health insurance to make an offer to all full-time employees and contribute 72.5 percent of the cost toward an individual policy and 65 percent toward a family policy. Today, employers on average contribute 83 percent toward the coverage of individual

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[65] Ben Furnas and Peter Harbage, "The Cost Shift from the Uninsured," The Center for American Progress (Mar. 2009).

[66] Paul Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," Health Affairs (May/June 2008) at 675.

[67] Supra note 10.

[68] Id.

[69] Center for American Progress (Feb. 2009), available at: *http:www.americanprogressaction.org/issues/2009/03/health—losses.html.*

[70] National Coalition on Health Care, "Health Insurance Costs," (2009), available at: *www.nchc.org/facts/cost.shtml*

[71] Supra note 61.

[72] Hacker at 10.

premiums and 71 percent toward the coverage of family premiums.[73]

The second phase of requirements under H.R. 3200 for existing employer health plans does not take effect until the end of 2018. At that time, in addition to making the required contribution amount, every employer-sponsored health plan will have to, at a minimum meet the essential benefit standards defined by the benefits committee, as well as satisfy the insurance reform standards specified in the bill. Employer health insurance plans will be required to be equivalent to no less than 70 percent of the actuarial value minus the cost sharing components of the essential benefit package. The majority of employers already meet this standard. According to the Congressional Research Service, the typical employer-sponsored PPO has an estimated actuarial value between 80–84 percent, while the typical employer-sponsored health savings account (HSA) and a qualified high deductible health plan (HDHP) has an estimated actuarial value of 76 percent, excluding contributions by an employer.[74]

While many employer plans already meet the bill's requirements, there are some notable omissions. For example, 10 percent of employer plans do not offer mental health and substance use disorder benefits and many include caps on lifetime limits and out of pocket expenses. In these cases, employers will have over 8 years to modify their plans and meet the requirements. Finally, H.R. 3200 extends the same benefit and insurance reform standards in all new employer and HIE plans, so that individuals and families have access in either case to affordable quality health coverage.

Protecting Small Business

For small business, health reform "is their number one need." [75] Forty-percent report that high costs have a "negative effect on other parts of their business, such as high employee turnover or preventing business growth." [76] According to the Small Business Majority, a non-profit independent group representing 27 million small businesses, small businesses spend 18 percent more than large employers for health care coverage.[77] The result is that in 2008, the percent of firms offering health insurance with three to nine employees dropped from 57 percent to 49 percent.[78]

Small businesses have small purchasing pools and one of the biggest obstacles they face in securing affordable health coverage is the lack of bargaining power they have against the insurance companies. In addition, the administrative costs paid by small businesses can be up to 27 percent of premiums to pay for marketing and paperwork costs and underwriting.[79]

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[73] "Employee Benefits in the United States, March 2008," Bureau of Labor Statistics (Aug. 7, 2008).

[74] Chris Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service (May 29, 2009) at 3–4.

[75] John Arensmeyer, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Arensmeyer)(Jun. 23, 2009) at 1.

[76] Taking the Pulse on Main Street, "Small Businesses, Health Insurance and Priorities for Reform (Jan. 2009).

[77] Arensmeyer at 2.

[78] Id.

[79] "The Economic Impact of Healthcare Reform on Small Business," Small Business Majority (Jun. 11, 2009) .

LaShonda Young, a small business owner, testified to the Committee about the problems she has had in seeking coverage for her forty employees. She received eight bids and each was from the same insurance company. She testified her experience isn't unique, as there are only one or two health insurers in her area.[80] She went on to testify that, "it's been years since we've been able to afford group health insurance . . . we got quotes from a couple of different places, [the] quotes came in at about 13 percent of payroll. [We're] willing to pay our fair share but we just couldn't afford 13 percent . . . "[81] Even if she was able to afford the coverage, she knew that it wouldn't cover the pre-existing conditions of her employees for up to 18 months and there was no guarantee the costs would remain stable.[82] As a result, small employers like Young are looking to other ways to help their employees find coverage on their own. Young testified that her company offers small stipends to employees to buy insurance on their own.

High health care costs also present an enormous obstacle for those trying to start or maintain a new business. While small businesses have traditionally played an essential role during prior economic recoveries, the high cost of health care is deterring entrepreneurs from starting a business in the first place. Louise Hardaway started her own business near Nashville, Tennessee. When attempting to get health care insurance she was quoted $12,800 a month to cover herself, her husband, business partner, and her business partner's spouse and child. Due to her inability to find affordable health care coverage Ms. Hardaway went out of business and went to work for another company where she could get health care.[83]

Recognizing the economic reality for many small businesses, in addition to driving down health care costs overall, H.R. 3200 contains numerous provisions such as tax credits and access to the HIE to help these employers provide coverage and alleviate their costs. In addition, the bill exempts employers from the pay or play requirement if they have payrolls of $250,000 or less. For employers with payrolls above $250,000 who choose not to offer coverage and would rather pay a penalty, that penalty is phased-up so that only employers with payrolls over $400,000 must pay the 8 percent penalty.

The Small Business Majority reports that small businesses, workers and the economy stand to save billions of dollars with the enactment of health care reform.[84] Absent health care reform small businesses will spend $2.4 trillion in health care costs over the next ten years. With health reform, small businesses will save 36 percent of those costs, as much as $855 billion. Without health reform, small businesses stand to lose $52.1 billion in profits due to high health care costs over the next ten years. Health reform will decrease these losses and save $29.2 billion. Reduced health care costs will allow employers to reinvest in their business and their workers. Without health reform, individuals working for small businesses could lose up to $834 billion in lost wages as employers

[80] LaShonda Young, Testimony before the Committee on Education and Labor Committee, "The Tri-Committee Draft for Health Care Reform," (hereinafter Young)(Jun. 23, 2009) at 2.
[81] Young at 2.
[82] Id.
[83] Simona Covel, "Sick and Getting Sicker," Wall St. Journal (Jul. 23, 2009).
[84] Supra note 76.

pass increased health care costs onto their employees over the next ten years. Health reform could save workers over $300 billion over the next ten years.[85] Reduced health care costs will allow employers to reinvest in their business and their workers.

THE HEALTH INSURANCE EXCHANGE WILL HELP SMALL EMPLOYERS

H.R. 3200 creates a health insurance exchange (HIE) for the uninsured and employees of small businesses to purchase health insurance in the initial years after enactment. Due to the disadvantages small businesses face when trying to purchase health care coverage on their own, both proponents and opponents of the bill believe that a health insurance exchange is essential for small business: "a broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed."[86] Furthermore, it "can be a vehicle that facilitates and monitors the movement of the system toward achievements of many national health care reform goals." Eighty-percent of small business owners in a recent state survey stated they favor a health insurance pool that they can put their employees into to buy coverage.[87]

A health insurance exchange is an organized marketplace where individuals and some employers can go to purchase health insurance. The HIE is advantageous to those looking to purchase insurance because it provides transparency when individuals and families shop for their health insurance. Currently, insurers are regulated by a patchwork of state laws. Beyond licensing requirements to sell insurance, private health insurance companies and health maintenance organizations (HMO) operate with considerable autonomy. The result is that policies can vary greatly and many policies leave people underinsured.

The robust HIE will not only organize the marketplace but also include insurance reforms and consumer protections, administer affordability credits, and provide people with choice of plans. The HIE will require that insurers, both private and public, adhere to the same rules. To help consumers make educated decisions the Commissioner will conduct outreach and provide assistance to consumers. The Commissioner will ensure that information is readily available in plain language and is provided in a culturally and linguistically appropriate manner. Furthermore, qualified health benefits plans (QHBP) including those participating in the HIE will be required to comply with transparency requirements established by the Commissioner, including the accurate and timely disclosure of plan documents, plan terms and conditions, as well as information on cost-sharing and payments with respect to out-of-network coverage, claims denials and other information to help educate consumers.

In addition to monitoring and streamlining the insurance industry, the HIE will play a significant role in containing health care costs. Health care costs are comprised of both the underlying costs of providing health care services as well as the administrative costs

[85] Id.
[86] Arensmeyer at 4.
[87] Id.

related to the provisions of coverage.[88] The HIE will require participating plans to offer standardized benefit packages which will increase the ability to compare plans and "reinforce incentives for insurers to price premiums as competitively as possible."[89] Lower cost plans in the HIE will help those employers who "play" by putting their employees into HIE because they will be responsible for a set contribution amount regardless of the plan an employee choose.[90] Furthermore, the affordability credits available to individuals in the HIE who do not enter the exchange with an employer contribution are tied to the average of the lowest three plans which will then incentivize individuals to choose low-cost plans. By the same token, insurers will be incentivized to offer low-cost plans in order to get more business.[91]

Access & Cost Containment Through A Public Health Insurance Option

The inclusion of a strong public health insurance option in the HIE will save over one hundred billion dollars and provide choice to millions of consumers who currently have little or no choice when looking for a health plan. Its inclusion in the HIE will promote value and innovation in the private health insurance industry by increasing competition. The result is that the public option will lower costs for consumers across the private market.

The public health insurance option will provide access to meaningful choice, something many Americans have never had when searching for a health plan. Many areas only have one or two dominant insurance options that control the market and thus have no downward pressure on costs.[92] Furthermore, "it is often in [these insurers'] interest to pay higher rates to key doctors and hospitals because they can pass on these costs to individuals and employers."[93] For insurers trying to enter a market, this practice makes it difficult for them to compete and reduce costs.

While the public option will be subject to the same standards as private plans, the public option can use administrative efficiencies to control costs. On average, private insurance overhead was about 11.7 percent of premiums which is significantly higher when compared to public insurers (Medicare is estimated at 3.6 percent and Medicaid at 6.8 percent).[94] In addition, because the public option is a health plan available nationwide it will have a broad reach and be able to obtain larger volume discounts and will not operate for profit.[95] Accordingly, the public option in H.R. 3200 will serve as a "benchmark for private plans, a backup to allow consumers access to a good plan with broad access to providers in all parts of the country, and to serve as a cost-control backstop."[96]

Ultimately, it will be up to consumers in the HIE to decide whether to enroll in the public option or a private plan. H.R. 3200

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[88] Linda Bloomberg and Karen Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals" (Apr. 2009).
[89] *Id.*
[90] However, an employer is always permitted to contribute an amount greater than the minimum should it choose.
[91] *Id.*
[92] Hacker at 5.
[93] *Id.*
[94] John Holahan and Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform," Urban Institute (2009).
[95] Hacker at 7.
[96] *Id.*

intends to create a level playing field for both to compete. Consumers will be able to compare what each plan offers—private plans or the public option—and decide which plan serves them and their families best.[97]

Ensuring Access to Health Care Through Insurance Market Reforms

Comprehensive insurance reforms are another critical element of health reform. Guaranteeing access to health care and protecting against medical debt largely depends on implementing comprehensive insurance reforms. About "20 percent of the population accounts for 80 percent of health spending;" the "sickest one-percent accounting for nearly one-quarter of health expenditures."[98] This uneven distribution of medical care creates incentives for insurance companies to avoid risk altogether rather than trying to spread it among the insured population.[99] As a result, health insurers—particularly in the individual market—have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy.[100] These practices include: denying health coverage based on pre-existing conditions or medical history,[101] even minor ones; charging higher, and often unaffordable, rates based on one's health; excluding pre-existing medical conditions from coverage; charging different premiums based on gender;[102] and rescinding policies after claims are made based on an assertion that an insured's original application was incomplete.[103] In addition, while "state and federal laws give individuals the right to renew their health insurance coverage, guaranteed renewability provides no protection against rate increases."[104]

Discrimination based on health, gender and other factors has severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured.[105] As noted earlier, these practices have resulted in about 57 million Americans having debt because of medical bills,[106] and over 42 million of that number has some sort of

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[97] *Id.*

[98] Karen Pollitz, testimony before the Committee on Energy and Commerce, Subcommittee on Health (hereinafter Pollitz) (Mar. 17, 2009).

[99] Linda Blumberg, testimony before the Committee on Ways And Means (April 22, 2009).

[100] Mila Kofman, testimony before the Committee on Energy and Commerce, Subcommittee on ealth (hereinafter Koffman)(Mar. 17, 2009); Blumberg, *supra* 94.

[101] *See* Fran Visco, testimony before the Committee on Education and Labor (June 22, 2009). Ms Visco testifying on behalf of the National Breast Coalition, stressed how no insurance or inadequate insurance has had a devastating effect on women diagnosed with breast cancer.

[102] A 2008 report by the National Women's Law Center examined individual insurance policies in 47 states and the District of Columbia and found that most of the states engage in a practice called "gender rating" where insurance companies arbitrarily charge women and men different rates for individual insurance premiums. Specifically, they found that women under 55 are charged more for health insurance than men (at age 25, 4% to 45% more; at age 40, 4 to 48% more). In addition, the report discovered that the vast majority of individual policies do not cover maternity leave, and in 9 states and the District of Columbia, insurers can reject survivors of domestic violence and those who have had C-sections. *See: Nowhere to Turn: How the Individual Insurance Market Fails Women*, National Women's Law Center (2008).

[103] *Id*, Pollitz, supra 98.

[104] *Id.*

[105] *Id*; Pollitz, *supra* 98. While 47 million Americans have no health insurance at all, almost as many are underinsured.

[106] Pollitz, *supra* 98, testified that "when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5% of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills."

medical coverage.[107] Medical debt is now the leading cause of personal bankruptcy.[108]

A key element to health reform is to prohibit risk selection practices and to support those factors based on quality and efficiency. Where states have prohibited these discriminatory practices, consumers have benefitted. For example, since 1993, Maine requires insurers to provide health insurance to individuals or small businesses on a "guarantee issue" basis. In addition, it also has an "adjusted community rating" so that prices for policies are set based on "the collective claims experience of anyone with a policy" and not on any one individual's medical history.[109]

H.R. 3200 includes insurance market reforms ending discriminatory practices conducted by insurance companies. These reforms will apply both inside and outside the HIE to end the discriminatory practices currently practiced by insurance companies. The bill requires that all policies be sold on a guaranteed issue basis; prohibits insurers from excluding coverage based on pre-existing conditions; and prohibits insurers from charging higher rates based on health status, gender, or other factors. It would allow premiums to vary based only on age (no more than 2:1),[110] geography and family size. In addition, the bill prohibits lifetime and annual limits on benefits so that families no longer face bankruptcy as a result of a serious medical illness.

STRENGTHENING THE HEALTH CARE WORKFORCE

As millions of new people gain access to health care coverage, H.R. 3200 recognizes that significant investments in the health care workforce are needed. There is mounting evidence that the nationwide healthcare workforce shortage is accelerating. The Health Resources and Services Administration, within the Department of Health and Human Services, reported in January of this year that twenty states were experiencing scarcities of physicians and nurses.[111] In particular, dramatic shortages in the health care workforce are seen in primary care and nursing.

Indeed, demand for primary care physicians outpaces supply more than in other specialty group.[112] Specifically, the Association of American Medical Colleges (AAMC) estimates that primary care accounts for 37 percent of the total projected shortage in 2025.[113] Primary care physicians are leaving the practice of medicine sooner than other physician specialties at the same time that fewer medical students and residents are choosing to make the practice of general internal medicine and primary care their central career

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[107] Pollitz, *supra* 98.

[108] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007*, The American Journal of Medicine (2009) at 3, finding that in 2007, 62.1% of all bankruptcies in the United States were medical, compared with 8 percent in 2001. *See also:* Pollitz, *supra* 98; Kofman, *supra* 100, both of whom testified that most medical bankruptcies are filed by insured people.

[109] Kofman, *supra* 100.

[110] Pollitz, *supra* 98, testified that age is "a strong proxy for health status."

[111] *See*, http:newsroom.hrsa.gov/insidehrsa/jan2009

[112] "The Complexities of Physician Supply and Demand: Projections Through 2025," Association of American Medical Colleges (AAMC) (Nov. 2008).

[113] *Id*.

goal.[114] For many students, the costs of medical education are so high that they feel compelled to specialize in more lucrative subspecialties in order to manage their debt.[115]

While registered nurses constitute the largest single healthcare profession in the United States, there is a worsening nursing shortage.[116] In 2000, the national supply of full time registered nurses was estimated at 1.89 million while the demand was estimated at 2 million, a shortage of 110,000 nurses.[117] Studies published in both *The New England Journal of Medicine* and *The Journal of the American Medical Association* confirms that the shortage of registered nurses is influencing the delivery of health care in the United States and negatively affecting patient outcomes.[118]

The current nursing shortage is a product of several trends including: a diminishing pipeline of new students to nursing, a decline in RN earnings relative to other career options, an aging nursing workforce, low job satisfaction and poor working conditions that contribute to high attrition rates.[119] Compounding these problems is the fact that nursing colleges and universities across the country are struggling to expand enrollment to meet the rising demand for nursing care. According to an American Association of Colleges of Nursing report, nursing schools turned away 49,948 qualified applicants from baccalaureate and graduate nursing programs in 2008 due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.[120]

The shortage of health care workers in this country disproportionately impacts those Americans residing in rural areas. The National Health Service Corps (NHSC) was established in the Emergency Health Personnel Act of 1970 (P.L. 91–623) to improve the distribution of health workers in underserved rural areas by providing scholarship support to students in qualified medical professions in exchange for a period of service in a Health Professional Shortage Area (HPSA).

Administered by the Health Resources and Services Administration, in 2008, 14,000 students applied to the program for financial assistance. However, the Agency was only budgeted to grant one of every seven requests.[121]

H.R. 3200 includes significant investments in the health care workforce to directly address the shortages outlined. The legislation provides resources to help train more primary care physicians as well as registered nurses. It puts into place incentives to encourage more people to become doctors and nurses, particularly in rural areas. Specifically, the bill increases funding for the National Health Service Corps in order to expand scholarships and loans for health professionals that work in shortage professions and areas. In addition, it creates an advisory committee on health workforce evaluation to assess the adequacy and appropriateness of the

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[114] Lipner RS, Bylsma WH. Arnold GK, Fortna GS, Tooker J. Cassel CK. Who is maintaining certification in internal medicine-and why? A national survey 10 years after initial certification. Ann Intern Med. (2005)

[115] Pear, Robert. "Shortage of Doctors an Obstacle to Obama Goals." The NY Times (Apr. 26, 2009).

[116] *See*, Henry J. Kaiser Family Foundation, "Addressing the Nursing Shortage" (Jun. 2008).

[117] *Id.*

[118] *Id.*

[119] *Id.*

[120] *See*, American Association of Colleges of Nursing, "Enrollment and Graduations in Baccalaureate and Graduate programs in Nursing (2008–2009), *available* at: www.acne.nche.edu/IDS.

[121] *See*, http:newsroom.hrsa.gov/insidersa/jan2009.

health workforce, and to make recommendations to the Secretary of Health and Human Services on federal workforce policies to ensure the health workforce is meeting the nation's needs.

V. SECTION-BY-SECTION SUMMARY [122]

Division I

Title I—Protections and Standards for Qualified Health Benefits Plans

Subtitle A—General Standards

Sec. 100. Purpose; Table of Contents of Division; General Definitions

Purpose

The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending. In addition, this division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken. Insurance reforms that this division encompasses are:

- Enacting insurance market reforms
- Creating a new Health Insurance Exchange, with a public health insurance option alongside private plans
- Including sliding scale affordability credits
- Initiating shared responsibility among workers, employers, and the government

This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

General Definitions (Created within this Act)

- Acceptable Coverage—qualified health benefits plan coverage, coverage under a grandfathered health insurance coverage or current group health plan, Medicare Part A, Medicaid, Military Health System, coverage under Veteran's Health Care Program (VA), and other coverage's the Secretary of HHS in coordination with the Health Choices Commissioner sees fit.
- Basic Plan—a plan that offers the essential benefits package's minimum requirements to be a qualified health benefits plan.
- Cost-sharing—includes deductibles, coinsurance, copayments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.
- Employment-Based Health Plan—the term given to group health plans (as defined in section 733(a)(1) of ERISA—(as an employee welfare benefit plan to the extent that plan provides medical care to employees or their dependents, either directly, through insurance or otherwise)), and is comprised of federal and state government plans, tribal plans and church plans. Following an amend-

[122] This section-by-section summary is based in part on a summary initially prepared by the Congressional Research Service elaborated upon to reflect the views of the Committee.

ment at Committee, this term was also defined as excluding TRICARE.

• Enhanced Plan—a plan that offers, in addition to the level of benefits under a basic plan, a lower level of cost-sharing equivalent to approximately 85 percent of the actuarial value of the benefits provided.

• Essential Benefits Package—health benefits coverage, consistent with the standards set forth by the Secretary no later than 18 months after enactment of this bill.

• Health Benefits Plan—health insurance coverage and a group health plan, including the public health insurance option.

• Health Insurance Exchange—created by this bill to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

• Premium Plan—a plan that offers, in addition to the level of benefits under a basic plan, a lower level of cost-sharing equivalent to approximately 95 percent of the actuarial value of the benefits provided.

• Premium Plus Plan—a premium plan that also offers additional benefits, such as oral health and vision care, all of which is approved by the Commissioner.

• Qualified Health Benefits Plan (QHBP)—a health benefits plan that meets the requirements set forth in Title I (by the Secretary) including the public health insurance option.

• QHBP Offering Entity—an entity can be any of the following: a health benefits plan (that is a group health plan) in which the employer is the main source of financing, health insurance coverage which the insurance issuer is offering the coverage, the public health insurance option, a non-federal government plan established by the State or political subdivision of a State, and a federal government plan.

• Public Health Insurance Option—a public plan (only available through the Health Insurance Exchange) with payment rates established by the Secretary. The public option would be required to offer basic, enhanced, and premium plans, and would be allowed to offer premium-plus plans. Payment rates for prescription drugs not covered by Medicare part A or B will be covered by the public option at prices negotiated by the Secretary.

• Service Area, Premium Rating Area—with respect to health insurance coverage: (1) if not within the Health Insurance Exchange, an area established by a QHBP offering entity of such coverage in accordance with applicable state law or (2) within the Health Insurance Exchange, an area established by such entity in accordance with state law and applicable rules set forth by the Commissioner for exchange-participating health benefits plans.

• "State"—given term for purposes of the Medicaid program, but only includes the 50 states and the District of Columbia.

• Y1, Y2, etc.—2013, 2014, etc.

Sec. 101. Requirements Reforming Health Insurance Marketplace

Current Law

Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope

and includes requirements related to the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Federal regulation of the private market is more narrow in scope and applicable mostly to employer-sponsored health insurance (i.e., through the Employee Retirement Income Security Act of 1974 (ERISA)).

Proposed Law

This provision would require "qualified health benefits plans" (QHBPs) to meet the new federal health insurance standards specified in Subtitles B (relating to affordable coverage), C (relating to essential benefits) and D (relating to consumer protection) of Title I. The section also provides terminology for the phrases "enrollment in employment-based health plans;" and "individual and group health insurance coverage."

This provision also includes a Sense of Congress that the final bill must meaningfully address the health care needs of the territories.

Sec. 102. Protecting the Choice to Keep Current Coverage

Current Law

See description under Sec. 101.

Proposed Law

"Grandfathered health insurance coverage" would be defined as individual health insurance coverage that is in effect before the first day of 2013, as long as the insurance carrier does not (1) enroll new individuals on or after the first day of 2013 (would not affect subsequent enrollment of a dependent); (2) change any terms or conditions of the individual coverage, except as required by law; and (3) vary the percentage increase in premiums for a risk group of enrollees without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner. The Commissioner would establish a five-year grace period beginning in 2013 for existing group health plans to transition to the new federal health insurance standards applied to QHBPs. The grace period would not apply to limited benefits plans specified in the provision, such as dental only, vision only, flexible spending arrangements, and others.

Individual health insurance coverage that is not grandfathered, may only be offered after the first day of 2013 as an Exchange-plan. Excepted benefits (e.g., accident or disability insurance) could be offered as long as they are offered and priced separately from health insurance coverage. New group health plans would have to comply with this Act on 2013.

For purposes of the individual mandate (established under title III of Division A), an individual would be required to have "acceptable coverage." In order for an individual health insurance policy to be considered acceptable coverage, the policy would be either grandfathered health insurance coverage or offered through the HIE (established under title II of Division A) or otherwise deemed or determined to be acceptable coverage under the bill. Group health coverage, including group health coverage consisting of a

consumer-directed plan, provided during the grace period would be considered acceptable coverage.

Section 102(b)(3), providing an exception for treating consumer-directed health plans and arrangements as acceptable coverage, was added by an amendment which originally called for a "permanent" exception. The word "permanent" was dropped from the amendment by unanimous consent, as Members of the Committee agreed that such exception for treating consumer-directed health plans as acceptable coverage should only be effective during the five-year grace period, not permanently.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting Pre-Existing Condition Exclusions

Current Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, limits the duration that issuers in the group market may exclude coverage for pre-existing health conditions for "HIPAA eligible" individuals, among other provisions. Group plans may impose pre-existing condition exclusions for no longer than 12 months (18 months in the case of a late enrollee), and must decrease that exclusion period by the number of months an enrollee had prior "creditable coverage." HIPAA outright prohibits issuers in the individual market from excluding coverage for pre-existing conditions for HIPAA eligibles.

All states require health issuers to reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of January 2009 in the small group market, 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard. And as of December 2008 in the individual market, 42 states limit the period of time when coverage for pre-existing health conditions may be excluded for non-HIPAA eligible enrollees in that market.

Proposed Law

This provision would create a uniform minimum standard prohibiting a qualified health benefits plan from excluding coverage for pre-existing health conditions, or otherwise limiting or conditioning such coverage with respect to an individual or dependent based on any health status-related factors. Such factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability.

Sec. 112. Guaranteed Issue and Renewal for Insured Plans

Current Law

HIPAA requires that coverage sold to small groups (2–50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. (Guaranteed issue rules do not address premiums.) HIPAA also guarantees that each issuer in the individual market make at least two policies available ("guaranteed availability") to all HIPAA eligible individuals. In addition, HIPAA guarantees renewal or continu-

ation of group coverage at the option of the plan sponsor (e.g., employer) and individual coverage at the option of the individual, with some exceptions. Insurers may not renew coverage under specified circumstances, such as nonpayment of premiums or fraud.

All states require issuers to offer policies to firms with 2–50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009 in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to self-employed "groups of one." And as of December 2008 in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals.

Proposed Law

This provision would require issuers to offer all health insurance coverage on a guaranteed issue and renewal basis beginning in 2013, whether offered through the HIE (established under Subtitle A of Title II), through any employment-based health plan, or otherwise. Rescissions of coverage would be prohibited, except in cases of fraud.

Sec. 113. Insurance Rating Rules

Current Law

There are no federal rating rules applicable to the private health insurance market. Most states currently impose rating rules on insurance carriers in the small group and individual markets. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as age. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any characteristic related to a person's or group's risk, including health. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other key risk factors, such as gender. Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Moreover, both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as industry. And for each characteristic, the state typically specifies the amount of allowable variation. As of January 2009 in the small group market, one state has pure community rating rules, eleven have adjusted community rating rules, and 35 have rate bands. As of December 2008 in the individual market, two states have pure community rating rules, five have adjusted community rating rules, and eleven have rate bands.

There are no federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the individual and small group markets that include geographic location as a factor on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

Proposed Law

This provision would impose new federal rating rules on qualified health benefits plans. QHBP premiums would vary only by age (by no more than a 2:1 ratio within age categories specified by the Commissioner (established under Sec. 141)), premium rating area (as permitted by state regulators or, in the case of an Exchange plan, as specified by the Commissioner), and family enrollment (as specified under State law and consistent with Commissioner rules).

The Commissioner, in coordination with the Secretaries of Health and Human Services (HHS) and Labor, would conduct a study of the large group market to examine (1) characteristics of employers who purchase fully-insured health insurance products and employers who self-fund health benefits, including characteristics related to bearing risk and solvency, and (2) the extent to which rating rules cause adverse selection in the large group market or encourage small and mid-size employers to self-insure health benefits. The Commissioner would submit this report to Congress and the applicable agencies no later than 18 months after enactment, and include any recommendations to ensure that the law does not provide incentives for small and mid-size employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers.

Sec. 114. Nondiscrimination in Benefits

Current Law

HIPAA established federal rules regarding non-discrimination based on health status-related factors. It prohibits group issuers from establishing rules for eligibility and premium contributions based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 establishes that if an employer provides mental health benefits there must be parity with physical health benefits.

Proposed Law

This provision would require QHBPs to comply with non-discrimination standards regarding health benefits or benefit structures established by the Commissioner, building on existing federal non-discrimination rules in ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code of 1986. Existing mental health parity rules, apply to QHBPs, regardless of whether coverage is offered in the individual or group market.

Sec. 115. Ensuring Adequacy of Provider Networks

Current Law

HIPAA established special rules for network plans. It allows small group issuers to (1) limit the employers that apply for coverage to those firms with eligible individuals who live or work in the network service area, and (2) deny coverage to small employers if the issuer demonstrates (if required) to the State that it has limited provider capacity due to obligations to existing enrollees and it is applying this decision uniformly without regard to claims experience or health status-related factors. HIPAA also prohibits a small group issuer that has denied coverage in any service area to offer small group coverage in that area for 180 days after the denial.

Proposed Law

This provision would require QHBPs that use provider networks to meet provider network standards that may be established by the Commissioner to ensure the adequacy of networks, and transparency in the cost-sharing differences between in- and out-of-network coverage. The term "provider network" means the providers with respect to covered benefits, treatments, and services available under a health benefit plan.

Sec. 116. Ensuring Value and Lower Premiums

Current Law

Medical loss ratio is the share of total premium revenue spent on medical claims. Medigap insurance policies are private supplemental health care policies that Medicare beneficiaries can purchase to help cover some items, services, and cost sharing not covered under Medicare. Medigap plans are required to have a minimum medical loss ratio of 65 percent for individual policies and 75 percent for group policies. In addition, most states impose medical loss ratios or related requirements on insurers in the individual and/or small group health insurance markets.

Proposed Law

This provision would require a QHBP to comply with a medical loss ratio standard to be determined by the Commissioner but not less than 85 percent. For any QHBP that does not meet such a standard, it would be required to provide rebates to enrollees, in a manner specified by the Commissioner, in sufficient amounts to meet such a loss ratio. To establish the medical loss ratio standard, the Commissioner would build on the definition and methodology, developed by the HHS Secretary under Section 161, for determining how to calculate such a ratio. The methodology would set the highest ratio possible to ensure adequate QHBP participation, competition both in and out of the HIE, and value for consumers so that their premium contributions are used for medical claims.

Sec. 117. Consistency of costs and coverage under qualified health benefits plans during plan year

This provision would prohibit insurance companies from changing the coverage or costs of a health plan mid-year except if the costs are lowered and/or the coverage is increased.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 121. Coverage of Essential Benefits Package

Current Law

There are limited federal benefit mandates for health insurance. These standards were added to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and are described in the discussion of Section 122, below.

Proposed Law

This provision would require a "qualified health benefits plans (QHBP)" to cover at least an "essential benefit package." QHBPs could be offered in or outside of an Exchange. QHBPs offered outside of an Exchange would be allowed to offer additional benefits beyond those specified in the essential benefits package. For QHBPs offered through the Exchange, a plan offering a premium-plus level of benefits (established under Section 203) could provide additional benefits.

The requirements under Division A would not affect the offering of limited-purpose benefit plans, including policies covering dental or vision treatment, long-term care, Medicare supplement policies, workers' compensation, and other similar benefits, if such benefit plans are offered under a separate policy, contract, or certificate of insurance.

A QHBP would not be allowed to impose coverage restrictions (except cost sharing) unrelated to the clinical appropriateness of the health care items and services.

Sec. 122. Essential Benefit Package Defined

Current Law

Federally mandated benefits. Laws are found in the Employee Retirement Income Security Act (ERISA—covering employer-sponsored plans), the Public Health Service Act (PHSA—covering insurance plans and state and local government plans), and the Internal Revenue Code (IRC—covers Church plans in certain circumstances).

Those mandates include:

• The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 established that employers who offer mental health and substance use disorder benefits must offer them in an equal manner as physical health benefits are offered. The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96–hour stay in the case of a cesarean section).

• The Women's Health and Cancer Rights Act of 1998 contains protections for patients who elect breast reconstruction in connection with a mastectomy. For plan participants and beneficiaries re-

ceiving benefits in connection with a mastectomy, plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

• The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination based on genetic information by health insurers and employers. GINA strengthens and clarifies existing HIPAA nondiscrimination and portability provisions. Broadly, GINA prohibits health insurers from engaging in three practices: (1) using genetic information about an individual to adjust a group plan's premiums, or, in the case of individual plans, to deny coverage, adjust premiums, or impose a preexisting condition exclusion; (2) requiring or requesting genetic testing; and (3) requesting, requiring, or purchasing genetic information for underwriting purposes.

• Michelle's Law ensures that dependent post secondary education students who take a medically necessary leave of absence do not lose health insurance coverage. The law provides that a group health plan may not terminate a college student's health coverage simply because the student takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must be medically necessary, begin while the student is suffering from a serious illness or injury and would otherwise result in a loss of coverage.

Similarly, the Advisory Committee on Immunization Practices (ACIP), administered by the Centers for Disease Control and Prevention (CDC), reviews scientific evidence and makes recommendations to the Secretary and the CDC Director for the routine administration of vaccines to children, adolescents, and adults in the U.S. civilian population. The ACIP is not explicitly authorized; rather, it is based in general authorities of the Secretary in Titles II and III of the PHSA.

Proposed Law

This provision would require the essential benefits package to cover specified items and services, limit cost sharing, prohibit annual and lifetime limits on covered services, ensure the adequacy of provider networks, and be equivalent (as certified by the Office of the Actuary of the Centers for Medicare and Medicaid Services) to the average prevailing employer-sponsored coverage.

The essential benefits package would be required to cover the following items and services:

• Hospitalization;

• Outpatient hospital and clinic services, including emergency department services;

• Services of physicians and other health professionals;

• Services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;

• Prescription drugs;

• Rehabilitative and "habilitative" services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);

• Mental health and substance use disorder services;

• Preventive services, include those graded "A" or "B" by the Task Force on Clinical and Preventive Services, as well as cer-

tain other substance abuse and mental health services, and those vaccines recommended by the Director of the CDC;

- Maternity care;
- Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies, as defined under Section 1905(r) of the Social Security Act, for those under age 21; and
- Durable medical equipment, prosthetics, orthotics and related supplies.

The Committee recognizes that historically, insurers have not covered medical services addressing a range of women's health needs, resulting in high out-of-pocket costs for medical services, such as maternity care and preventive screenings. Women have a variety of essential health needs throughout their lifetimes. Therefore, the Committee intends that the bill require the basic benefits package include the full range of medical services for women's unique health needs, at all stages of life, including, but not limited to, maternity care, preventive screenings such as mammograms, annual gynecological exams, diagnostic, routine care, and recommended treatments.

The Committee believes that medically necessary evidence-based behavioral intervention services, including those provided to individuals with autism, are included within the ambit of section 122(b) of the bill.

The essential benefits package would be subject to various requirements concerning cost-sharing. The package would be required to provide preventive items and services without cost-sharing. The annual out-of-pocket limit in 2013 would be $5,000 for an individual and $10,000 for a family. These limits would be annually adjusted for inflation using the Consumer Price Index (CPI). To the extent possible, the Commissioner would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee). Cost-sharing would result in coverage equal to approximately 70 percent of the actuarial value of the benefits if there were no cost-sharing imposed.

Sec. 123. Health Benefits Advisory Committee

Current Law

None.

Proposed Law

A Health Benefits Advisory Committee (HBAC) would be established to recommend covered benefits and the essential, enhanced, and premium plans. The HBAC would be chaired by the Surgeon General. The HBAC membership would be comprised of

- Nine members, appointed by the President, who are neither federal employees nor officers;
- Nine members, appointed by the Comptroller General, who are neither federal employees nor officers; and
- An even number, up to eight members, appointed by the President, who are federal employees and officers.

The initial appointments would be made within 60 days of enactment. Each HBAC member would serve a three-year term, except the terms of the initial appointments would be adjusted to provide

for staggered years of appointment. The members would reflect the interests of the many diverse groups of stakeholders so that no single interest would unduly influence the HBAC's recommendations. At a minimum, committee membership would reflect educated patients or consumer advocates, providers, employers, labor, health insurance issuers, experts in health care and delivery, experts in health disparities, and government agencies. In addition, at least one HBAC member would be a practicing physician or health professional, and another member would be an expert on children's health. At least one member must be an expert on the scientific evidence and clinical practice of integrative medicine.

The HBAC's recommendations to the Secretary on the essential benefits package (as defined in Section 122), cost-sharing levels for the enhanced plans and premium plans (as defined in Section 203), and periodic updates of the package would be required to incorporate innovation in health care. The HBAC members would also consider how the package would reduce health disparities, would take into account integrative medicine, and would allow for public input as part of developing its recommendations. The HBAC's initial benefit recommendations must be made to the Secretary within one year of enactment.

In developing standards for the enhanced and premium plans, the HBAC would be required to calculate cost-sharing such that the enhanced plan would have benefits that are actuarially equivalent to about 85 percent of the actuarial value of the benefits provided in the essential benefits package, and the premium plans would have benefits that are actuarially equivalent to about 95 percent of the actuarial value of the benefits provided in the essential benefits package.

The Committee intends that, in developing its recommendations regarding benefit standards, the Health Benefits Advisory Committee shall take into account the special characteristics of group health plans that are multiemployer plans as defined in section 3(37) of the Employee Retirement Income Security Act and the impact of the recommendations on such plans. Among the special characteristics to be considered is that these plans are funded, and their costs borne, by the workers who tradeoff wages for employer contributions, that a plan's income fluctuates with the availability of covered work, and that workers are equally represented on the plans' boards of trustees who design the rules and benefit programs.

HBAC members would serve without pay, but would receive federal travel expenses, including per diem expenses. In addition, the HBAC would be subject to the Federal Advisory Committee Act although the members would not become Federal employees.

The Secretary would be required to publish all recommendations developed pursuant to this Section in the Federal Register and on the HHS website.

Following an amendment at Committee, this provision would also instruct the Health Benefits Advisory Committee to examine current state laws and to seek input from the states as it forms its recommendations for the federal benefits standards.

Sec. 124. Process for Adoption of Recommendations; Adoption of Benefit Standards

Current Law

None.

Proposed Law

This Section proposes a timeline by which the Secretary must choose whether to adopt the recommendations of the HBAC established under Section 123 of this bill. Within 45 days of receiving the HBAC's recommendations regarding the essential benefits package, the Secretary would be required either to adopt the benefit standards as written or not adopt the benefit standards, notify the HBAC of the reasons for this decision, and provide an opportunity for the HBAC to revise and resubmit its recommendations.

The Secretary would be required to adopt an initial set of benefit standards within 18 months of enactment either by adopting the recommendations (and any revisions) of the HBAC, or absent that, by proposing an initial set of benefit standards.

The Secretary would be required to publish all determinations under this Section in the Federal Register.

The Secretary would be required to periodically update the benefit standards. However, an essential benefits package that does not meet the essential benefits requirements specified in Section 122 could not be adopted.

Sec. 125. Prohibition of Discrimination in Health Care Services Based on Religious or Spiritual Content

This provision would prohibit the Commissioner or any health insurance issuer offering health insurance coverage through the HIE from discriminating against approving or covering health care services based on religious or spiritual content if expenditures for such a health care service are allowable under 213(d) of the Internal Revenue Code of 1986.

Subtitle D—Additional Consumer Protections

Sec. 131. Requiring Fair Marketing Practices by Health Insurers

Current Law

States have established varying marketing standards to prohibit insurers from marketing their insurance products only to healthy risks.

Proposed Law

This provision would require the Commissioner to establish uniform marketing standards for QHBPs.

Sec. 132. Requiring Fair Grievance and Appeals Mechanisms

Current Law

ERISA does mandate compliance to certain standards if an employer chooses to offer health benefits, such as procedures for appealing denied benefit claims. The Department of Labor has issued regulations for plan internal appeal processes but does not provide for external appeals other than through judicial review. In addi-

tion, as of February 2008, 44 states and the District of Columbia mandate the independent review of benefit denials by an entity outside of the health plan ("external review"). The Supreme Court has upheld the application of state external review laws to ERISA covered plans.

Proposed Law

This provision would require QHBPs to provide for a uniform timely grievance and appeals mechanisms as established by the Commissioner. QHBPs would provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) promulgated by the Labor Department and published in the Code of Federal Regulations on November 21, 2000 (65 Fed. Reg. 70246). Such a process would be updated in accordance with any relevant standards that may be established by the Commissioner. The Commissioner would establish standards for an external review process (including expedited review of urgent claims), and any determination made with respect to a QHBP under an external review process would be binding. Aggrieved individuals would have state law rights and remedies to appeal adverse QHBP decisions.

Sec. 133. Requiring Information Transparency and Plan Disclosure

Current Law

ERISA requires applicable health plans (as well as other "welfare benefit" plans) to disclose and report certain plan information to enrollees and regulators. For example, plan administrators must provide to enrollees a written summary plan description (SPD) which contains the terms of the plan and the benefits offered, including any material modifications, and the SPD must be written in a manner that can be understood by the average enrollee. Certain plans must file an annual report with the Department of Labor, containing information about the operation, funding, assets, and investments of those plans.

Proposed Law

This provision would require QHBPs to comply with disclosure standards established by the Commissioner concerning plan terms and conditions, claims payment policies, plan finances, claims denials, and other information as determined appropriate by the Commissioner. One specified disclosure requirement would be a list of health care providers under the plan trained and accredited in integrative medicine. The Commissioner would require such disclosure to be provided in plain language. QHBPs would be required to comply with standards established by the Commissioner to ensure transparency regarding reimbursements between the plan and health care providers. A change in a QHBP could not be made without reasonable and timely advance notice to enrollees about the change.

Sec. 134. Application to Qualified Health Benefits Plans Not Offered Through the Health Insurance Exchange

Current Law

None.

Proposed Law

The Committee intends that the Commissioner may make any or all of the requirements of Subtitle D applicable to qualified health benefits plans outside of the HIE if the Commissioner determines that such an extension is necessary to accomplish the fundamental purposes of this Act. The Commissioner may make the requirements applicable to only health insurance issuers, and not to self-funded plans or to multiemployer plans based upon the Commissioner's determination that such plans satisfy the consumer protections provided for in this Act.

Sec. 135. Timely Payment of Claims

Current Law

Under Medicare Advantage (MA), private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. MA plans include health maintenance organizations and private fee-for-service (PFFS) plans. MA PFFS plans are required to pay 95 percent of "clean claims" within 30 days of receipt. The Centers for Medicare and Medicaid Services (CMS) defines a clean claim as a claim that has no defect or impropriety, and is submitted with all the required documentation. The 30–day rule also applies to claims submitted to any MA organization by a provider who does not have a written contract with the plan. MA organizations are required to pay interest on clean claims that are not paid within 30 days. All other claims from non-contracted providers must be paid within 60 days. MA organizations that do contract with providers (i.e., HMOs and PPOs) must include a prompt payment provision in their contracts.

Proposed Law

This provision would require QHBPs to comply with the prompt pay requirements applicable to Medicare Advantage plans.

Sec. 136. Standardized Rules for Coordination and Subrogation of Benefits

Current Law

While there are no federal statutes specifying primary and secondary payment rules for multiple insurers in the private market, the Medicare statutes can be cited as providing an example. Section 1862(b) of the Social Security Act authorizes the Medicare Secondary Payer (MSP) program, which identifies specific conditions under which another party pays first and Medicare is only responsible for qualified secondary payments. The statute authorizes several methods to identify cases when an insurer other than Medicare is the primary payer and to facilitate recoveries when incorrect Medicare payments have been made. Under certain conditions, the law makes Medicare the secondary payer to insurance plans and programs for beneficiaries covered through (1) a group health plan based on either their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program. The purpose of the MSP program is to shift costs from Medicare to private sources of payment, thus reducing Medi-

care expenditures. Additionally, the Medicare statutes exclude Medicare coverage for items and services paid for directly or indirectly by a government entity, subject to certain limitations. This includes the Department of Veterans Affairs, among others.

The states have long established rules on coordination of benefits and subrogation of claims but in recent years, health plans have challenged aspects of the traditional rules leading to confusion and uncertainty in this area.

Proposed Law

The Commissioner would establish standards for the coordination of benefits and reimbursement of payments in cases involving individual and multiple plan coverage.

Sec. 137. Application of Administrative Simplification

Current Law

To support the growth of electronic record keeping and claims processing, HIPAA's Administrative Simplification provisions instructed the Secretary to adopt electronic format and data standards for several routine administrative and financial transactions between health care providers and health plans/payers. The standards apply to health care providers (who transmit any health information in electronic form in connection with a HIPAA-specified transaction), health plans, and health care clearinghouses. Although providers have made significant progress in streamlining administrative processes, much work remains to achieve uniforms claims and billing processes.

Proposed Law

This provision would require QHBP offering entities (as defined in the bill) to comply with the new administrative simplification standards adopted under Sec. 163 (discussed below).

Sec. 138. Records Relative to Prescription Information

This provision would ban the sales of physician prescribing habits to the pharmaceutical industry when the physician serves patients enrolled in a qualified health benefit plan.

Subtitle E—Governance

Sec. 141. Health Choices Administration; Health Choices Commissioner

Current Law

No specific provision in federal law.

Proposed Law

This provision would establish an independent agency in the Executive Branch of the United States called the Health Choices Administration, "Administration." The Administration would be headed by a Health Choices Commissioner, "Commissioner," who would be appointed by the President, by advice and consent of the Senate. Section 702 of the Social Security Act (detailing compensation, terms, general powers, rule-making, and delegation as applied to

the Commissioner of Social Security and the Social Security Administration) would apply to the Commissioner.

Sec. 142. Duties and Authority of Commissioner

Current Law

None.

Proposed Law

This provision would make the Commissioner responsible for carrying out the following functions:

- Qualified Plan Standards—Establishing qualified health benefits plan ("QHBP") standards, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.
- Health Insurance Exchange—Establishing and operating the Health Insurance Exchange.
- Individual Affordability Credits—Administering individual affordability credits, including the determination of eligibility for such credits.
- Promoting Accountability—Undertaking activities in accordance with this section to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through or outside the Health Insurance Exchange.
- Compliance Examination and Audits—coordinating with States to conduct audits of qualified health benefits plan compliance with Federal requirements. These audits would include random compliance audits and targeted audits in response to complaints or other suspected non-compliance.
- Recoupment of Costs in Connection with Examination and Audits—authorizing to recoup from qualified health benefits plans reimbursement for costs of such examinations and audit of such QHBP offering entities.
- Data Collection—Collecting data for the purposes of carrying out the Commissioner's duties, including promoting quality, value, protecting consumers and addressing disparities in health care; the commissioner may share such data with Secretary of Health and Human Services. The Committee believes populations who experience disparities in health care include people with disabilities.
- Sanctions Authority—Providing any of the following remedies (in addition to any other authorized by law) in coordination with State insurance regulators and the Secretary of Labor if it is determined that a QHBP offering entity violates a requirement:

  1. Civil money penalties of not more than the amount applicable under similar circumstances for similar violations under Medicare;
  2. Suspension of plan enrollment of individuals under such plan after the date the Commissioner notifies the entity of a decision, until the Commissioner is satisfied with rectification;
  3. In the case of an Exchange-participating health benefits plan, suspension of payment under the Health Insurance Exchange for individuals enrolled in the plan after the date the

Commissioner notifies the entity of such decision and until the Commissioner is satisfied with corrective action; or

4. Work with State insurance regulators to terminate plans for repeated failure by the QHBP offering entity to meet this title's requirements.

Standard Definitions of Insurance and Medical Terms—providing the development of standards for defining terms used in health insurance coverage, including insurance-related terms.

Sec. 143. Consultation and Coordination

Current Law

None.

Proposed Law

The Commissioner, as appropriate, would be required to consult with, at a minimum, the National Association of Insurance Commissioners, State attorneys general, and State insurance regulators concerning the standards and enforcement for insured qualified health benefits plans described in this title. Concurrently, the Commissioner would be required to consult with, at a minimum, Indian tribes and tribal organizations, appropriate federal agencies, and appropriate State agencies concerning affordability credits and the offering of Exchange-participating health benefits plans (including Medicaid concerning standards for insured qualified health benefits plans).

Sec. 144. Health Insurance Ombudsman

Current Law

The Department of Health and Human Services receives various complaint handling and client-assistance ombudsmen including:

Long-term Care Ombudsman—mandated by Older Americans Act of 1965, consists of 1,000 paid and 14,000 volunteers who identify, investigate, and resolve complaints made by, or on the behalf, of residents. They have a blend of federal and state oversight.

Medicare Beneficiary Ombudsman—Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173), it is intended to ensure those eligible for Medicare have reliable and current information about their benefits, rights and protections under the Medicare program, and the procedures for getting problems and disputes resolved. The Ombudsman is to aid Medicare recipients in filing appeals if their insurance did not pay proper amounts for their medical services or those services were denied.

State Health Insurance Ombudsman—Several states (VT, MN, and IL to name a few) have created State health insurance ombudsmen, with the core responsibilities of rectifying concerns encompassing access to care, billing problems, and access to health insurance. The ombudsman provides information on state and federal programs that may be available, explains continuation rights under an existing health plan, provides help on how to shop for health insurance, and assists in appealing decisions made by their health insurance.

Proposed Law

The Commissioner would appoint within the Health Choices Administration a Qualified Health Benefits Ombudsman (with experience and expertise in the fields of health care and education). The Ombudsman would be required to perform the following duties:

• Receive and provide assistance with complaints, grievances, and requests for information submitted by individuals. The assistance would be provided more specifically in instances such as helping individuals determine relevant information for an appeal, assisting with any problems arising from disenrollment, choosing a qualified health benefits plan to enroll, and presenting information relevant to affordability credits.

• Submit annual reports to Congress and the Commissioner describing the activities of the Ombudsman, including recommendations for improvement in the Administration of this Division, as determined appropriate. The Ombudsman would not serve as an advocate for any increases in payments or new coverage of services, but would identify issues and problems in payment or coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 151. Relation to Other Requirements

Current Law

None.

Proposed Law

• Coverage Not Offered Through the Exchange—The requirements of this provision would not supersede specified provisions of federal and state laws with respect to the health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan).

• Coverage Offered Through the Exchange—The requirements under this title would not supersede any requirements relating to genetic information non-discrimination and mental health for such health insurance coverage (as long as those related do not prevent the application of requirements detailed in this division; as determined by the Commissioner). Concurrently, individual rights and remedies under State laws would apply. Nothing in this paragraph would be construed as preventing the application of rights and remedies under State laws.

Sec. 152. Prohibiting Discrimination in Health Care

Current Law

HIPAA established federal rules regarding non-discrimination based on health status-related factors. It prohibits group issuers from establishing rules for eligibility and premium contributions based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 (GINA, P.L.

110–233) prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 establishes parity by requiring an employer offering mental health and substance use disorder benefits in an equal manner as physical health benefits are offered.

In addition, Title VI of the Civil Rights Act of 1964 prohibits discrimination by the recipients of federal funds, which includes many hospitals, clinics and social service agencies. However, the Civil Rights Act's link to the receipt of federal funds has insulated many insurance companies from any obligation to comply with nondiscrimination protections.

Proposed Law

Unless explicitly permitted within this Act and subsequent related regulations, all health care and related services, (including insurance coverage and public health activities) covered by this Act would be provided regardless of personal characteristics extraneous to the provision of high quality health care or related services.

Within 18 months of enactment, the Secretary would be required to ensure that all health care and related services would be provided without regard for extraneous personal characteristics.

Sec. 153. Whistleblower Protection

Current Law

None.

Proposed Law

No employer may discharge any employee (or otherwise discriminate against) with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee):

- Provides or causes to provide to the employer, Federal Government, the attorney general of a relevant State, information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of any provision, order, rule, or regulation promulgated under this Act.
- Testifies or is about to testify in a proceeding concerning such violation.
- Assists, participates or about to assist and participate in such a proceeding.
- Objects to, or refused to participate in any activity, policy, practice, or assigned task that the employee reasonably believes to be in violation of any provision, order, rule and regulation promulgated under this Act.

Enforcement Action—An employee covered by this section who alleges discrimination by an employer in violation may bring an action governed by the rules, procedures, legal burden of proof, and remedies detailed in section 40(b) of the Consumer Product Safety Act.

Employer Defined—The term employer in this section means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization

including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

Rule of Construction—The rule of construction set forth concerning employee protections in the United States Code would apply to this section.

Sec. 154. Construction Regarding Collective Bargaining

Current Law

None.

Proposed Law

Nothing in this division may be construed to alter or supersede any statutory or other obligation to engage in collective bargaining over the terms and conditions of employment related to health care. This rule of construction clarifies that long-standing principles of law continue to apply in the context of this health reform legislation. Where a new law sets mandatory minimum labor standards, the parties in a collective bargaining relationship must abide by such standards. Where, however, a new law leaves some discretion to an employer with regard to how to achieve compliance, which this bill indeed does on many levels, an employer with collective bargaining obligations may not make unilateral changes to the terms and conditions of employment but must bargain with the employees' bargaining representative over those matters.[123]

Sec. 155. Severability

Current Law

None.

Proposed Law

If any provision of this Act, or the application thereof towards any person or circumstance, is held unconstitutional, the application of the remaining provisions would not be affected.

Sec. 156. Rule of Construction Regarding Hawaii Prepaid Health Care Act

Added with an amendment at Committee, this provision would maintain Hawaii's Prepaid Health Care Act exemption under ERISA, including with respect to the provisions of H.R. 3200, where such state statute ensures health care benefits equivalent to or greater than those benefits that would be guaranteed by H.R. 3200.

Sec. 157. Increasing Meaningful Use of Electronic Health Records

This provision would require the Health Choices Commissioner to study how to increase the meaningful use of electronic health records and then use the results of that study to potentially require

[123] See, e.g., Murphy Oil USA, 286 N.L.R.B. 1039, 1042 (1987); Standard Candy Co., 147 N.L.R.B. 1070, 1073 (1964); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 20 (1987).

higher reimbursement rates for providers that use health information technology.

Sec. 158. Private Right of Contract with Health Care Providers

This provision forbids any other provision in this bill from being construed to preclude any participant or beneficiary in a group health plan from entering into any contract or arrangement for health care with any health care provider.

Subtitle G—Early Investments

Sec. 161. Ensuring Value and Lower Premiums

The Committee did not exercise jurisdiction over this provision.

Sec. 162. Ending Health Insurance Rescission Abuse

The Committee did not exercise jurisdiction over this provision.

Sec. 163. Administrative Simplification

The Committee did not exercise jurisdiction over this provision.

Sec. 164. Reinsurance Program for Retirees

Current Law

No current law.

Proposed Law

No later than 90 days after enactment, the Secretary would establish a temporary reinsurance program, to provide reimbursement to assist participating private or public sector employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents, including eligible and surviving spouses. Such plans include voluntary employee benefit associations (VEBAs) and multi-employer plans covering retirees. Health benefits would be required to include medical, surgical, hospital, prescription drug, and other benefits determined by the Secretary. An eligible employment-based plan would submit an application to the Secretary, as required. A participating employment-based program would submit claims for reimbursement to the Secretary, documenting the actual cost of items and services for each claim. Each claim would be based on the actual amount expended by the participant. The participating employment-based plan would take into account any negotiated price concessions, such as discounts, subsidies, and rebates. The cost of deductibles and cost-sharing would be included in the cost of the claim, along with the amounts paid by the plan. For any valid claim, the Secretary would reimburse the plan for 80 percent of the portion of costs above $15,000 and below $90,000. This amount would be adjusted annually based on the percent increase in the medical care component of the Consumer Price Index, rounded to the nearest multiple of $1,000. Amounts paid to a participating employment-based plan would be used to lower cost directly to participants and beneficiaries in the form of premiums, co-payments, deductible, co-insurance, or other out-of-pocket costs, but would not be used to reduce the costs of an employer maintaining the employment-based plan. The Secretary would establish an appeals process for denied

claims, procedures to protect against fraud, waste, and abuse, and would conduct annual audits of claims date.

The Retiree Reserve Trust Fund would be established, consisting of such amounts as appropriated or credited to the Fund to enable the Secretary to carry out the reinsurance program. The Secretary could request such sums as necessary to carry out this section, not to exceed $10 billion. Amounts appropriated and outlays from such appropriation would not be taken into account for purpose of any budget enforcement procedures, thus exempting the Fund from the framework of the budget resolution and the points of order which enforce that framework. The Secretary would have the authority to stop taking applications or take other steps to reduce expenditures to ensure that expenditures did not exceed available funds.

Sec. 165. Prohibition Against Post-Retirement Reductions of Retiree Health Benefits by Group Health Plans

This provision would prohibit group health plans from reducing retirees' health benefits after those retirees have retired, unless the reduction is also made to benefits for active participants.

Sec. 166. Limitations on Preexisting Condition Exclusions in Group Health Plans in Advance of Applicability of New Prohibition of Preexisting Condition Exclusions

This provision would require that the limit on pre-existing conditions exclusions in the insurance market start immediately at the bill's passage instead of 2013 as the introduced version of H.R. 3200 instructs. The permitted "look back" period is reduced from six months to 30 days, and the amount of time during which a provider can exclude coverage for pre-existing conditions is shortened.

Sec. 167. Extension of COBRA Continuation Coverage

This section was added by amendment at Committee. This provision would end the current COBRA eligibility limit and allow those currently enrolled in COBRA to keep their insurance until they find another job offering coverage or until they become eligible to participate in the HIE.

Title II—Health Insurance Exchange and Related Provisions

Subtitle A—Health Insurance Exchange

Current Law

No specific provision in federal law.

Proposed Law

Text.

Sec. 201. Establishment of Health Insurance Exchange; Outline of Duties; Definitions

A Health Insurance Exchange, "Exchange" would be established to facilitate access of individuals and employers to a variety of choices of affordable, quality health insurance coverage, including a public health insurance plan option. The HIE would exist within the Health Choices Administration under the direction of the Health Choices Commissioner (described above in Sections 141 and

142). As described in greater detail in the following sections, regarding the Exchange, the Commissioner would (1) establish standards for, accept bids from, and negotiate and enter into contracts with entities seeking to offer qualified health benefits plans (QHBPs) through the Exchange, (2) facilitate outreach and enrollment of Exchange-eligible individuals and employers, and (3) conduct appropriate activities related to the Exchange, including establishment of a risk pooling mechanism and consumer protections.

Sec. 202. Exchange-eligible Individuals and Employers

Beginning in 2013, all individuals generally would be eligible to obtain coverage through the Exchange, unless they were enrolled in the following (as determined by the Commissioner, in coordination with the Treasury Secretary):

- a group plan through a full-time employee (including a self-employed person with at least one employee) for which the employer makes an adequate contribution (described below in Section 312),
- Medicare,
- Medicaid (except in certain cases, discussed below), or
- military and VA coverage.

Except for the Medicaid exception, individuals would lose eligibility for Exchange coverage once they become eligible for Medicare Part A, Medicaid (although in this case, the Commissioner could permit continued Exchange eligibility for such limited time as the Commissioner determines it is administratively feasible and consistent with minimizing disruption in the individual's access to health care), and other circumstances as the Commissioner provides. Besides those cases, once individuals enroll in an Exchange plan, they would continue to be eligible until they are no longer enrolled.

Exchange-eligible employers could meet the requirements of the employer responsibility (Section 312) by offering and contributing adequately toward employees' enrollment through the Exchange. Those employees would be able to choose any of the available Exchange plans. Once employers are Exchange eligible and enroll their employees through the Exchange, they would continue to be Exchange eligible, unless they decided to then offer their own qualified health benefits plan(s).

In 2013, employers with 15 or fewer employees would be Exchange-eligible. In 2014, employers with 25 or fewer employees would be Exchange-eligible. Beginning in 2015, employers with 50 or fewer employees would be Exchange-eligible, however the Commissioner could permit employers larger than 50 to participate in the Exchange. These additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate. ("Employer" and other employment-related definitions would be defined by the Commissioner.)

The Committee intends that if and when the Commissioner permits "larger employers" to become Exchange-eligible employers, the Commissioner will also permit a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act) itself to become an Exchange-eligible employer on behalf of its contributing employers as if it were one employer.

The Commissioner would have the authority to establish rules to deal with special situations with regard to uninsured individuals participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

The Commissioner would be required to provide for periodic surveys of Exchange-eligible individuals and employers concerning their satisfaction with the Exchange and its plans.

The Commissioner would conduct an Exchange Access Study—a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and enrolled in HIE plans. The goal of the study would be to determine if there are significant groups and types of individuals and employers who are not Exchange eligible but who would have improved benefits and affordability if made eligible. The study also would examine the terms, conditions, and affordability of group health coverage offered by employers and QHBP-offering insurers outside of the Exchange compared to Exchange-participating health benefits plans, as well as the affordability-test standard for access of certain employed individuals to coverage in the Health Insurance Exchange. The Commissioner would submit the study to Congress by January 1 of 2015, 2018, and thereafter, and would include in the report recommendations regarding changes in standards for Exchange eligibility for individuals and employers.

This provision would also give the Commissioner authority to define terms such as "employer" and "employee" for purposes of this division. The Commissioner should take care that such definitions minimize incentives to misclassify workers as non-employees. Moreover, the Commissioner should take into consideration any special employer or industry organizational structures such as "employers of record" in the home health industry and hour of service calculations for airline personnel in the airline industry in light of relevant federal rules and industry practices when defining these employment terms.

Sec. 203. Benefits Package Levels

The Commissioner would specify the benefits to be made available under HIE plans during each plan year, consistent with this section and Sections 121–134 above. The Commissioner could not enter into a contract with an entity wanting to offer coverage through the Exchange in a service area(s), unless the following requirements are met:

- The entity offers only one Basic plan in the service area.
- The entity may offer one Enhanced plan in the service area.
- If the entity offers an Enhanced plan in a service area, the entity may offer one Premium plan for the area.
- If the entity offers a Premium plan for a service area, the entity may offer one or more Premium-Plus plans for the area.

All such plans could be offered under a single contract with the Commissioner.

Consistent with the standards in Sections 101–164 above, the Commissioner would also establish the following standards for the three primary levels of Exchange plans—Basic, Enhanced, and Premium—and for additional benefits that may be offered in a Pre-

mium-Plus plan. Besides offering the essential benefits package (Section 122 above) for a QHBP, Basic plan benefit packages would be modified to provide for reduced cost-sharing for individuals eligible for the "affordability cost-sharing credit," described below in Section 244. Excluding the credit, the benefit package of a Basic plan would have an actuarial value representing payment for approximately 70 percent of all the covered items and services in the essential benefits package (Section 122 above). Enhanced plans would have lower cost-sharing than Basic plans, representing approximately 85 percent of the actuarial value of all the covered items and services in the essential benefits package. Premium plans would have lower cost-sharing than Enhanced plans, representing approximately 95 percent of the actuarial value of all the covered items and services in the essential benefits package. Premium-Plus plans would be Premium plans that also provide additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits would be separately specified.

The Commissioner would establish a permissible range of variation of cost-sharing for the Basic, Enhanced and Premium plans. Such variation would permit variations up to 10 percent in cost-sharing with respect to several benefit categories (Section 122).

If a state requires health insurers to offer benefits beyond the essential benefits package, such requirements would continue to apply to Exchange plans, but only if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any resulting net increase in affordability premium credits (Section 243).

Sec. 204. Contracts for the Offering of Exchange-participating Health Benefits Plans

The Commissioner would establish standards, described below, for Exchange-participating entities and their health benefits plans. The Commissioner would certify entities and plans if the standards are met. The Commissioner would solicit and review bids from QHBP-offering entities for offering Exchange plans, negotiate with the entities, and enter into contracts with the entities for offering plans through the Exchange under terms negotiated between the Exchange and the entities.

The Federal Acquisition Regulation (the principal set of rules that govern the contracting process for the federal government) would not apply to contracts between the Commissioner and QHBP-offering entities for offering Exchange plans.

The standards for Exchange-participating entities would consist of the following requirements:

- The entity must be licensed or otherwise permitted to offer health insurance coverage under state law for each state in which it offers coverage.
- The entity must provide for reporting data/information specified by the Commissioner, including information necessary to administer the risk pooling mechanism in Section 206 and information to address disparities in health and health care.
- The entity must provide for implementation of the affordability credits provided for enrollees (described in Sections 241–246 below).

• The entity must accept all applicable enrollment via the Exchange, subject to such exceptions (such as capacity limitations) in accordance with the federal requirements for QHBPs (discussed under Title I), and would notify the Commissioner if it projects or anticipates reaching a capacity that would result in a limitation in enrollment.

• The entity must participate in the pooling mechanism as established by the Commissioner (described in Section 206 below).

• Regarding the Basic plan offered by the entity, the entity must contract for outpatient services with certain federally supported health care providers. The Commissioner would also specify how this requirement would apply to Health Maintenance Organizations (HMOs).

• The entity must provide culturally and linguistically appropriate communication and health services.

• The entity must comply with other applicable requirements of this title specified by the Commissioner, which would include standards regarding billing and collection practices for premiums and grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Exchange.

For the contracting process, entities' bids would have to contain the information required by the Commissioner. Contracts would last at least one year, but could be automatically renewed in the absence of notice of termination by either party. The contract would provide that if the Commissioner determines that a plan's provider network is not adequate, then the cost-sharing charged to a person who received out-of-network care would be the same as if the care had been provided in-network.

In coordination with state insurance regulators, the Commissioner would establish processes to oversee, monitor, and enforce applicable requirements on Exchange-participating entities and QHBPs, including plan marketing. In conjunction with state insurance regulators, the Commissioner would establish a process for individuals and employers to file complaints concerning violations. The Commissioner could terminate a contract with an entity if it fails to comply with the requirements of this title; the Commissioner could also impose one or more intermediate sanctions.

Any determination by the Commissioner to terminate a contract would be made in accordance with formal investigation and compliance procedures established by the Commissioner under which (a) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner's determination; and (b) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract. However, these procedures need not apply if the Commissioner determined that a delay in termination would pose an imminent and serious risk to the health of individuals enrolled under the plan.

Sec. 205. Outreach and Enrollment of Exchange-eligible Individuals and Employers in Exchange-participating Health Benefits Plan

Outreach. The Commissioner would conduct outreach activities to inform and educate individuals and employers about the Exchange and its participating health plans. Such outreach would include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments. The Commissioner's required outreach activities would include the following:

- broadly disseminate information on Exchange-participating plans, provided in a comparative manner and including information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction;
- provide assistance to Exchange-eligible individuals and employers via a toll-free telephone hotline and an Internet website;
- develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities;
- assist Exchange-eligible individuals in selecting plans and obtaining benefits; and
- ensure the information is developed using plain language (described in Section 133 above).

Enrollment. The Commissioner would be required to make timely determinations of whether individuals and employers are eligible for Exchange coverage and to establish and carry out an enrollment process, including at community locations. Enrollment would be permitted by mail, telephone, electronically, or in person.

Open enrollment for individuals and employers to enroll in an Exchange plan and affordability credits (described in Sections 241–245 below) would be at least 30 days and would be during September through November of each year before benefits would begin, or such other time that would maximize the timeliness of income verification. However, the Commissioner would also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who loses acceptable coverage, experiences a change in marital or other dependent status, moves outside the plan's service area, or experiences a significant change in income. The Commissioner, potentially with other appropriate entities, would be required to broadly disseminate information on the enrollment process, including before each enrollment period.

The Commissioner would establish a process to automatically enroll the following individuals into an appropriate Exchange plan (potentially involving a random assignment or some other form of assignment that takes into account the health care providers used by the individual, or such other relevant factors specified by the Commissioner):

- those who have applied for affordability credits, been determined eligible, have not opted out from receiving such credit, and do not enroll in another Exchange plan; and
- those enrolled in an Exchange plan that is terminated (during or at the end of a plan year) who do not enroll in another Exchange plan.

Under the enrollment process, individuals enrolled in an Exchange plan would pay such plans directly, not through the Commissioner or the Exchange.

Special provisions apply to newborns born in the United States without acceptable coverage at birth. Until other acceptable coverage begins, the child would be considered a non-traditional Medicaid-eligible individual (for whom the state would be paid 100 percent federal reimbursement) and would be deemed as having elected Medicaid coverage. This coverage would end no later than the end of the month 60 days after the child's birth; at the end of that period, if the child still does not have acceptable coverage, the child is deemed a traditional Medicaid-eligible individual, for whom the state receives the regular Medicaid federal matching rate.

As of the day before the first day of 2013, CHIP-eligible children, including targeted low-income children in a Medicaid-expansion CHIP program, would be deemed to be Exchange eligible. The Commissioner would notify each state in 2013 whether the Exchange could support enrollment of these children.

A "traditional Medicaid eligible individual" is a Medicaid-eligible individual *excluding* (1) those who are eligible because of the expansion of Medicaid in Section 1701 of this legislation to individuals up to 133⅓ percent FPL and (2) a childless adult who would not otherwise be classified as categorically needy (as per current Medicaid statute, Section 1902(a)(10)(A)) or medically needy (as per current Medicaid statute, Section 1902(a)(10)(C)) as in effect as of the day before the date of enactment of this Act. A "non-traditional Medicaid-eligible individual" is a Medicaid-eligible individual who is not a traditional Medicaid-eligible individual. Section 202 of the legislation includes provisions so that a non-traditional Medicaid eligible individual could be Exchange-eligible if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the six months before the individual became a non-traditional Medicaid eligible individual. Under this section, the Commissioner would provide these individuals with the option to enroll in Medicaid rather than an Exchange plan and to change that election during open enrollment periods described earlier in this section. The Commissioner would provide for a process to automatically enroll these individuals into Medicaid if they have not elected to enroll in any Exchange plan.

An Exchange-eligible individual could apply for a Medicaid-eligibility determination. If the individual is determined to be eligible, the Commissioner would provide for the individual's enrollment under the state Medicaid plan in accordance with the Medicaid memorandum of understanding. In the case of such an enrollment, the state would provide for the same periodic redetermination of eligibility under Medicaid that would apply if the individual had directly applied to the state Medicaid agency. The legislation would require the Commissioner, in consultation with the HHS Secretary, to enter into a memorandum of understanding with each state with respect to coordinating enrollment of individuals in Exchange plans and under state Medicaid programs, and to otherwise coordinate the implementation of these provisions with respect to the Medicaid program. This memorandum would permit the exchange of information consistent with limitations specified in Medicaid statute with respect to providing safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the state Med-

icaid plan, and at state option, the exchange of information necessary to verify eligibility for other federal programs (e.g., for free and reduced price school lunches). None of these provisions could be construed as permitting such memorandum to modify or vitiate any requirement of a state Medicaid plan.

In carrying out this section, the Commissioner would establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

Sec. 206. Other Functions

The Commissioner would be required to coordinate the distribution of affordability premium and cost-sharing credits (described below in Sections 243–244) to the Exchange plans. The Commissioner would also be required to establish a risk-pooling mechanism, to adjust premium payments to Exchange plans to take into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the Exchange plans.

An Office of the Special Inspector General for the Exchange would be established, headed by a Special Inspector General appointed by the President and confirmed by the Senate. The Special Inspector General's nomination would be made as soon as practicable after the establishment of the Exchange.

The duties of the Special Inspector General would consist of the following:

- conduct, supervise, and coordinate audits, evaluations and investigations of the Health Insurance Exchange to protect the integrity of the Exchange as well as the health and welfare of participants in the Exchange;
- report both to the Commissioner and to the Congress regarding program and management problems and recommendations to correct them;
- related to the duties above, have other duties described as applying to the Special Inspector General of the Troubled Asset Relief Program (TARP), per paragraphs (2) and (3) of Section 121 of P.L. 110–343; and
- in carrying out these duties, have the authorities of inspectors general in Section 6 of the Inspector General Act of 1978.

Other provisions of the TARP Special Inspector General would also be applied, regarding the basis of the Special Inspector General's appointment, how s/he might be removed, his/her salary, and available personnel, facilities and other resources.

Not later than one year after the confirmation of the Special Inspector General, and annually thereafter, the Special Inspector General would submit to the appropriate committees of Congress a report summarizing the activities of the Special Inspector General during the one year period ending on the date the report is submitted.

The Office of the Special Inspector General would terminate five years after the date of the enactment of this Act.

Following an amendment at Committee, this provision would also require the Commissioner, in consultation with the Small Business Administration, to establish and carry out a program to provide health insurance counseling and technical assistance to

small employers who provide their employees health care through the HIE.

Sec. 207. Health Insurance Exchange Trust Fund

A "Health Insurance Exchange Trust Fund" would be created within the U.S. Treasury, consisting of such amounts as may be appropriated or credited to the fund. The Commissioner would pay from the Trust Fund amounts as determined necessary to make payments to operate the Exchange, including affordability credits.

Dedicated payments to the Trust Fund would include the following:

- tax on individuals not obtaining acceptable coverage (Section 401);
- tax on employers electing to not provide health benefits (Section 412); and
- tax on employers who fail to satisfy health coverage participation requirements (Section 411).

Such additional sums as necessary would be appropriated. General provisions in the Internal Revenue Code regarding federal government trust funds would apply.

Sec. 208. Optional Operation of State-based Health Insurance Exchanges

If a state (or group of states, subject to the Commissioner's approval) applied to the Commissioner for approval of a state-based Health Insurance Exchange, and if the Commissioner approves such state-based Exchange, then the state-based Exchange would operate instead of the federal Exchange in that state(s).

The Commissioner could not approve a state-based Exchange unless the following requirements were met (and would be required to approve it if the conditions were met):

- The state-based Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that it could carry out the functions specified for the federal Exchange in the state(s) including:
  - negotiating and contracting with qualified plans;
  - enrolling Exchange-eligible individuals and employers in plans;
  - establishing sufficient local offices to meet the needs of Exchange-eligible individuals and employers;
  - administering premium and cost-sharing credits (described below in Sections 241–246) using the same methodologies, and at least the same income verification methods, as would otherwise apply and at a cost to the federal government that is not greater than what would otherwise apply; and
  - enforcement activities consistent with federal requirements.
- There is no more than one Exchange in operation in any one state.
- The state provides assurances satisfactory to the Commissioner that approval of such an Exchange would not result in any net increase in expenditures to the federal government.
- The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Com-

missioner that it will vigorously enforce violations of applicable requirements.

- Such other requirements as the Commissioner may specify.

A state-based Exchange could, at the option of the state, and only after providing timely and reasonable notice to the Commissioner, cease operation. In this case, the federal Exchange would be operational in the state(s).

The Commissioner could terminate the approval (for some or all functions) of a state-based Exchange if the Commissioner determined that it no longer met the requirements listed above or was no longer capable of carrying out such functions. In lieu of terminating the state-based Exchange's approval, the Commissioner could temporarily assume some or all functions of the state-based Exchange until the Commissioner determined that it met the applicable requirements and was capable of carrying out those functions. The ceasing or termination of a state-based Exchange would be effective in such time and manner as the Commissioner would specify.

Enforcement authorities of the Commissioner would be retained by the Commissioner. The Commissioner could specify functions of the federal Exchange that may not be performed by a state-based Exchange or that could be performed by both the Commissioner and the state-based Exchange.

In the case of a state-based Exchange, except as the Commissioner may otherwise specify, any references to the "Exchange" or to the "Commissioner" in the area in which the state-based Exchange operates would be deemed a reference to the state-based Exchange and the head of that Exchange.

In the case of a state-based Exchange, funding assistance would be provided for its operation in the form of a matching grant, with a state share of expenditures required.

Sec. 209. Participation of Small Employer Benefit Arrangements

This provision would allow the Commissioner to enter into contracts with small business co-ops operating a small business benefit arrangement to facilitate their participation in the HIE.

Subtitle B—Public Health Insurance Option

Sec. 221. Establishment and Administration of a Public Health Insurance Option As An Exchange-Qualified Health Benefits Plan

Current Law

Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program including eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost sharing amounts.

Proposed Law

The provision would require the Secretary of Health and Human Services (Secretary) to provide for the offering of a public health insurance option through the Exchange starting 2013. The Secretary would be required to ensure that the public option provided choice,

competition and stability of affordable, high quality coverage throughout the United States. The Secretary's primary responsibility would be to create a low-cost plan without compromising quality or access to care.

The public option would only be available through the Health Insurance Exchange. The public option would be required to comply with requirements applicable to Exchange-participating health benefit plans, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing. The public option would be required to offer basic, enhanced, and premium plans, and would be allowed to offer premium-plus plans.

The Secretary would be allowed to enter into contracts for the administration of the public option in the same manner as the Secretary is allowed to enter into contracts for the administration of the Medicare program. These administrative functions include, subject to restrictions, determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance. The Secretary would have the same authority to enter into contracts for the public option, as the Secretary has with respect to the Medicare program. The provision would prohibit contracts that involve the transfer of insurance risk.

The Secretary would be required to establish an office of the ombudsman for the public health insurance option which would have duties similar to those of the Medicare Beneficiary Ombudsman.

The Secretary would be required to collect data necessary to establish premiums and payment rates and for other purposes, including improving quality and reducing disparities in health care based on race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation as determined appropriate by the Secretary. Such data collection would be on a voluntary basis and consistent with certain privacy standards.

With respect to the public health insurance option, the Secretary would be treated as an entity offering a Quality Health Benefit Plan through the Exchange.

The provisions relating to access to Federal courts for enforcement of rights under Medicare would apply to the public option and individuals enrolled under the public option in the same manner that they apply to Medicare and Medicare beneficiaries.

Sec. 222. Premiums and Financing

Current Law

No current law.

Proposed Law

The Secretary would be required to establish geographically-adjusted premiums for the public option in a manner that complies with the premium rules established by the Commissioner for Exchange-participating health benefit plans and at a level sufficient to fully finance the cost of health benefits and administration for the public option. Premiums would be required to include an appropriate amount for a contingency margin.

The provision would establish an account in the Treasury for receipts and disbursements attributable to the public option, including start-up funding. The start-up funding would be equal to the sum of $2 billion for the establishment of the public option, and such sums as may be necessary to cover 90 days worth of reserves based on projected enrollment. These amounts would be authorized to be appropriated to the Secretary out of any funds in the Treasury not otherwise appropriated. The Secretary would be required to provide for repayment of the start-up funding in an amortized manner over a 10 year period starting in 2013. The provision specifies that nothing in this section could be construed as authorizing any additional appropriations to the account, other than amounts otherwise provided with respect to other Exchange-participating plans. As under the Medicare Advantage program, states would be prohibited from imposing a premium tax or similar tax with respect to the public option.

Sec. 223. Payment Rates for Items and Services

Current Law

No current law.

Proposed Law

The Secretary would be required to establish payment rates for services and health care providers under the public option.

In general, during the first three years of the public option, the Secretary would be required to base payment rates on the rates for similar services and providers under Medicare. For services furnished in 2013, 2014 and 2015, physicians and other health care practitioners who participate in both Medicare and the public option would receive payment rates 5% greater than rates otherwise established by the Secretary for items and professional services. Pediatricians and other practitioners who do not typically participate in Medicare—as determined by the Secretary—would also be eligible for the increased payment rates. Beginning in 2016, the Secretary would be required to continue to use an administrative process to set payment rates to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of health care. The Secretary would be prohibited from setting rates at levels expected to increase overall medical costs for the public option beyond what would be expected if Medicare rates (plus the 5% addition) were to continue.

The provision specifies that nothing would prevent the use of innovative payment methodologies such as those described in Section 224 in connection with the negotiation of payment rates. As introduced and reported, H.R. 3200 would allow the Secretary discretion to establish a prescription drug formulary, and use other methods, including those used by private sector pharmacy benefit managers, to reduce prescription drug costs under the public health insurance option, and the Committee expects that the Secretary would implement such a formulary.

Health care providers participating in Medicare would be participating providers in the public health insurance option unless they opted out in a process established by the Secretary.

The provision would prohibit administrative or judicial review of a payment rate or methodology established under this section, or Section 224.

Sec. 224. Modernized Payment Initiatives and Delivery System Reform

Current Law

No current law.

Proposed Law

Beginning in the first year of the public option, the Secretary would be given the authority to use innovative payment mechanisms and policies to determine payments for items and services under the public option. The payment mechanisms and policies may include the following: patient-centered medical home, other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. The Secretary would be required to design and implement the payment mechanisms and policies in a way that promotes care that is integrated, patient-centered, efficient and of quality, and that seeks to either (a) improve health outcomes, (b) reduce health disparities, (c) address geographic variation in the provision of health services, (d) prevent or manage chronic illness, or (e) provide efficient and affordable care. To the extent allowed under the rules for Exchange-participating plans, the provision would allow cost sharing and payment rates under the public option to be modified to encourage the use of services that promote health and value. The provision specifies that nothing in the subtitle would prevent the Secretary from varying payments based on different payment structure models for different geographic areas.

Sec. 225. Provider Participation

Current Law

No current law

Proposed Law

The Secretary would be required to establish conditions of participation for health care providers under the public option. The Secretary would be prohibited from allowing a health care provider to participate unless appropriately licensed or certified under State law. A health care provider that was excluded from participation in a Federal health care program (as defined in Section 1128(f) of the Social Security Act), would be prohibited from participating under the public option.

Annually, the Secretary would be required to provide for physicians to participate in the public plan in one of two classes: (a) preferred physician, or (b) participating, non-preferred physician. A preferred physician would be one who agreed to accept the established rate as payment in full. A participating non-preferred physician would be one who could balance bill-impose charges that exceed the charges that may be imposed for such items and services (in relation to the payment rate for such items and services under

Medicare). The participating non-preferred physician would agree not to impose charges that exceed 115 percent of the amount established under Sec. 223 (consisting of the Medicare rate and the 5 percent addition). The Secretary would be required to provide for the participation of non-physician providers. Non-physician providers would only be allowed to participate if they accepted the established rates as payment in full.

Sec. 226. Application of Fraud and Abuse Provisions

Current Law

Title XVIII of the SSA, the Medicare statutes, requires activities that prevent, detect, investigate and prosecute health care fraud and abuse. In general, initiatives designed to fight fraud, waste, and abuse are considered program integrity activities. Program integrity is considered a component of the effective and efficient administration of government programs, which are entrusted with ensuring that taxpayer dollars are spent wisely. Efforts to ensure Medicare program integrity encompass a wide range of activities and require coordination among multiple private and public entities. This includes processes directed at reducing payment errors to Medicare providers, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse.

Proposed Law

The provisions of law (other than criminal law) identified by the Secretary by regulation, in consultation with the Inspector General, that impose sanctions with respect to waste, fraud, and abuse under Medicare would also apply to the public health insurance option.

Sec. 227. Sense of the House Regarding Enrollment of Members in the Public Option

This provision would create a Sense of the House of Representatives that any members who vote in support of the public health insurance option are urged to forgo their right to participate in the FEHBP and enroll under the public option.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability Through Health Insurance Exchange

Current Law

None.

Proposed Law

This provision would provide premium and cost-sharing credits to "affordable credit eligible individuals" (defined in Section 242) for certain individuals enrolled in coverage through the Exchange. The Commissioner would pay each QHBP participating in the Exchange the aggregate amount of credits for all eligible individuals enrolled in that plan.

An Exchange-eligible individual could apply to the Commissioner, through the Exchange or another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner, through the Health In-

surance Exchange or through another public entity under an arrangement made with the Commissioner, would make a determination as to eligibility of an individual for affordability credits. The Commissioner would establish a process whereby, on the basis of information otherwise available, individuals may be deemed eligible for credits. The Commissioner would also establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

If the Commissioner determines that a state Medicaid agency has the capacity to make a determination of eligibility for affordability credits under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding (described above in Section 205), the state Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination, and the Commissioner would reimburse the state Medicaid agency for the costs of conducting such determinations.

In addition, there would be a Medicaid screen-and-enroll obligation, that when individuals apply for affordability credits, a determination would be made as to whether they are eligible for Medicaid. If they are determined eligible for Medicaid, the Commissioner, through the Medicaid memorandum of understanding, would provide for their enrollment under the state Medicaid plan, and the state would provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply.

During the first two years of implementation, credits would be allowed for coverage under a Basic plan only. Beginning in the third year, credits would be allowed for coverage under Enhanced or Premium plans by a process established by the Commissioner. The individual would be responsible for any difference between the premium for an Enhanced or Premium plan and the credit amount based on a Basic plan applicable to that enrollee.

The Commissioner would be authorized to request from the Treasury Secretary information that may be required to carry out this subtitle (regarding individual affordability credits), consistent with existing rules regarding confidentiality and disclosure of tax return information. Individuals who are eligible to receive credits would not receive them in the form of cash payments.

Sec. 242. Affordable Credit Eligible Individual

Current Law

None.

Proposed Law

This provision would define an "affordable credit eligible individual" as an individual who (1) is lawfully present in a state in the United States (other than those lawfully present as non-immigrants, with some exceptions), (2) is enrolled in an Exchange plan and is not enrolled through an employer plan that meets the employer responsibility to contribute toward employee and dependent coverage (described below in Section 312), (3) has family income below 400 percent FPL, and (4) who is not a Medicaid-eligible individual (other than some exceptions described above in Section 202).

Family members who are eligible for credits will be treated as a single affordable credit eligible individual.

Credits would not be available to full-time employees of an employer offering coverage consistent with the employer contribution rules described in Section 312. The Commissioner would make exceptions to this rule for divorced or separated individuals, or dependents of employees who would otherwise be eligible for credits. Exceptions would also be made, beginning in 2014, for full-time employees whose premium and cost sharing costs under a group health plan exceed 11 percent of family income.

Income would be defined as "modified adjusted gross income" (MAGI), per the new 59B of the Internal Revenue Code, added in Sec. 401. The Commissioner would conduct a study to examine the application of income disregards for the purposes of the affordability credits. The Commissioner would submit a report to Congress of such a study, including recommendations as the Commissioner determines appropriate. Affordability credits would not be treated as a federal means-tested public benefit for eligibility purposes for qualified aliens under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Sec. 243. Affordable Premium Credit

Current Law

None.

Proposed Law

This section would establish the rules for determining the amount of the premium credit provided to eligible individuals enrolled in an Exchange plan. The "affordability premium credit" would be an amount equal to the lesser of (1) the amount by which the enrollee's premium exceeds a specified level that is considered affordable ("affordable premium amount"), or (2) the amount by which the "reference premium" (the average premium of the three least expensive Basic plans in the individual's premium rating area) exceeds the "affordable premium amount." In calculating the reference premium, the Commissioner may exclude plans with extremely limited enrollments.

The affordable premium credit amount would be calculated on a monthly basis, based on the following table, to limit individuals' premium payments to a percentage of family income (MAGI) relative to the poverty level, as specified in the table below.

Federal poverty level (FPL)	Premium payment limit, as a percent of income
133% or less	1.5%
150%	3%
200%	5%
250%	7%
300%	9%
350%	10%
400%	11%

The Commissioner would establish premium percentage limits so that for individuals whose family income is between the income tiers specified in the table, the percentage limits would increase on a linear sliding scale.

Sec. 244. Affordability Cost-Sharing Credit

Current Law

None.

Proposed Law

The affordability cost-sharing credit under this section would be available to those enrolled in an Exchange plan whose income is less than 400 percent FPL. The Commissioner would specify reductions in cost-sharing amounts and the annual limitation (out-of-pocket maximum) on cost-sharing under a Basic plan so that the average percentage of covered benefits paid by the plan (as estimated by the Commissioner) is equal to the percentages (actuarial values) in the table for each income tier.

Federal poverty level (FPL)	Actuarial value percentage
150% or less	97%
200%	93%
250%	85%
300%	78%
350%	72%
400%	70%

The Commissioner would provide payments to QHBP-offering entities in an amount equivalent to the increased actuarial value of benefits resulting from the cost-sharing reductions.

Sec. 245. Income Determinations

Current Law

None.

Proposed Law

This provision would use an individual's adjusted gross income in the most recent taxable year for determination of a credit under this Subtitle. The Commissioner would take steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle. The Commissioner would request information from the Treasury Secretary as may be permitted to verify income information submitted in applications for credits. The Commissioner would establish procedures for verification of income if no tax return is available for the most recent completed tax year. The Commissioner would establish special rules for cases when an individual's income is expected (in a manner specified by the Commissioner) to be significantly different from the income submitted for application for and determination of a credit. The Commissioner would establish rules under which an individual would be required to inform the Commissioner when there is a significant change in income. Such mechanism would provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the family income of the individual, the Commissioner would provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

For a CHIP-eligible child deemed to be eligible for coverage through the Exchange, during the first year of implementation the Commissioner would establish rules under which family income of the child is deemed to be no greater than the family income of that child as most recently determined by the State under CHIP. The Commissioner would examine the feasibility and implication of adjusting the application of the federal poverty level in this Subtitle to take into account geographic differences, in order to reflect cost-of-living variations across the country. The Commissioner would submit a report to Congress, no later than the first day of the second year of implementation, on such a study and make recommendations as appropriate. An individual who intentionally misrepresents family income or fails to disclose to the Commissioner a significant change in family income would be liable for repayment of any improperly received credit and, in the case of intentional misrepresentation, may be required to pay an additional penalty as imposed by the Commissioner.

Sec. 246. No Federal Payment for Undocumented Aliens

Current Law

None

Proposed Law

No credits would be given to individuals who are not lawfully present in the country.

Subtitle D—State Innovation

Sec. 251. Waiver of ERISA Limitation; Application Instead of State Single Payer System

Added by an amendment at Committee, this provision would create an ERISA waiver to permit States to enact single payer laws. The Department of Labor would determine whether the State plan meets certain requirements to obtain the waiver. With such a waiver, a state single payer system would operate in lieu of the HIE in such state.

Title III—Shared Responsibility

Subtitle A—Individual Responsibility

Sec. 301. Individual Responsibility

The Committee did not exercise jurisdiction over this section.

Subtitle B—Employer Responsibility

Sec. 311. Health Coverage Participation Requirements,

Sec. 312. Employer Responsibility to Contribute Towards Employee and Dependent Coverage,

Sec. 313. Employer Contributions in Lieu of Coverage,

Sec. 314. Authority Related to Improper Steering,

Sec. 321. Satisfaction of Health Coverage Participation Requirements under the Employee Retirement Income Security Act of 1974,

Sec. 322. Satisfaction of Health Coverage Participation Requirements under the Internal Revenue Code of 1986,

Sec. 323. Satisfaction of Health Coverage Participation Requirements under the Public Health Service Act, and

Sec. 324. Additional rules relating to health coverage participation requirements

Current Law

There is no federal requirement that employers offer health insurance coverage to employees or their families. As with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162 of the Code. In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.

ERISA[124] preempts state law relating to certain employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, the courts have held that self-insured employer-sponsored health plans cannot be regulated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance with a few limited standards if an employer chooses to offer health benefits, mainly compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[125] and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")[126], adding other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

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[124] Pub. L. No. 93–406

[125] Pub. L. No. 99–272.

[126] Pub. L. No. 104–191.

Proposed Law

Section 311. Health Coverage Participation Requirements

Section 311 of the bill sets forth the basic requirement for an employer to offer individual and family health care coverage, to make timely contributions to such coverage when accepted by the employee, and to make contributions to the HIE in lieu of such coverage when the employee declines the coverage but obtains coverage from an HIE plan.

Additionally, employers that meet certain economic hardship qualifications could apply for a two-year employer hardship exemption that waives an employer's obligation to provide coverage required by this bill. The Secretary shall develop rules on the form and manner of such exemption applications and should take a robust approach to collecting information from an employer applicant and determining how significant and unavoidable such claimed hardship is. For example, employers should not be allowed to game or abuse this exemption through timed outlays, like executive bonuses, in order to create a balance sheet designed to demonstrate hardship when it comes to complying with health coverage requirements. The Committee expects the Secretary to require adequate documentation of the employer's financial circumstances to demonstrate whether it qualifies for this exemption.

Section 312. Employer Responsibility to Contribute towards Employee and Dependent Coverage

Section 312 specifies the minimum contribution amounts an employer must make to satisfy the coverage requirements for full-time and non-full-time employees. An employer may not satisfy the minimum contribution requirement through a salary reduction arrangement with the employee. This section also provides rules for the automatic enrollment of employees into employer plans and how employees may opt out of such automatic enrollment.

Employers offering health benefit plans would be required to offer individual and family coverage under a qualified health benefits plan (or certain grandfathered health insurance plans)[127] and to make contributions to help discharge the coverage costs of employees enrolled in the employer-provided plan. For full time employees, the employer would be required to contribute at least 72.5 percent of the lowest cost plan offered by the employer which meets the requirements of the essential benefits package[128] (65 percent for eligible employees electing family coverage). For part time employees, the contribution amount from the employer would be a fraction of the minimum contributions made for full time employees, with such fraction being equal to a ratio of the average weekly hours worked by the employee compared to the minimum weekly hours specified by the Health Choices Commissioner. Employers would be required to provide information to the Secretaries of Labor, Health and Human Services, and the Treasury, to assist the

[127] For a plan to be a "qualified health benefits plan" it would need to meet certain minimum coverage requirements, but it need not be offered through the Exchange.

[128] The essential benefits package would include certain specified limits on required cost sharing, would ban annual or lifetime limit on covered health care items or services and certain specified minimum services, and would impose certain requirements as to network adequacy as determined by the Health Choices Commissioner.

Secretaries with ascertaining compliance with the proposal's requirements.

Sec. 313. Employer Contributions in Lieu of Coverage

Employers that elect not to provide eligible health benefit plans to their employees would be subject to a contribution to the Health Insurance Exchange Trust Fund equal to 8 percent of wages (as defined in section 3121 for purposes of FICA). There is a special rule for an employer who is considered a small employer, defined as any employer with an annual payroll for the preceding calendar year which does not exceed $400,000.

Employers with payrolls that do not exceed $250,000 would be exempt. Employers with payrolls that exceed $250,000 but do not exceed $300,000 would be subject to a contribution equal to 2 percent of wages; employers with payrolls that exceed $300,000 but do not exceed $350,000 would be subject to a contribution of 4 percent of wages; and employers with an annual payroll that exceeds $350,000 but do not exceed $400,000 would be subject to a contribution of 6 percent of wages.

Related employers and predecessors would be treated as a single employer for purposes of determining whether an employer qualifies for the special rule for small employers.

Section 314. Authority related to improper steering

The Health Choices Commissioner (in coordination with the Secretaries of Labor, Health and Human Services, and the Treasury) would have the authority to set standards for determining whether employers were undertaking any actions to affect the risk pool within the Health Insurance exchange by inducing employees to enroll in Exchange-participating health plans rather than in employer-provided plans. An employer found to be violating these standards would be treated as not meeting the coverage requirements.

Section 321. Satisfaction of Health Coverage Participation Requirements under the Employee Retirement Income Security Act of 1974

Section 321 amends ERISA and sets forth the requirements for an employer to satisfy the health coverage participation requirements under the bill.

Elections

Under the proposal, employers would be required to make an affirmative election regarding whether to offer health benefit plans to employees. Those employers electing to offer health benefit plans would be required to have their plans meet certain minimum coverage requirements. Employers choosing not to offer health benefit plans, or that offered plans that did not meet the proposal's qualification requirements, would be subject to additional taxes or penalties. Employers with payrolls of $250,000 or less would be exempt from the pay or play requirements.

The Secretaries of Labor, Health and Human Services, and the Treasury, would prescribe coordinated rules for employer elections regarding coverage, including rules for the time, manner and form of elections, and the treatment of affiliated groups of employers,

separate lines of business, and full versus part time employees.[129] Subject to Section 151, employers electing to offer health benefit plans would be treated as having established and maintained a group health plan for purposes of ERISA and the Public Health Service Act ("PHSA"),[130] and the proposal's health coverage participation requirements would be deemed to be part of the terms and conditions of the employer-provided plan.

Employers would be required to provide verification of their compliance with the proposal's health coverage participation requirement to the Health Choices Commissioner and to the Secretaries of Labor, Health and Human Services, and the Treasury.

Aggregation Rules

For affiliated groups of employers, the identity of the employer would generally be determined by applying the employer aggregation rules in section 414(b), (c), (m), and (o).[131] The same election would apply to all employers in the aggregated group. Employers would be able to make separate elections for employees in separate lines of business, or for full time employees and part time employees.

Noncompliance with Coverage Requirements

Employers who elected to provide coverage but whose health benefit plans failed to meet the proposal's minimum health coverage participation requirements would be subject to penalties of $100 per day for each employee to whom the failure applied.[132] The penalties would not apply to (1) periods during which an employer used reasonable diligence but did not discover any failures, and (2) failures that were corrected within 30 days of discovery (but only if such failures were due to reasonable cause and not willful neglect). Penalties imposed on employers for unintentional failures (i.e., due to reasonable cause and not to willful neglect) would be limited to the lesser of: 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for group health plans, or $500,000.

The Secretaries would also be able to terminate an employer's election (and thus subject them to the required contribution imposed on employers that do not offer coverage) if it was determined that the employer was substantially noncompliant with health coverage participation requirements.

The Secretary of Labor would be required to conduct periodic audits of employers in order to discover noncompliance with health

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[129] The Commissioner and Secretaries would also be required to issue regulations applying the proposal's requirements to multiemployer plans (as defined in section 3(37) of ERISA).

[130] 42. U.S.C. 6A.

[131] Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the certain requirements under section 414(m).

[132] The proposal would permit the penalties to be assessed through an excise tax or a civil penalty under ERISA or PHSA. Penalties for any particular failure would not be duplicated, however. The Secretary of Labor or Health and Human Services, as appropriate, would be required to give advance written notification of failure to employers prior to the assessment of a penalty. The Secretary of Health and Human Services would be able to bring civil actions in Federal court to collect civil penalties assessed under PHSA.

coverage participation requirements. The Secretary of the Treasury and the Health Choices Commissioner would be informed of audit results.

To facilitate such audits, especially with respect to the problem of employers misclassifying employees as independent contractors, the Secretary of Labor would be authorized to issue regulations that would require employers to keep records on both employees and certain claimed independent contractors. The Secretary should craft such recordkeeping requirements to assist in uncovering and remedying any misclassification of workers.

Sec. 322 Satisfaction of Health Coverage Participation Requirements under the Internal Revenue Code

The Committee did not exercise jurisdiction over this section.

Sec. 323. Satisfaction of Health Coverage Participation Requirements under the Public Health Service Act

The Committee did not exercise jurisdiction over this section.

Sec. 324. Additional Rules Relating to Health Coverage Participation Requirements

The Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury would be required to execute an interagency memorandum of understanding to ensure coordination with respect to regulations, rulings, interpretations, and enforcement of the proposal.

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

The Committee does not have jurisdiction over Title IV of Division A.

Division B—Medicare and Medicaid Improvements

The Committee does not have jurisdiction over Division B.

Division C—Public Health and Workforce Development

The Committee has jurisdiction over certain provisions in Division C, summarized below.

Sec. 2502. Establishment of Grant Program

Current Law

PHSA Section 831 establishes a Nurse Education, Practice, and Retention Grants program. Under this program, the Secretary may award grants or enter into contracts with a school of nursing, health care facility, or a partnership of the two, to respond to the nursing shortage and increase the number of registered nurses in specific priority areas, as described. Funds may be used to promote career advancement for nurses. Appropriations authority for this grant program expired at the end of FY2007.

Proposed Law

This provision would establish a new partnership grant program, administered by the Secretary of Labor, to provide matching grants

for nursing training programs that aim to increase the number and skill levels of nurses, and expand nurse training capacity, in order to address projected nursing shortages. The Secretary of Labor would be required to establish this partnership grant program within six months of enactment.

Eligible entities would be: (1) a health care entity that is jointly administered by a health care employer and a labor union representing that organization's health care employees, and that carries out activities using training funds as provided under Section 302(c)(6) of the Labor Management Relations Act (relating to funds paid by an employer to a trust fund established by a union to provide specified benefits or defray the costs of apprenticeship or training programs); (2) an entity that operates a training program jointly administered by one or more health care providers, facilities, or a trade association of health care providers; and by organizations that represent the interests of direct care health care workers or staff nurses, and include their leadership input; or (3) a State training partnership program that consists of non-profit organizations that have equal participation from industry (including both public and private employers) and labor organizations (including joint labor-management training programs), which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing. Eligible entities would be required to submit an appropriate application to the Secretary of Labor.

An eligible entity that is a health care employer would also be required to demonstrate that it: (1) has an established nursing retention program; (2) provides nursing wages and benefits that are competitive for its market or that have been collectively bargained with a labor organization; and (3) provides support for employees participating in the training program through one or more specified means, including paid leave time, or contributions to a training fund, among others.

The Secretary of Labor would be prohibited from awarding grants unless the applicant agrees to provide non-Federal matching funds that are equal to or no less than one dollar for each Federal dollar received. Matching funds could be secured from donations or provided through the cash equivalent of paid release time provided to incumbent worker students participating in educational programs. In addition, eligible entities would be required to demonstrate collaboration with accredited schools of nursing.

Awardees would be required to use funds to create training programs to allow incumbent health care workers to become nurses, to provide for the advanced training of nurses, or both. In each case, a number of specified program components would be required.

In making awards, the Secretary of Labor would be required to give preference to programs that improve nurse retention; that improve the diversity of nursing graduates; that improve the quality of nursing education; that have demonstrated success for transitioning health care workers into nursing or have established pilot programs to increase nurse faculty; or that are modeled after or affiliated with established transitioning and pilot programs mentioned above.

Awardees would be required annually to submit an evaluation to the Secretary of Labor, which must include a description of the grantee's activities and an evaluation of program outcomes. Several outcomes that may be reported are specified.

The Secretary of Labor would be required, within two years of enactment and annually thereafter, to report to Congress on the overall effectiveness of the grant programs carried out under this provision. This provision would authorize to be appropriated such sums as may be necessary to carry out the partnership grant program.

Subtitle F—Standards for Accessibility to Medical Equipment for Individuals with Disabilities

Sec. 2541. Access for Individuals with Disabilities

This provision would require the development of standards for accessible equipment, and require relevant agencies to ensure that all entities covered by the legislation meet the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

Subtitle G—Other Grant Programs

Sec. 2551. Reducing Student-to-School Nurse Ratios

This provision would make available demonstration grants to eligible local education agencies with the purpose to reduce the student-to-school nurse ratio in public elementary and secondary schools with special consideration given to high-need local educational agencies who demonstrate the greatest need for new or additional nursing services by providing information on the current ratios of students to school nurses.

Sec. 2552. Wellness Program Grants

This provision would authorize the Secretary of Labor to offer incentives to employers who establish qualified wellness programs for their employees. Participating employers must offer the programs to all employees and cannot mandate participation nor use participation as a condition to receive any financial incentive. The Committee recognizes the success of workplace wellness programs in promoting health and well-being and in reducing medical expenditures. The Committee urges the Secretary to promote both public and private workplace wellness programs.

Sec. 2553. Health Professions Training for Diversity Programs

This provision would authorize the Secretary of Labor to make grants to certain health care workforce development programs, particularly those focused on low-income persons, veterans, or rural or urban underserved populations.

Subtitle H—Long-Term Care and Family Caregiver Support

Sec. 2561. Long-Term Care and Family Caregiver Support

This provision would establish an advisory panel and a pilot program focused on improving the working conditions and training for the long-term care workforce.

Subtitle I—Online Resources

Sec. 2571. Web Site on Health Care Labor Market and Related Educational and Training Opportunities

This provision would require the Secretary of Labor to establish a web site that would serve as a clearinghouse of information on the health care labor market, including educational and training opportunities and financial aid information.

Sec. 2572. Online Health Workforce Training Programs

This provision would establish a grant program with the Secretary of Labor to award grants to qualifying entities providing health care workers with online training.

VI. EXPLANATION OF AMENDMENTS

The Amendment in the Nature of a Substitute and amendments thereof are explained in the body of this report.

VII. APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1, the Congressional Accountability Act, requires a description of the application of this bill to the legislative branch. The Committee has determined that the bill would apply to the legislative branch and its employees in the same way it would apply to employers and employees in the private sector.

VIII. REGULATORY IMPACT STATEMENT

The Committee has determined that H.R. 3200 provides for a new Health Insurance Exchange, in which participation is voluntary, and that such Exchange will be governed by a new Health Choices Administration which will establish, among other things, standards for what constitutes a qualified health benefit plan. With several exceptions for other acceptable coverage, employers and individuals will be required to maintain coverage via a qualified health benefit plan or pay a fee for not doing so. This new health care policy infrastructure will have the impact of ensuring that 97% of Americans have meaningful health insurance coverage and reduce the cost of providing such coverage for both employers and individuals.

IX. UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. The Committee anticipates that this issue will be addressed in a CBO cost estimate letter for the bill when it proceeds to consideration on the House floor, following the merger of the three versions of the bill reported by the three committees of jurisdiction.

X. EARMARK STATEMENT

H.R. 3200 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e) or 9(f) of rule XXI.

XI. ROLL CALL

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 1 **BILL: H.R. 3200** **DATE: July 16, 2009**
AMENDMENT NUMBER: 3 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: KLINE / STRIKES TITLES I & II OF DIVISION A

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT				X
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI		X		
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 2 **BILL: H.R. 3200** **DATE: 7/16/2009**
AMENDMENT NUMBER: 4 **ADOPTED: 29 AYES / 19 NOES**
SPONSOR/AMENDMENT: TITUS / INCREASE SIZE OF EMPLOYERS ELIGIBLE FOR THE EXCHANGE

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman	X			
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT				X
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Mr. GRIJALVA	X			
Mr. TIMOTHY BISHOP	X			
Mr. SESTAK	X			
Mr. LOEBSACK	X			
Ms. HIRONO	X			
Mr. ALTMIRE	X			
Mr. HARE	X			
Ms. CLARKE	X			
Mr. COURTNEY	X			
Ms. SHEA-PORTER	X			
Ms. FUDGE	X			
Mr. POLIS	X			
Mr. TONKO	X			
Mr. PIERLUISI	X			
Mr. SABLAN	X			
Ms. TITUS	X			
Ms. CHU	X			
Mr. KLINE, Senior Republican Member		X		
Mr. PETRI		X		
Mr. McKEON		X		
Mr. HOEKSTRA		X		
Mr. CASTLE		X		
Mr. SOUDER		X		
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. WILSON		X		
Mrs. McMORRIS RODGERS		X		
Mr. PRICE		X		
Mr. ROB BISHOP		X		
Mr. GUTHRIE		X		
Mr. CASSIDY		X		
Mr. McCLINTOCK		X		
Mr. HUNTER		X		
Mr. ROE		X		
Mr. THOMPSON		X		
TOTALS	**29**	**19**		**1**

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 3 **BILL: H.R. 3200** **DATE: 7/16/2009**
AMENDMENT NUMBER: 5 **ADOPTED: 32 AYES / 17 NOES**
SPONSOR/AMENDMENT: SCOTT / ADD EPSDT FOR KIDS TO 21 IN COVERED BENEFIT CATEGORIES

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman	X			
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Mr. GRIJALVA	X			
Mr. TIMOTHY BISHOP	X			
Mr. SESTAK	X			
Mr. LOEBSACK	X			
Ms. HIRONO	X			
Mr. ALTMIRE	X			
Mr. HARE	X			
Ms. CLARKE	X			
Mr. COURTNEY	X			
Ms. SHEA-PORTER	X			
Ms. FUDGE	X			
Mr. POLIS	X			
Mr. TONKO	X			
Mr. PIERLUISI	X			
Mr. SABLAN	X			
Ms. TITUS	X			
Ms. CHU	X			
Mr. KLINE, Senior Republican Member		X		
Mr. PETRI		X		
Mr. McKEON		X		
Mr. HOEKSTRA		X		
Mr. CASTLE	X			
Mr. SOUDER		X		
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS	X			
Mr. WILSON		X		
Mrs. McMORRIS RODGERS		X		
Mr. PRICE		X		
Mr. ROB BISHOP		X		
Mr. GUTHRIE		X		
Mr. CASSIDY		X		
Mr. McCLINTOCK		X		
Mr. HUNTER		X		
Mr. ROE		X		
Mr. THOMPSON		X		
TOTALS	**32**	**17**		

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 4 **BILL: H.R. 3200** **DATE: July 16, 2009**
AMENDMENT NUMBER: 6 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: THOMPSON / STRIKES NATIONAL HEALTH INSURANCE EXCHANGE

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT				X
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI		X		
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 5 **BILL: H.R. 3200** **DATE: July 16, 2009**
AMENDMENT NUMBER: 7 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: ROE / STRIKES GOVERNMENT-RUN HEALTH INSURANCE OPTION

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT				X
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI		X		
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 6 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 9 **DEFEATED: 19 AYES / 28 NOES**
SPONSOR/AMENDMENT: GUTHRIE / STRIKES EMPLOYER MANDATE

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	28		2

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 7 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 11 **DEFEATED: 18 AYES / 29 NOES**
SPONSOR/AMENDMENT: BIGGERT/ GRANDFATHER EXISTING ERISA PLANS

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	18	29		2

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 8 **BILL: H.R. 3200** **DATE: 7/17/2009**
AMENDMENT NUMBER: 12 **ADOPTED: 28 AYES / 18 NOES**
SPONSOR/AMENDMENT: FUDGE/TITUS / ASSISTANCE FOR SMALL EMPLOYERS

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman	X			
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY				X
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Mr. GRIJALVA	X			
Mr. TIMOTHY BISHOP	X			
Mr. SESTAK	X			
Mr. LOEBSACK	X			
Ms. HIRONO	X			
Mr. ALTMIRE	X			
Mr. HARE	X			
Ms. CLARKE	X			
Mr. COURTNEY	X			
Ms. SHEA-PORTER	X			
Ms. FUDGE	X			
Mr. POLIS	X			
Mr. TONKO	X			
Mr. PIERLUISI				X
Mr. SABLAN	X			
Ms. TITUS	X			
Ms. CHU	X			
Mr. KLINE, Senior Republican Member		X		
Mr. PETRI		X		
Mr. McKEON		X		
Mr. HOEKSTRA		X		
Mr. CASTLE		X		
Mr. SOUDER		X		
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. WILSON		X		
Mrs. McMORRIS RODGERS		X		
Mr. PRICE		X		
Mr. ROB BISHOP				X
Mr. GUTHRIE		X		
Mr. CASSIDY		X		
Mr. McCLINTOCK		X		
Mr. HUNTER		X		
Mr. ROE		X		
Mr. THOMPSON		X		
TOTALS	**28**	**18**		**3**

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 9 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 15 **DEFEATED: 18 AYES / 28 NOES**
SPONSOR/AMENDMENT: KLINE / CARD CHECK "KEEP WHAT YOU HAVE" PROVISION

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER				X
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	18	28		3

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 10 BILL: H.R. 3200 DATE: 7/17/2009
AMENDMENT NUMBER: 18 ADOPTED: 27 AYES / 19 NOES/1 PASSING
SPONSOR/AMENDMENT: KUCINICH / ERISA WAIVER FOR STATE SINGLE PAYER OPTION

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE	X			
Mr. ANDREWS		X		
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS		X		
Mr. GRIJALVA	X			
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK	X			
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE	X			
Mr. COURTNEY		X		
Ms. SHEA-PORTER	X			
Ms. FUDGE	X			
Mr. POLIS	X	•		
Mr. TONKO	X			
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU **(voted as passing)**				
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY		X		
Mr. McCLINTOCK		X		
Mr. HUNTER		X		
Mr. ROE		X		
Mr. THOMPSON		X		
TOTALS	**27**	**19**		**2**

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 11 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 21 **DEFEATED: 19 AYES / 28 NOES**
SPONSOR/AMENDMENT: MCCLINTOCK / TRIGGER / NO DIVISON A IF NOT DEFICIT NEUTRAL

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	28		2

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 12 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 27 **DEFEATED: 19 AYES / 28 NOES**
SPONSOR/AMENDMENT: KLINE / PRESERVE ERISA REMEDIES FOR ERISA PLANS

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	28		2

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 13 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 29 **DEFEATED: 19 AYES / 28 NOES**
SPONSOR/AMENDMENT: PRICE / STATE WAIVER

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH	X			
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP				X
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	28		2

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 14 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 31 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: SOUDER / NO MANDATED COVERAGE OF ABORTION SERVICES

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE		X		
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT		X		
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 15 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 32 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: SOUDER / NO FUNDS IN TITLE I, II, III SPENT FOR ABORTION

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE		X		
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT		X		
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 16 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 37 **DEFEATED: 21 AYES / 27 NOES**
SPONSOR/AMENDMENT: MCKEON / ADD SMALL BUSINESS/ASSOCIATION HEALTH PLANS

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE	X			
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS	X			
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	21	27		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 17 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 40 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: PRICE /DEFINED CONTRIBUTION

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 18 **BILL: H.R. 3200** **DATE: July 17, 2009**
AMENDMENT NUMBER: 41 **DEFEATED: 19 AYES / 29 NOES**
SPONSOR/AMENDMENT: PRICE / BALANCED BILLING

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman		X		
Mr. KILDEE, Vice Chairman		X		
Mr. PAYNE		X		
Mr. ANDREWS		X		
Mr. SCOTT		X		
Ms. WOOLSEY		X		
Mr. HINOJOSA		X		
Mrs. McCARTHY		X		
Mr. TIERNEY		X		
Mr. KUCINICH		X		
Mr. WU		X		
Mr. HOLT		X		
Mrs. DAVIS		X		
Mr. GRIJALVA		X		
Mr. TIMOTHY BISHOP		X		
Mr. SESTAK		X		
Mr. LOEBSACK		X		
Ms. HIRONO		X		
Mr. ALTMIRE		X		
Mr. HARE		X		
Ms. CLARKE		X		
Mr. COURTNEY		X		
Ms. SHEA-PORTER		X		
Ms. FUDGE		X		
Mr. POLIS		X		
Mr. TONKO		X		
Mr. PIERLUISI				X
Mr. SABLAN		X		
Ms. TITUS		X		
Ms. CHU		X		
Mr. KLINE, Senior Republican Member	X			
Mr. PETRI	X			
Mr. McKEON	X			
Mr. HOEKSTRA	X			
Mr. CASTLE	X			
Mr. SOUDER	X			
Mr. EHLERS	X			
Mrs. BIGGERT	X			
Mr. PLATTS	X			
Mr. WILSON	X			
Mrs. McMORRIS RODGERS	X			
Mr. PRICE	X			
Mr. ROB BISHOP	X			
Mr. GUTHRIE	X			
Mr. CASSIDY	X			
Mr. McCLINTOCK	X			
Mr. HUNTER	X			
Mr. ROE	X			
Mr. THOMPSON	X			
TOTALS	19	29		1

COMMITTEE ON EDUCATION AND LABOR

ROLL CALL: 19 BILL: H.R. 3200 DATE: 7/17/2009
AMENDMENT NUMBER: ADOPTED: 26 AYES / 22 NOES
SPONSOR/AMENDMENT: ANDREWS / MOTION TO FAVORABLY REPORT THE BILL TO THE HOUSE WITH AN AMENDMENT IN THE NATURE OF A SUBSTITUTE, AND THAT THE COMMITTEE AUTHORIZE THE CHAIRMAN TO TRANSMIT THE BILL, WITH AN AMENDMENT IN THE NATURE OF A SUBSTITUTE, TO THE COMMITTEE ON BUDGET IN COMPLIANCE WITH SECTION 310 OF THE CONGRESSIONAL BUDGET ACT OF 1974 AS THE FIRST PART OF THIS COMMITTEE'S RECOMMENDATIONS, PURSUANT TO THE RECONCILIATION INSTRUCTION IN S. CON. RES. 13

MEMBER	AYE	NO	PRESENT	NOT VOTING
Mr. MILLER, Chairman	X			
Mr. KILDEE, Vice Chairman	X			
Mr. PAYNE	X			
Mr. ANDREWS	X			
Mr. SCOTT	X			
Ms. WOOLSEY	X			
Mr. HINOJOSA	X			
Mrs. McCARTHY	X			
Mr. TIERNEY	X			
Mr. KUCINICH	X			
Mr. WU	X			
Mr. HOLT	X			
Mrs. DAVIS	X			
Mr. GRIJALVA	X			
Mr. TIMOTHY BISHOP	X			
Mr. SESTAK	X			
Mr. LOEBSACK	X			
Ms. HIRONO	X			
Mr. ALTMIRE		X		
Mr. HARE	X			
Ms. CLARKE	X			
Mr. COURTNEY	X			
Ms. SHEA-PORTER	X			
Ms. FUDGE	X			
Mr. POLIS		X		
Mr. TONKO	X			
Mr. PIERLUISI				X
Mr. SABLAN	X			
Ms. TITUS		X		
Ms. CHU	X			
Mr. KLINE, Senior Republican Member		X		
Mr. PETRI		X		
Mr. McKEON		X		
Mr. HOEKSTRA		X		
Mr. CASTLE		X		
Mr. SOUDER		X		
Mr. EHLERS		X		
Mrs. BIGGERT		X		
Mr. PLATTS		X		
Mr. WILSON		X		
Mrs. McMORRIS RODGERS		X		
Mr. PRICE		X		
Mr. ROB BISHOP		X		
Mr. GUTHRIE		X		
Mr. CASSIDY		X		
Mr. McCLINTOCK		X		
Mr. HUNTER		X		
Mr. ROE		X		
Mr. THOMPSON		X		
TOTALS	**26**	**22**		**1**

XII. STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

XIII. NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of 3(c)(3) of rule XIII of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee anticipates that a CBO cost estimate letter on H.R. 3200 will address these issues when the bill proceeds to consideration on the House floor. CBO is unable to provide a cost estimate prior to the reconciliation of the versions of the bill as amended and reported by the three committees of jurisdiction.

XIV. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c) of House rule XIII, the goal of H.R. 3200 is to increase access to affordable quality health coverage and contain costs.

XV. CONSTITUTIONAL AUTHORITY STATEMENT

Under clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee must include a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by H.R. 3200. The amendments and new law made by this bill are within Congress' authority under Article I, Section 8, Clauses 1, 3, and 18 of the Constitution.

XVI. COMMITTEE ESTIMATE

Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 3200.

The Committee anticipates that, as noted earlier, a CBO cost estimate will address these issues when the bill proceeds to consideration on the House floor.

XVII. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

Subtitle B—Regulatory Provisions

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

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Subpart B—Other Requirements

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Sec. 715. Protection against post-retirement reduction of retiree health benefits.

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PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

Sec. 801. Election of employer to be subject to national health coverage participation requirements.
Sec. 802. Treatment of coverage resulting from election.
Sec. 803. Health coverage participation requirements.
Sec. 804. Rules for applying requirements.
Sec. 805. Termination of election in cases of substantial noncompliance.
Sec. 806. Regulations.

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

* * * * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

* * * * * * *

CIVIL ENFORCEMENT

SEC. 502. (a) A civil action may be brought—

(1) * * *

* * * * * * *

(6) by the Secretary to collect any civil penalty under [paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c)] *paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)* or under subsection (i) or (l);

* * * * * * *

(c)(1) * * *

* * * * * * *

(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

(B) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this paragraph, the term "health coverage participation requirements" has the meaning provided in section 803.

(C) LIMITATIONS ON AMOUNT OF PENALTY.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

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

(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under subparagraph (A) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding 1-year period for group health plans, or

(II) $500,000.

(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

(F) DEPOSIT OF PENALTY COLLECTED.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous receipts in the Treasury of the United States.

[(10)**]** *(12)* The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act.

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY

SEC. 701. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the **[**6-month period**]** *30-day period* ending on the enrollment date;

(2) such exclusion extends for a period of not more than **[**12 months**]** *3 months* (or **[**18 months**]** *9 months* in the case of a late enrollee) after the enrollment date; and

* * * * * * *

SUBPART B—OTHER REQUIREMENTS

* * * * * * *

SEC. 715. PROTECTION AGAINST POST-RETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

(a) IN GENERAL.—Every group health plan shall contain a provision which expressly bars the plan, or any fiduciary of the plan, from reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement unless such reduction is also made with respect to active participants.

(b) NO REDUCTION.—Notwithstanding that a group health plan described in subsection (a) may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or his or her beneficiary under the terms of the plan if such reduction of benefits occurs after the date the participant retired for purposes of the plan and reduces

benefits that were provided to the participant, or his or her beneficiary, as of the date the participant retired unless such reduction is also made with respect to active participants.

* * * * * * *

PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

(b) TIME AND MANNER.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

SEC. 802. TREATMENT OF COVERAGE RESULTING FROM ELECTION.

(a) IN GENERAL.—If an employer makes an election to the Secretary under section 801—

(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

(b) PERIODIC INVESTIGATIONS TO DISCOVER NONCOMPLIANCE.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to such sampling of plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

(c) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of the trade or business in which the employer is engaged, has engaged for the performance of labor or services.

SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

For purposes of this part, the term "health coverage participation requirements" means the requirements of part 1 of subtitle B of title III of division A of America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of such Act).

SEC. 804. RULES FOR APPLYING REQUIREMENTS.

(a) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election under section 801 shall be made

by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

(1) separate lines of business, and

(2) full-time employees and employees who are not full-time employees.

SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.

The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

SEC. 806. REGULATIONS.

The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.

* * * * * * *

REHABILITATION ACT OF 1973

* * * * * * *

TITLE V—RIGHTS AND ADVOCACY

* * * * * * *

SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

(a) STANDARDS.—Not later than 9 months after the date of enactment of the America's Affordable Health Choices Act of 2009, the Architectural and Transportation Barriers Compliance Board shall issue guidelines setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that such equipment is accessible to, and usable by, individuals with disabilities, including provisions to ensure independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.

(c) INTERIM STANDARDS.—Until the date on which final regulations are issued under subsection (d), purchases of examination tables, weight scales, and mammography equipment and used in (or

in conjunction with) medical settings described in subsection (a), shall adhere to the following interim accessibility requirements:

(1) Examination tables shall be height-adjustable between a range of at least 18 inches to 37 inches.

(2) Weight scales shall be capable of weighing individuals who remain seated in a wheelchair or other personal mobility aid.

(3) Mammography machines and equipment shall be capable of being used by individuals in a standing, seated, or recumbent position, including individuals who remain seated in a wheelchair or other personal mobility aid.

(d) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

(1) prescribe regulations in an accessible format as necessary to carry out the provisions of such Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

(2) ensure that health care providers and health care plans covered by the America's Affordable Health Choices Act of 2009 meet the requirements of the Americans with Disabilities Act and section 504, including provisions ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

(e) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (d).

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WORKFORCE INVESTMENT ACT OF 1998

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TITLE I—WORKFORCE INVESTMENT SYSTEMS

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Subtitle D—National Programs

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SEC. 171. DEMONSTRATION, PILOT, MULTISERVICE, RESEARCH, AND MULTISTATE PROJECTS.

(a) * * *

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(f) HEALTH PROFESSIONS TRAINING FOR DIVERSITY PROGRAM.—

(1) IN GENERAL.—The Secretary shall make available 20 grants of no more than $1,000,000 annually to nonprofit organizations for the purposes of providing workforce development training program for those who are currently employed in the health care workforce.

(2) ELIGIBILITY.—For the purposes of providing assistance and services under the program established in this subsection, grants are to be awarded to Area Health Education Centers or similar nonprofit organizations involved in the development and implementation of health care workforce development programs and that—

(A) have a formal affiliation with a hospital or community health center, and institution of higher education as defined by section 101 of the Higher Education Act of 1965;

(B) have a history of providing program services to minority populations; and

(C) provide workforce development programs to low-income persons, veterans, or urban and rural underserved communities.

(g) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

(1) GRANT PROGRAM.—

(A) IN GENERAL.—The Secretary shall award National Health Workforce Online Training Grants on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grant with other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

(B) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

(i) an entity shall be an educational institution, community-based organization, non-profit organization, workforce investment board, or local or county government; and

(ii) an entity shall provide online workforce training for individuals seeking to attain or advance in health care occupations, including nursing, nursing assistants, dentistry, pharmacy, health care management and administration, public health, health information systems analysis, medical assistants, and other health care practitioner and support occupations.

(C) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

(iii) conduct training for occupations with national or local shortages.

(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

(i) the number of participants;

(ii) the services received by the participants;

(iii) program completion rates;

(iv) factors determined as significantly interfering with program participation or completion;

(v) the rate of job placement; and

(vi) other information as determined as needed by the Secretary.

(E) OUTREACH.—Grantees under this paragraph shall conduct outreach activities to disseminate information about their program and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be used to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected to be achieved by the grantee on the indicators of performance.

(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $50,000,000 for fiscal years 2011 through 2020.

(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.—

(A) DESCRIPTION OF GRANT.—The Secretary shall award one grant to an eligible postsecondary educational institution to provide the services described in this paragraph.

(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

(i) have demonstrated the ability to disseminate research on best practices for implementing workforce investment programs; and

(ii) be a national leader in producing cutting-edge research on technology related to workforce investment systems under subtitle B.

(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

(i) to provide technical assistance to entities that receive grants under paragraph (1);

(ii) to collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

(iii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.

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OLDER AMERICANS ACT OF 1965

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TITLE II—ADMINISTRATION ON AGING

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FUNCTIONS OF ASSISTANT SECRETARY

SEC. 202. (a) * * *

(b) To promote the development and implementation of comprehensive, coordinated systems at Federal, State, and local levels that enable older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, the Assistant Secretary shall, consistent with the applicable provisions of this title—

(1) collaborate, coordinate, and consult with other Federal entities responsible for formulating and implementing programs, benefits, and services related to providing long-term care, and may make grants, contracts, and cooperative agreements with funds received from other Federal entities*, and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and assisting States in developing a comprehensive state workforce development plans with respect to such workforce including efforts to systematically assess, track, and report on workforce adequacy and capacity*;

* * * * * * *

(g)(1) The Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel and pilot program to improve working conditions and training for long term care workers, including home health aides, certified nurse aides, and personal care attendants.

(2) The Panel shall include representatives from—

(A) relevant health care agencies and facilities (including personal or home care agencies, home health care agencies, nursing homes and residential care facilities);

(B) the disability community;

(C) the nursing community;

(D) direct care workers (which may include unions and national organizations);

(E) older individuals and family caregivers;

(F) State and federal health care entities; and

(G) experts in workforce development and adult learning.

(3) Within one year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary articulating core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources.

(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish

a 3-year demonstration program in 4 states to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

(5) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to each House of the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.

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TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

PART A—GENERAL PROVISIONS

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AUTHORIZATION OF APPROPRIATIONS; USES OF FUNDS

SEC. 303. (a) * * *

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(e)(1) * * *

(2) There are authorized to be appropriated to carry out part E (relating to family caregiver support) $166,500,000 for fiscal year 2008, **[**$173,000,000 for fiscal year 2009, $180,000,000 for fiscal year 2010, and $187,000,000 for fiscal year 2011**]** *and $250,000,000 for each of the fiscal years 2010, 2011, and 2012.*

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XVIII. COMMITTEE CORRESPONDENCE

None.

XIX. MINORITY VIEWS

MINORITY VIEWS

Introduction

Committee Republicans agree that health care reform legislation should make health care more affordable, improve quality, and reduce the number of uninsured Americans. As policymakers, we should be doing all that we can to make positive reforms to the health care system that would use private markets to lower the cost of health care insurance; improve affordability and accessibility for both employers and employees; give employers and employees the tools they need to encourage healthier behavior; change health care provider reimbursement structures to reward high-quality results; and address the long-term solvency of existing entitlement programs, like Medicare and Medicaid.

Considering that the majority of Americans obtain health insurance coverage through their employers, the employment-based system plays a central role in the delivery of health care. Recognizing the importance of employment-based health coverage, Committee Republicans have led efforts in recent years to lower the cost and increase the affordability of employment-based health coverage. Committee Republicans continue to support efforts to assist employers and employees in obtaining cost-effective, high quality coverage.

In assessing health care reform legislation, Committee Republicans bear in mind a number of important principles. Foremost, reform efforts should allow individuals who are satisfied with their current coverage to keep it, and give Americans the freedom to choose the health plans and medical providers that best fit their needs. Second, reforms should make quality health care coverage affordable and accessible for every American, regardless of pre-existing health conditions. Third, we must guard against a new government-run health care plan that would eliminate the health coverage that more than 100 million Americans currently receive through their job, or limit their choice of doctors and medical treatment options. Fourth, reform efforts must ensure that medical decisions are made by patients and doctors, not government bureaucrats. Finally, reforms must improve Americans' lives through effective prevention, wellness, and disease management programs, while developing new treatments and cures for life-threatening diseases.

Measured against these principles, H.R. 3200, as reported from the Committee on Education and Labor, wholly fails to meet the mark. For these reasons, and as set forth more fully below, Committee Republicans oppose the bill.

H.R. 3200, Procedural History

On the afternoon of Friday, June 19, 2009, House Democrats circulated the "TriCommittee Draft Proposal for Health Care Reform," an 852-page health care plan crafted behind closed doors by the Democrat Chairmen of three House committees with jurisdiction over health care issues. The draft proposal was not formally introduced or assigned a legislative bill number. There were vast shortcomings and gaps in the draft proposal, including the lack of a cost estimate and the absence of several key provisions, including specific financing mechanisms. House Republicans were denied the opportunity to provide meaningful input on the "draft proposal," and met for the first time with Committee Democrats only two days before the proposal was publicly circulated.

On Tuesday, June 23, 2009, the Committee on Education and Labor held a hearing on the draft proposal. Although Committee Republicans and invited witnesses provided valuable commentary, the short time frame for review and the significant gaps in the draft proposal hindered the ability to comprehensively analyze the Democrat health care reform plan prior to the hearing on June 23.

Thereafter, on July 14, 2009, House Democrat Leaders formally introduced their health care reform bill, H.R. 3200, the "America's Affordable Health Choices Act of 2009." The introduced bill totaled 1,017 pages (an increase of 165 pages) and contained numerous technical and substantive changes. No formal estimate of the cost of H.R. 3200 has been provided; rather, prior to the Committee's consideration of the bill a "preliminary," incomplete score of H.R. 3200 prepared by the Congressional Budget Office (CBO) was provided. This "preliminary" analysis was not based on H.R. 3200, but rather on "technical specifications" of the June 19 TriCommittee draft proposal that were provided to CBO by House Democrats.

On the afternoon of July 15, 2009, the full Committee on Education and Labor commenced its markup of H.R. 3200 with Member opening statements. Late on that same afternoon, Committee Republicans were provided with the Chairman's Amendment in the Nature of a Substitute, which totaled 1,040 pages (adding another 23 pages) and contained further substantive changes to H.R. 3200. Not one hearing was held on the Democrat-generated health care reform provisions of H.R. 3200, or on the Chairman's Amendment in the Nature of a Substitute. On the morning of July 17, 2009, after consideration of 42 amendments, the Committee completed its consideration of H.R. 3200, and the bill was ordered favorably reported to the House of Representatives by a vote of 26–22. Three Democrats joined with all Committee Republicans in opposing the bill.

General Concerns Regarding H.R. 3200

Committee Republicans are concerned about the inexplicable rush to legislate on this important issue. The changes contemplated by H.R. 3200 will significantly impact more than one-sixth of the American economy, yet House Democrats drafted the partisan bill behind closed doors and without any meaningful participation by Republicans and even many Democrats. Committee Republicans have not been provided with an adequate amount of time to fully analyze the complex provisions of H.R. 3200. Further, we expect

that the bill will change yet again following consideration by the three House Committees of jurisdiction, and prior to consideration by the full House, if it should occur. However, our review to date reveals numerous and significant policy concerns.

In general, Committee Republicans are concerned that H.R. 3200 fails to address the problems in the U.S. health care system, and in fact will only serve to exacerbate these problems through the adoption of misguided and historically ineffective policies. Moreover, the bill's true cost is unknown, but will likely be excessive. The cost will likely exceed $1.3 trillion over ten years, and the latest CBO estimate indicates that the bill will add more than $239 billion to the federal deficit over a ten-year period. More troubling is the fact that under H.R. 3200, the federal government starts collecting new taxes and revenues within a year or two of enactment, but implementation of many of the programs (i.e., the creation of a new federal bureaucracy and insurance coverage subsidies) is delayed, which artificially lowers the "cost" of the legislation under consideration by CBO. Further, in the later years of the CBO ten-year estimate, the costs of the program significantly outstrip new revenues, meaning the true costs of the Democrat legislation are much higher over the long term (i.e., beyond CBO's limited ten-year period). This is a cost the country cannot afford to bear.

The specific problems of the bill are numerous. For instance, Democrats attempt to pay for some of the cost through significantly higher taxes on individuals and businesses, with small business owners (those who create the majority of American jobs) appearing to shoulder a disproportionate share of the burden. It creates a massive new federal bureaucracy with unprecedented powers to determine "acceptable" health care coverage, and tax those who fail to comply with the bill's numerous legal mandates. The bill essentially eliminates current state-based private markets for health insurance. H.R. 3200 creates a "public health insurance option" (i.e., government-run health insurance plan) controlled by the new federal bureaucracy that is based on the flawed Medicare payment structure, and will undermine the private health insurance coverage currently enjoyed by millions of Americans. H.R. 3200 does little, if anything, to change the flawed health care delivery and payment structure, which is critical to control health care costs, increase affordability, and make coverage more accessible to Americans. The goal of H.R. 3200 appears to be nothing less than centralization of the country's health care sector in the federal government. It should be rejected.

Concerns Relating to ERISA Group Health Plans

The 1,040-page bill is divided into three separate Divisions: Division A, entitled "Affordable Health Care Choices"; Division B, "Medicare and Medicaid Improvements"; and Division C, "Public Health and Workforce Development". The Committee on Education and Labor maintains jurisdiction over much of Division A, and a portion of Division C. Considering this Committee's jurisdiction over the Employee Retirement Income and Security Act of 1974 (ERISA) and the provision of employer-sponsored group health coverage, this Committee's consideration of H.R. 3200 focused primarily on Division A.

Division A of H.R. 3200 contains several controversial Democrat proposals, including the establishment of a new federal bureaucracy which would be charged with defining "acceptable" health benefits, creating and regulating a new national health insurance exchange, distributing massive new federal subsidies for low and middle-income individuals to purchase "acceptable" health insurance through the exchange, and regulating the provision of insurance nationally. Also, Division A contains a provision creating a new government-run health insurance plan option, which would be a federally-created and administered government-run insurance plan based on Medicare, allegedly designed to "compete" with private insurance plans.

Democrats attempt to pay for this new bureaucracy through a number of new tax provisions that affect all Americans. For instance, H.R. 3200 institutes a new mandate on every individual to obtain "acceptable" coverage or pay a 2.5 percent tax. It creates a "pay or play" mandate on virtually all employers to provide "acceptable" insurance coverage or pay a new 8 percent payroll tax to the federal government. The introduced bill also provides some details left out of the June 19 Tri-Committee draft proposal, such as a provision exempting only the very smallest businesses, and new tax increases that are intended to pay for this massive new federal entitlement program. Many of the new taxes set forth in H.R. 3200 disproportionately impact small businesses and small business owners. Even so, Democrats' attempt to pay for the cost of this legislation falls far short as the bill's costs increase substantially over time and will likely result in at least a $239 billion increase in the federal deficit.[1] The overwhelming cost of the Democrat bill, and its bevy of new taxes, has raised significant concerns among many Americans. Committee Republicans believe that the bill creates a massive new federal bureaucracy and places significant new liabilities and tax burdens on all Americans and virtually all American employers, even those that are not profitable, which will likely have a negative impact on future economic growth.

Employer "Pay or Play" Mandate

Over 160 million people, or about 62 percent of the population under age 65, obtain health care insurance from their employers. Despite rising costs, this number has remained relatively consistent over the past decade, and most employees are happy with the coverage they receive from their employers. One of the primary reasons for the success of the employer-sponsored system is the ERISA-based regulatory structure that generally allows multi-state employers to voluntarily offer uniform health benefits to their employees, irrespective of location, by freeing the employer-sponsored plan from regulation by the states. Under the current ERISA structure, many employers gain administrative efficiencies and voluntarily design health plans tailored to the needs of their employees and families. This has permitted the private sector to develop inno-

[1] See, letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to the Honorable George Miller, Chairman, Committee on Education and Labor, dated July 17, 2009. The letter provides a preliminary analysis by the CBO and the Joint Committee on Taxation of H.R. 3200, as introduced on July 14, 2009, and does not reflect any modifications or amendments made after that date.

vative benefit designs and payment policies to control health care costs and improve quality.

As reported, H.R. 3200 imposes an unprecedented new tax on virtually all employers. Specifically, Title III, Subtitle B, "Employer Responsibility," mandates that all employers offer "acceptable" coverage under a "qualified health benefits plan" to each of their employees, or pay an 8 percent payroll tax to the federal government.[2] The "acceptable" coverage will be designed and determined by the new Health Benefits Advisory Committee and the Health Choices Commissioner. Section 312 provides that for full-time employees, employers have to contribute at least 72.5 percent of the applicable premium of the lowest cost plan for individuals, and 65 percent of the applicable premium of the lowest cost plan for family coverage. The mandate is also extended to part-time employees, but the bill fails to specify who is a part-time employee and leaves it to the federal government to define this term and create new employer contribution rules for such employees. In a provision only trial lawyers could like, the bill subjects ERISA group health plans to state court lawsuits. Finally, under Section 321, employers will be subjected to fines of up to $500,000 in the event they are found to be in noncompliance with the Act's onerous new mandates.

The new taxes on employers pose multiple problems, and have been the subject of much commentary from the representatives of those employers who will be directly impacted by the Democrats' new tax plan. For example, in a letter dated July 9, 2009 to Chairman Miller and Ranking Member Kline, Steve Pfister, the Senior Vice President of the National Retail Federation stated:

> Employer mandates of any kind amount to a tax on jobs. We can think of few more dangerous steps to take in the middle of a recession. We need to add new jobs, not exacerbate the near double-digit unemployment numbers. We cannot afford to have new and existing jobs priced out of our collective reach because of mandated health coverage.

In a July 15, 2009 general letter, Susan Eckerly, Senior Vice President of Public Policy for the National Federation of Independent Business (NFIB), stated that the NFIB, the nation's leading small business advocacy organization, opposed H.R. 3200 because of the inclusion of an employer mandate. Ms. Eckerly stated, in part:

> Research shows an employer mandate could cost 1.6 million jobs with more than 1 million of those jobs lost in the small business sector. The approach fails to increase affordability and, instead, devastates the economy—with the greatest impact being levied on the low-income community who will pay through depressed wages and lost jobs. . . . As if the mandate alone isn't destructive enough, the legis-

[2] The only exception to the mandate considered by the Committee was a sliding scale wage tax in Section 313, exempting only the very smallest employers with annual payrolls of less than $250,000, and limiting the payroll tax for companies with payroll of less than $400,000 annually. Under Section 313, employers with a payroll of less than $250,000 are not subject to any payroll tax. Companies with payrolls of $250,000 to less than $300,000 are subject to a 2 percent payroll tax; $300,000 to under $350,000 at 4 percent; and employers with payroll of $350,000 to less than $400,000 are taxed at 6 percent. Companies with payroll of more than $400,000 are taxed the full eight percent.

> lation uses perhaps the most egregious penalty of all—a payroll tax—as the penalty for those who cannot meet the obligations laid out in the bill. A payroll tax is particularly regressive because employers pay it regardless of whether or not their business is profitable. . . . The legislation even punishes employers who are currently providing insurance to their employees, but don't meet the premium contribution requirements in the bill (72.5% for individuals and 65% for family plans).

In a letter dated July 15, 2009 to Chairman Miller and Ranking Member Kline, R. Bruce Josten, Executive Vice President, Government Affairs for the United States Chamber of Commerce, expressed opposition to the employer mandate. Mr. Josten stated:

> the bill contains a job-killing employer mandate and accompanying 8 percent payroll tax. Attempts to carve out some small businesses will not prevent the adverse economic consequences of this provision.

The Majority claims that H.R. 3200 will save money and create new jobs. These assertions ignore the analysis of CBO which indicates that the pending legislation adds at least $239 billion to the federal deficit over ten years, with that number likely to grow substantially in the following decade. Further, CBO has not found that H.R. 3200 controls or reduces underlying systemic health care costs, which is essential to making care and coverage more affordable. Finally, as reflected in the comments above, the new taxes on all employers will slow economic growth and stunt new job creation, particularly among those employers who struggle to reach or maintain profitability.

Finally, some Committee and House Democrats have expressed serious reservations regarding the onerous requirements on employers. For example, in a letter dated July 9, 2009 from the fiscally conservative Blue Dog Coalition to Speaker Nancy Pelosi and Majority Leader Steny Hoyer, forty "Blue Dog" Democrats stated that "any additional requirements for employers must be carefully considered and done so within the context of what is currently offered. Small business owners and their employees lack coverage because of high and unstable costs—not because of an unwillingness to provide or purchase it. We cannot support a bill that further exacerbates the challenges faced by small businesses."[3]

Committee Republicans believe that the employer "pay or play" mandate is simply flawed policy that will destroy the voluntary, employer-sponsored ERISA health benefits structure, limit future flexibility to design affordable health plans, increase costs and cause significant job losses, and depress wage growth, especially for low-income Americans. This mandate would be especially hard on smaller or mid-sized firms that may not be eligible for an exemption, and who may struggle to reach and maintain profitability.

[3] See, letter from "Democratic Blue Dog Coalition" to The Honorable Nancy Pelosi, Speaker, and The Honorable Steny Hoyer, Majority Leader, dated July 9, 2009. The letter, signed by forty Democrat Members of Congress, stated their belief that the tri-committee health care reform proposal "lacks a number of elements essential to preserving what works and fixing what is broken" in the health care system, and that legislation must include provisions to ensure deficit neutrality, delivery system reform, small business protections, rural health equity, and bipartisanship.

Further, the proposed tax penalty percentage (eight percent for most employers) could increase in the future at the whim of Congress, especially if the federal government needs additional revenues to cover shortfalls in this massive new entitlement program, potentially increasing the burdens on employers.

In addition, numerous structural components of the proposed mandate are problematic for employers and the current ERISA structure. In the fifth year of the exchange, employers whose workers choose coverage through an exchange will be forced to pay the eight percent tax to finance their workers' exchange policy, even if they provide coverage to their employees. This will certainly place increasing pressure on employer group health plans in the form of adverse risk selection, since employees could leave the group health plan for the exchange and shrink the size of the group plan's pool of participants. Many employers may simply choose to drop coverage and pay the tax, rather than administer and pay for an increasingly inefficient group health plan.

Further, under the Democrat bill, there is no way of knowing whether the coverage currently enjoyed by tens of millions of employees and their families, including health savings accounts used in conjunction with high deductible health plans (HSA/HDHP), will meet the future "acceptable" benefit and employer contribution requirements. For example, an HSA/HDHP individual plan with an actuarial value of 69 percent will not meet the requirements of this bill. Employers would have to change this benefit to comply with the new mandates, or the individual employee could face the individual tax for non-compliance.[4] Also, employers who contribute less than the statutory amounts (72.5 percent and 65 percent for individual and family coverage, respectively) will have to change or be subjected to a new tax. This could cause some employers to drop coverage altogether.

Clearly, the employer "pay or play" provisions are designed to make it more difficult for employers to offer ERISA-based group health plan coverage, and direct more employees and their families to the new federal health insurance exchange and its government plan, Medicare-based, option. Contrary to Democrat political rhetoric, there is a substantial likelihood that employees who like their current coverage will not be able to keep it.

For these reasons, Committee Republicans object to the employer "pay or play" mandate in H.R. 3200.

Impact on ERISA Preemption and Remedies

Under current law, the ERISA regulatory structure preempts employers and group health plans from liability under state law. This has resulted in significant administrative savings and contributes to the ability of employers and group health plans to offer high quality, affordable health insurance coverage to more than 130 million Americans.

The Tri-Committee bill raises serious questions and concerns regarding the continued viability of the current ERISA regulatory structure, and whether H.R. 3200 exposes employers and group

[4] *See*, H.R. 3200, Sections 301, 401, July 14, 2009, regarding the new tax on individuals who fail to obtain acceptable insurance coverage.

health plans to new liabilities for claim decisions. Under current law, group health plans are required to comply with the requirements of ERISA, and any disputes are governed and resolved under its provisions. This ensures that employers, who may provide health insurance coverage for workers in all 50 states, must comply with the federal law only, which permits the delivery of uniform benefits and saves administrative costs. They cannot be sued in state courts, under different laws.

The bill appears to change this by creating two different penalty regimes inside the new insurance exchanges; for group health plans and their beneficiaries, there would be varied and unlimited penalties set forth under 50 different state laws. To the extent that group health plans are permitted to purchase through the insurance exchanges, they will be subjected to potentially expansive new state court liabilities.

At the same time that they are subjecting private plans to a patchwork of state laws, Democrats chose to apply a uniform federal scheme similar to Medicare to the government-run health insurance plan. This would provide an unfair financial advantage to the government-run health plan since, unlike ERISA group health plans, the government-run plan would not have to face lawsuits and comply with up to 50 different sets of state laws.

Two groups appear to benefit from this proposed structure: trial lawyers and the government bureaucrats running the government-run health plan. Further, ERISA group health plans would face significant new liabilities and costs which would likely cause them to drop coverage altogether, accelerating the movement from private, employer-sponsored health insurance to a government-run plan.

For these reasons, Committee Republicans object to new liabilities imposed on ERISA employers and group health plans in H.R. 3200.

The New Federal Bureaucracy and the Government-Run Health Plan

Committee Republicans are concerned that H.R. 3200 creates a massive new federal health insurance bureaucracy, the "Health Choices Administration," that would create a "one-size-fits-all" standard for health coverage and vest unprecedented control with one individual, the new "Health Choices Commissioner." This new Commissioner would be charged with governing the national exchange, enforcing insurance plan standards, distributing taxpayer subsidies, and fining non-compliant individuals, plans and employers. This structure would restrict the sale of insurance outside of the exchange, and ultimately would eviscerate private insurance markets over time.

Under H.R. 3200, the Department of Health and Human Services (HHS) will be charged with creating a public health insurance option that would only be available in a national health insurance exchange. Although the plan would have to comply with requirements on private, exchange-available plans, the exchange would have no power under the bill to reject, sanction or terminate the government option run by HHS. Further, the government plan would be subject to lawsuit only in federal courts; this differs substantially

from private plans, including employer-sponsored group health plans currently regulated under the federal ERISA law, which would be subject to state court lawsuits (raising the costs for private plans).

With respect to government-plan funding, "start-up" funds in the amount of $2 billion in taxpayer money would be provided from the Treasury. Although the plan's premium rates would be required to cover the cost of the benefits and administration, going forward there is no requirement that the government plan maintain a certain "reserve" level, similar to those required of state-based private insurance companies. This could give the government plan a potentially significant competitive advantage over private insurers.

Importantly, the government plan would be based on the failed Medicare payment structure. Specifically, the plan would pay Medicare rates for at least the first three years, with Medicare-participating physicians getting a five percent bonus for the first three years. The problems with this structure are numerous. First, Medicare pays on a fee-for-service basis, which rewards those providers that increase the volume of medical services, as opposed to those providers that limit utilization and provide high quality care. The Medicare reimbursement structure is historically inflexible when it comes to designing and implementing more innovative policies and reimbursement structures. Private innovations, like paying for health care provider performance, and the adoption of prevention and wellness programs, are exceedingly difficult to duplicate in the Medicare structure given that it is a government-administered program which is highly resistant to change.

Second, government health entitlement programs, like Medicare and Medicaid, routinely underpay health care providers, resulting in a cost-shift to private plans and private payers. This was confirmed in the testimony of a New Jersey hospital executive at a hearing before the Subcommittee on Health, Education, Labor and Pensions in March 2009. Reliance on existing Medicare payment rates, with minor adjustments, will, according to an estimate by The Lewin Group, an independent consulting company, significantly underpay health care providers, compensating them at rates 20–30 percent below what private plans pay for the same services. Even if adjustments are made to lower the underpayment rates, by design, the government-run plan will underpay providers to reduce premium costs, in order to increase enrollment and crowd-out private insurers. This inherent cost advantage built into the government plan created by H.R. 3200 will result in a government plan with artificially low premiums, which will likely have a negative impact on health care quality.

These concerns were expressed in a letter from 13 health care providers and associations, including the Mayo Clinic, in a letter dated July 16, 2009 to Representative Ron Kind (D–WI). Specifically, these groups expressed concern that:

> . . . a public plan option with rates based on Medicare rates will have a severe negative impact on our facilities. Today, many providers suffer great financial losses associated with treating Medicare patients. For example, several of the systems that have signed onto this letter lost hundreds of millions of dollars under Medicare last year.

> These rates are making it increasingly difficult for us to continue to treat Medicare patients. The implementation of a public plan with similar rates will create a financial result that will be unsustainable for even the nation's most efficient, high quality providers, eventually driving them out of the market. In addition, should a public plan with inadequate rates be enacted, we will be forced to shift additional costs to private payers, which will ultimately lead to increased costs for employers who maintain insurance for their employees. We believe all Americans must have guaranteed portable health insurance, but it is critical that we not lose sight of the need to ensure adequate and equitable reimbursement.

The results of a government-run health insurance plan are undeniable. Although Democrats argue the purpose of the government plan is to increase competition, it will have the exact opposite effect. Considering that the government plan will possess certain advantages (discussed above) it will not, by design, compete fairly with private insurance and group health plans. Studies of the effect of a government plan option indicate that there will be movement from private insurance coverage to a government-run plan which would concentrate control of health care with the government, which already controls almost half of the country's health care spending. For example, CBO analyses provided to the Committee on July 14 and July 17 indicate movement of individuals from private coverage to the government plan. In a June 2009 study, The Lewin Group found that a government plan open to all, and based on Medicare-level reimbursement rates, would result in almost 114 million Americans losing their current private insurance coverage because of movement toward an artificially cheaper, benefit-rich government plan.[5] Simply put, the availability of a government plan will create a cycle of increasing costs for those with private plans, forcing employers to drop coverage and pushing more workers into the government plan.

The new federal health care bureaucracy, with its myriad rules for private plans and government-run insurance option, will ultimately decrease the competitiveness of private insurance and group health plans, essentially resulting in a government takeover of the health care system. The government's track record on health care is not one to be duplicated; the Medicaid program does not pay for the full cost of medical care, is routinely underfunded, and places a substantial burden on states. The Democrat answer in H.R. 3200 is to increase Medicaid eligibility to 133 percent of the federal poverty level, which would exacerbate health care provider underpayments, create a new entitlement mentality, and substantially increase the federal government's Medicaid payments in perpetuity. Medicare underpays health care providers, is an outdated and inflexible benefit design, and has unfunded obligations totaling $37.8 trillion. The House Democrat answer is not to first fix Medicare but to create a new federal entitlement program for those under 65

[5] See, The Impact of the House Health Reform Legislation on Coverage and Provider Incomes, Testimony of John Sheils, Vice President, The Lewin Group, before the Energy and Commerce Committee, U.S. House of Representatives, June 25, 2009. *http://www.lewin.com/content/publications/June25TestimonyUpdateJul09.pdf*.

based on Medicare, spend more than $1.3 trillion, and raise taxes on Americans. These policies do nothing to control existing health care costs, and only serve to worsen the nation's long-term fiscal outlook while removing decisions from the hands of doctors and patients and placing them in the hands of Washington bureaucrats.

Clearly, if Americans like their current coverage and the quality of their health care, it will be in jeopardy under the Democrats' plan as set forth in H.R. 3200.

Republican Alternative

Committee Republicans agree that the health care system is in dire need of reform and stand ready to work with Committee Democrats to forge a truly bipartisan compromise. However, Committee Republicans believe the policies contained in H.R. 3200, which seek to expand health care insurance coverage at great cost without first addressing and controlling underlying health care costs and provider shortages, are doomed to fail.

Republicans agree with Democrats that the problem of the uninsured must be addressed. The Majority notes that 47 million individuals are uninsured; however, this population is not homogenous. According to a report released by the Congressional Research Service on September 14, 2009, approximately 20 percent of the uninsured are non-citizens. Further, approximately 10 million more individuals may already be eligible for existing government insurance programs, but are not enrolled, and many millions more are young or voluntarily choose to go without coverage. Rather than creating a massive new federal entitlement program, Republicans believe underlying costs must be addressed in order to make coverage more affordable and accessible, with implementation of targeted approaches to address the specific characteristics of the uninsured population.

The first step to lower health care costs is to address overspending in the current system.[6] To lower costs, Committee Republicans would consider: changes to the tax code to permit individuals to share some of the same advantages as those with employer-sponsored coverage; promote incentives to save for future health care costs; promote meaningful medical liability reforms to reduce costly and unnecessary defensive medicine practices; provide existing government programs with additional authority and resources to stop fraud and abuse; and permit small business to band together to offer health insurance at lower costs.

Republicans and Democrats agree that small businesses face unique and difficult challenges in securing affordable health insurance coverage. Yet the Democrat response to this challenge is to construct an elaborate new federal bureaucracy and entitlement program, with the imposition of massive new taxes, administrative requirements and penalties on all but the very smallest employers, Republicans have tirelessly advocated for targeted, less costly measures to address the specific problems confronting small businesses—small business, or association, health plans constitutes one such measure that can be enacted immediately and would permit

[6] In testimony before the Senate Health, Education, Labor and Pensions Committee on July 16, 2009, 030 Director Douglas Elmendorf stated that all of the Democrat proposals reviewed to date, including H.R. 3200, do little, if anything, to control health care costs.

small businesses to band together to pool their purchasing power and enjoy the same benefits as larger employers.

Additionally, Committee Republicans support policies that would provide employers with greater flexibility to promote prevention and wellness programs, and financially reward employees who seek to achieve or maintain a healthy weight, quit smoking, and better manage chronic diseases like diabetes. Changing payment structures to reward high quality care, rather than volume of medical services, and increasing care coordination, can also help control health care costs. Further, before creating another federal entitlement program and adding to the federal deficit, Committee Republicans believe it is necessary to address the long-term fiscal solvency of existing federal entitlement programs.

Committee Republicans would also seek to expand access by strengthening employer-sponsored coverage to millions of people who are already eligible, encourage states to create or modify programs to guarantee all Americans have access to affordable coverage regardless of pre-existing medical conditions, promote policies to increase portability of coverage regardless of employment status, and help employers offer coverage by reducing administrative costs through a small business tax credit.

In short, Committee Republicans support policies that promote individual behavior and responsibility for health care and coverage decisions, and maintain the doctor-patient relationship, while keeping the federal government out of the business of dictating health care coverage requirements or favoring a government-insurance model over private coverage. Committee Republicans remain willing to work with Democrats in developing a compromise bipartisan health care reform bill.

Republican Amendments

Committee Republicans offered twenty-six amendments during the Committee's consideration of H.R. 3200 on July 16 and 17. Republican amendments attempted to highlight significant concerns with H.R. 3200 and improve some of the more troubling provisions of the bill. In general, Committee Republicans offered solutions to the health care crisis, and expressed significant concerns regarding: the significant cost of H.R. 3200; the adverse impact on the economy, workers, families and small businesses; the government takeover of the health care system; the fact that under H.R. 3200 those who like their coverage won't be able to keep it; preservation of the doctor-patient relationship; and opposition to likely rationing of medical care under the Democrat proposal.

Specifically, Committee Republicans offered amendments intended to:

- Strike provisions creating the new "Health Choices Administration;"
- Strike provisions creating the national health insurance exchange;
- Strike the employer "pay or play" mandate;
- Strike the government-run insurance plan;
- Ensure that the coverage provided by ERISA group health plans, now and in the future, would be preserved under the plan;

- Ensure deficit neutrality;
- Suspend the bill where the national unemployment rate exceeded 8% in two consecutive months;
- Preserve the protective remedies of ERISA for ERISA-governed plans;
- Prevent mandated coverage of abortion services;
- Prohibit federal funding for abortion services under the bill;
- Prohibit any tax increase on American families with annual incomes under $250,000;
- Provide employers and employees with greater flexibility to promote prevention and wellness programs, which are proven to increase personal responsibility and lower health care costs;[7]
- Permit consumer-directed health plans to remain viable options;[8] and
- Permit small businesses to pool together to purchase health insurance through Association Health Plans.

Each of these amendments was rejected, by and large on a party-line basis.

Although some amendments were adopted in an attempt to improve the legislation,[9] many attempts to amend and improve a flawed bill were rejected. Committee Republicans are concerned that the bill remains fundamentally flawed; nevertheless, Committee Republicans continue to stand ready to work with Committee Democrats to draft and enact bipartisan health care reform legislation.

Conclusion

Committee Republicans support the voluntary, private health care system and meaningful reforms to that structure, while opposing measures that would serve to increase federal government control over the health care system. Committee Republicans are also committed to ensuring that the costs of health care reform efforts do not add to the federal deficit or result in higher taxes, which will have the effect of restricting American economic growth. The goal of controlling health care spending is not accomplished by adding more than $1.3 trillion in new spending to America's health care bill. While perhaps well-intentioned, H.R. 3200 is not an acceptable health care reform bill. For all of the foregoing reasons,

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[7] Specifically, Republicans offered an amendment to permit employers to vary employees' health insurance premiums by up to 50 percent to encourage participation in health promotion and disease prevention programs. Current law already permits variations up to 20 percent. Employer-based prevention and wellness programs have a proven-track record of improving employee health and lowering health care expenses and insurance coverage premiums. See, Paul Speranza, Jr., Testimony before the Committee on Education and Labor, "The Tri-Committee Draft for Health Care Reform" (June 23, 2009) at 3–4. This amendment was voluntarily withdrawn in the hope that the Majority would work with Republicans to adopt this common-sense provision; Republicans continue to urge that this provision be included in any reform legislation.

[8] During this Committee's consideration of H.R. 3200, Republicans introduced an amendment to permanently grandfather consumer-directed health plans and arrangements, so that millions of individuals could continue to save for future health care needs and benefit from this coverage. The Majority rejected this amendment, which highlights the fact that if you like your current coverage, you will not be able to keep it under H.R. 3200.

[9] A limited number of amendments were adopted. For example, the Committee accepted language to exclude TRICARE (the Department of Defense's civilian healthcare program for active and retired military personnel) from the provisions of the bill; to express the sense of Congress that Members who vote for the bill enroll in the new government-run plan; to ensure non-discrimination for spiritual care; and to maintain the private right to contract for medical services.

we respectfully oppose enactment of H.R. 3200 as reported from the Committee on Education and Labor.

JOHN KLINE.
CATHY MCMORRIS RODGERS.
THOMAS E. PETRI.
TOM PRICE.
HOWARD P. "BUCK" MCKEON.
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TODD RUSSELL PLATTS.
GLENN THOMPSON.
JOE WILSON.

SUPPLEMENTAL VIEWS OF THE HONORABLE TOM PRICE

Over the course of nearly a quarter century as a physician, I cared for thousands of patients. And caring for each and every one of them was a privilege. So when I left the practice of medicine to shape public policy and the health care delivery system of this nation, I did so clinging to a steadfast aspiration to achieve full access to affordable, quality health care for all Americans, while preserving the patient-doctor relationship without governmental interference.

Relying on my experiences as a physician, I can attest to how current federal laws and incentives retard access to health care and often put a bureaucrat in between a patient, his family, and their doctor. The tax code institutes a third-party health care model making it difficult for those to gain coverage outside of an employer or government entity. And the federal health care programs that do exist dictate to patients which doctors they may see and how frequently, and which procedures or tests doctors may or may not order or provide.

H.R. 3200, America's Affordable Health Choices Act of 2009, marks the latest attempt to fundamentally alter our health care financing and delivery structure. This measure, however, is a transformational piece of legislation intended to erode personal and private decision-making while further institutionalizing the very errors of current federal health care laws and programs. The end result will be a system built on penalties, mandates, rationing, and bureaucracy—all of which are fundamental threats to quality care. For example:

- Sec. 102 of H.R. 3200 grandfathers out health insurance coverage on the individual market. Issuers of existing coverage may not enroll new individuals, alter benefits and cost-sharing, and increase premiums. These plans will no longer be available.
- Sec. 123 of H.R. 3200 creates the Health Benefits Advisory Committee, a new panel to recommend covered benefit standards, including treatments, items and services, and cost-sharing. The Committee is comprised primarily of either political appointees or federal bureaucrats, and these are the folks who will be making these critical decisions.
- Sec. 141 of H.R. 3200 creates the Health Choices Administration, a new federal agency charged with establishing the Health Insurance Exchange. The Administration is the final arbitrator of what is a qualified health benefits plan (i.e. "acceptable") under the exchange and is charged with enforcement.
- Sec. 301 and Sec. 401 of H.R. 3200 impose a "personal responsibility" on every American to obtain "acceptable" health insurance coverage or face a tax of 2.5 percent on gross income.
- Sec. 313 and Sec. 412 of H.R. 3200 impose a tax of eight percent of average wages paid on employers. Providing health care to

employees is no longer a voluntary benefit and only the smallest businesses are exempt.

• Sec. 221 of H.R. 3200 creates a public health insurance option, available through the Health Insurance Exchange, to "compete" against privately run health insurance coverage. Independent analysis by both the Congressional Budget Office and the Lewin Group has concluded that millions of Americans would lose their existing coverage as a result of this government-run plan.

Certainly, the status quo is unacceptable. Yet, a true health care reform package empowers patients first; it builds on what is working and fixes what is flawed without disrupting or destroying quality care; it does not ingrain what is broken and scraps what works.

Before consideration of H.R. 3200, a bipartisan, fundamental rethinking of this nation's health care delivery system could have been possible if reform focused on a patient-centered approach and championed personal ownership and coverage over government control. Further, any effort needed to embrace the same health care principles most Americans embrace: accessibility, affordability, choices, innovation, quality and responsiveness.

As the leader of a group of conservative Republicans in the House of Representatives faithfully committed to these principles and the implementation of reform, I introduced H.R. 3400, the Empowering Patients First Act. It represents the possibility of a new patient-centered era in American health care without putting the government in charge.

For starters, the measure ensures all Americans have access to affordable coverage through a series of tax credits, deductions, and tax equity. It makes it feasible for individuals to pick any health care plan, not just what is offered by the government or at work, meaning that no matter who is paying the bill, patients own and control their own health plan. This puts Americans in a position whereby insurance companies are responsive to them rather than a third-party.

There is portability to maintain coverage if someone changes jobs or moves across state lines. To establish a viable marketplace, barriers are knocked down so coverage can be purchased across state lines.

And since one cannot be serious about reform without addressing the medical liability crisis, the Empowering Patients First Act provides for the creation of specialized health care courts relying on the expertise of medical specialty societies to relieve upward pressure on medical costs.

This same commitment to principles and reform by dedicated Republicans inspired my personal efforts during the mark up of the America's Affordable Health Choices Act of 2009 before the Committee on Education and Labor. Yet every attempt to offer common sense amendments was defeated by Committee Democrats on near party line votes. For example:

> • An amendment to ensure current coverage provided by employer-sponsored group plans would be considered a qualified health benefits plan. Rejecting the amendment flies in the face of "If you like what you have, you can keep it," and restricts access to existing, affordable plans. (Amendment #11, defeated 18–29).

- An amendment to permit states a waiver out of Division A of the Act, which contains the new health care bureaucracies, the individual and employer mandates, and the public health insurance option. Various states have already taken innovative steps to adopt comprehensive health care reform. (Amendment #29, defeated 19–28)
- An amendment to enable employers to contribute to a worker's account and permit that worker to purchase insurance coverage of his choice. (Amendment #40, defeated 19–29)
- An amendment to eliminate the "tiered" payment structure for "preferred" and "non-preferred" physicians who participate in the public health insurance option. Without it, the existing provision forces health care providers to accept payments mandated by the federal government which are well below the actual cost and would likely result in the deterioration of quality care. (Amendment #41, defeated 19–29)

In the end, the America's Affordable Health Choices Act of 2009 rejects the health care principles most Americans embrace and embodies the go-it-alone attitude that House Democrats embarked on from the beginning. House Republicans were never consulted or brought into the process. In fact, more than 70 percent of amendments offered by Republicans for final consideration in the mark up of the Committee on Education and Labor were defeated on near party line votes.

It is why the end product is so terribly flawed and, if adopted, Congress will end up revisiting soon thereafter to correct many of its faults. It is with the sentiments outlined here that I oppose this legislation, and ask all House Republicans to do the same.

TOM PRICE.

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