

Affordable Health Choices Act
Senate HELP Committee
(S. 1679)

Summary of Title I Provisions

**TITLE I – QUALITY AFFORDABLE HEALTH CARE
FOR ALL AMERICANS**

Subtitle A – Effective Coverage for All Americans

Guaranteed Availability of Coverage

Health insurance issuers that offer coverage plans through either the individual or group markets will be required to accept every employer and individual in a state that applies for such coverage through special enrollment periods.

Prohibition of Preexisting Condition Exclusions

When offering coverage, the issuer is prohibited from excluding any individual from an insurance plan on account of any preexisting health condition the individual may have. It also may not establish eligibility rules for enrollment based on factors such as health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, receipt of health care, or total hourly or annual salary of full time employees.

Fair Insurance Coverage

Premium rates charged by a health insurance issuer to an individual or group may not vary with respect to a particular plan or coverage because of factors such as health status, gender, class of business, claims experience, or industry. Premium rates may vary only based on family structure, community rating area, the actuarial value of the benefit, age, tobacco use, and whether the individual is enrolled in a program of health promotion and disease prevention.

Guaranteed Availability and Renewability of Coverage

After coverage is granted to either an individual or group, the insurance issuer is required to either renew or continue that coverage at the option of the plan sponsor or the individual, and may not rescind the coverage once it has been issued (with the exception of fraud or misrepresentation on the part of the individual). Plans that provide coverage to dependent children must also continue to provide such coverage until the child reaches 26. No group or individual health plan may establish lifetime or annual limits on the dollar value of benefits for any participant or beneficiary.

No individual will be required to terminate any coverage held under a group or individual plan in which the individual was enrolled prior to the passage of the Act. Employers offering group plans before this bill may also continue to enroll new employees and their

families in the plan, so long as the plan has not been modified to a significant extent with respect to covered benefits or cost sharing requirements.

Increased Transparency of Health Care Costs and Regulatory Fees

A clear accounting for costs must be made by all health insurance issuers offering group or individual health insurance coverage. Insurers must publicly report the percentage of total premium revenue that the coverage expends on reimbursements for services, activities that improve health care quality, on taxes, licenses, surcharges or regulatory fee costs, and on all other non-claim costs, including an explanation of the nature of those costs.

Prohibition of Discrimination Based on Health Status

Health insurance issuers of group or individual plans are prohibited from establishing rules for eligibility based on any health status-related factors of individuals or their dependents, including health status, medical condition, mental illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Wellness Programs and Preventive Care

Programs of health promotion or disease prevention offered by employers that grant premium discounts or rebates to participating individuals are encouraged. Certain programs, depending upon whether the individual must satisfy a condition related to their health status, will be subject to various requirements as established by the Secretary of Health and Human Services (“Secretary”). Various types of programs not subject to further requirements issued by the Secretary include programs that reimburse individuals for the cost of fitness centers, diagnostic testing programs that reward individuals for participation regardless of outcome, programs that reimburse individuals for the cessation of smoking, as well as others. Health insurance issuers and group health plans will also be required to provide coverage for, and may not impose any cost sharing requirements for, certain recommended immunizations, preventive care and screenings for infants, children and adolescents, and additional preventive care and screenings for women (including pregnant women and individuals of child bearing age) that are supported by the Health Resources and Services Administration (“HRSA”).

Subtitle B – Available Coverage for All Americans

Building on the Success of the Federal Employees Health Benefits Program

Federal employees, under the Federal Employees Health Benefits Program (“FEHBP”) and large employers, under the Employee Retirement Income Security Act of 1974 (“ERISA”) have affordable choices among competing health benefit plans. The FEHBP ensures that the health benefit plans available to Members of Congress meet minimum standards of quality and effectiveness. All Americans should have the same kinds of meaningful choices of health benefit plans.

American Health Benefit Gateway

Affordable Health Benefit Gateways (“Gateways”) are mechanisms intended to facilitate the voluntary purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employers and to reduce the cost of health care.

Assistance to States

Gateways will be established in each state, with state flexibility to administer them. Within 60 days of enactment, the Secretary will make grant awards to states so that they may plan for and establish Gateways. Funding will be made available through fiscal year 2014. The Secretary may renew grants if a state is making progress in establishing a Gateway and implementing individual and group market reforms or meeting other specified benchmarks.

Requirements

A Gateway must be a governmental agency or nonprofit entity established either by a state (“establishing state”) or by the Secretary on behalf of a state (“participating state”). A Gateway will make available all qualified health plans to all qualified individuals and qualified employers, and will include a community health insurance option (a public option). Any health plan or other health insurance coverage that is not a qualified health plan will not be offered through the Gateway. Gateways may allow qualified health plans to offer benefits in addition to the set of specified essential health benefits, as long as states assume the additional costs and do not reduce affordability credits.

Gateways must, at a minimum: 1) establish certification procedures for qualified health plans; 2) ensure consumers receive accurate and culturally and linguistically appropriate information on costs, networks of providers, preventive services, medical loss ratios, and quality measures; 3) utilize the administrative simplification measures; 4) provide Gateway navigators; 5) provide coverage for long-term services; 6) handle the complaints of enrollees; 7) provide a toll-free help hotline; and 8) maintain a website with comparative information on benefit plans.

All insurance issuers offering qualified health benefit plans through the Gateways must pay surcharges to cover administrative and operational expenses. The surcharges may not exceed four percent of the premiums collected by those plans and several uses are excluded, such as excessive executive compensation.

Risk Adjustment

States may assess a risk adjustment charge on health plans where the actuarial risk of the enrollees is less than the average actuarial risk for all plans in that state. If the risk is greater than the average actuarial risk, those plans will be provided a payment by the state. Risk adjustments will be established by the Secretary and mirror those of Medicare+Choice (“Medicare Part C”) and the Voluntary Prescription Drug Benefit Program (“Medicare Part D”). These adjustments will not apply to self-insured group plans, which are subject to the provisions of ERISA.

Facilitating Enrollment

Using information technology to the extent practicable, Gateways must implement policies and procedures to identify the uninsured and to assist them in enrolling in affordable qualified health plans, Medicaid, the Children's Health Insurance Program ("CHIP"), or other federal programs. Those who are eligible for CHIP have the option of enrolling in either CHIP or a qualified health plan. Materials used to facilitate enrollment must be easily understandable and take into account language barriers and disabilities. The Secretary, in consultation with the Office of the National Coordinator for Health Information Technology ("ONCHIT"), will develop interoperable standards and protocols to facilitate enrollment. These standards may include electronic matching against existing federal and state data to serve as evidence of eligibility and the capability for individuals to manage eligibility information online. Grants to facilitate enrollment will be provided to states which: 1) use electronic enrollment software systems; 2) contract with groups experienced in working with the uninsured; 3) establish help lines for enrollment assistance; and 4) utilize public education campaigns. Grants may also be awarded to community-based organizations that help build infrastructure and training to establish electronic enrollment assistance programs.

Publication of Gateway Costs

Gateways must publish the average costs of income or other taxes, licensing or regulatory fees, surcharge amounts, and administrative costs on a website to educate consumers. The information published must also include monies lost to waste, fraud and abuse.

Certification

A Gateway may certify a health plan as a qualified health plan if it meets the specified criteria for certification, is in the interests of qualified individuals and employers, and the plan does not have a history of discriminating on the basis of age, expected length of life, disability, degree of medical dependency, or quality of life.

Flexibility

A Gateway may operate in more than one state, provided that each state permits its operation. A state may establish one or more subsidiary Gateway, as long as each such Gateway serves a geographically distinct area and the area served by each Gateway is at least as large as the community rating area established by the Secretary.

No Limitation on Contracting Based on Abortion

No provider or facility may be excluded from contracting with a health insurance issuer participating in the Gateway on the basis that the provider or facility performs abortions or refuses to perform abortions, except in an emergency, if performing abortions is contrary to the religious or moral beliefs of the provider or facility.

Portals to State Gateway

The Secretary shall establish a website to allow residents of any state to identify any Gateway operating in their state.

Choice

A qualified individual may enroll in any qualified health plan. A qualified employer may provide support for coverage of employees under a qualified health plan by selecting a tier of cost sharing. Each employee of a qualified employer may choose to enroll in a qualified health plan that offers coverage at the tier of cost sharing selected by an employer. Self-employed individuals are deemed to be qualified employers unless they notify the Gateway otherwise.

Single Risk Pool

All enrollees in an individual plan, including individuals who do not purchase such a plan through the Health Benefit Gateway, will be considered members of single risk pools. Similarly, enrollees in a small group health plan, other than a self-insured group health plan, including those plans not purchased through the Gateway, will be considered members of a single risk pool.

Market Outside Gateways

Health insurers may continue to offer health plans to qualified individuals outside of the Gateways. While these plans are not considered qualified health plans, nothing prohibits individuals from keeping their existing coverage or enrolling in these plans.

Criteria for Certification

The Secretary, after consulting with the National Association of Insurance Commissioners (“NAIC”), shall establish criteria for certification of health plans as qualified health plans, including that a plan: 1) not use marketing practices to discourage enrollment by individuals with significant health needs; 2) ensure insurance products are simple and comparable; 3) ensure a wide choice of providers; 4) include in networks providers that serve low-income, medically-underserved individuals; 5) make available detailed information on benefits offered, service area, required premiums, cost-sharing requirements, and grievance and appeals procedures; 6) provide coverage for at least the specified essential health benefits; 7) be accredited by the National Committee for Quality Assurance (“NCQA”) or other recognized entity; 8) implement a quality improvement strategy; 9) have adequate procedures for appeals of coverage determinations; 10) not have a benefit design likely to discourage enrollment by certain individuals; and 11) report applicable data on quality measures.

Quality Improvements

The Secretary shall establish a payment structure that provides increased reimbursement or other incentives for qualified health plans that improve health outcomes, reduce hospital readmissions, improve patient safety, reduce medical errors, and promote health. Plans in the Gateway will be required to periodically report their activities on implementing or carrying out these activities. Hospitals with greater than 50 beds must establish mechanisms to ensure that each patient receives a comprehensive program for hospital discharge. Mental health parity will apply to qualified health plans in the same manner and to the same extent that it currently applies to health insurance issuers and group health plans.

Informed Choice of Health Insurance Coverage

The Secretary shall develop standards for use by health insurance issuers offering health plans through the Gateway in the individual or group market in compiling and providing to enrollees a summary of benefits explanation that accurately represents the benefits and coverage of the plans. In developing these standards, the Secretary must consult with the National Association of Insurance Commissioners, consumer advocacy organizations, health insurers, health care professionals, and patient advocates including those representing individuals with limited English proficiency. The standards established for the summary of benefits explanation will require a uniform format, language understandable by the average enrollee, appropriate information essential to a consumers understanding of the benefits, and uniform definitions of insurance and medical terms. All plans must provide enrollees with the summary of benefits explanation annually or be subject to a fine.

Disclosure of Information

All health insurance issuers offering plans through the Gateway must disclose their right to change premium rates, co-payments, in- and out-of-provider networks, as well as the benefits and premiums available under their plan.

Financial Integrity

Gateways must keep accurate accountings of all activities, receipts, and expenditures which they must annually submit to the Secretary in a report. The Secretary, with the cooperation of a Gateway, may investigate the affairs of the Gateway, examine its property and records, and require periodic reports in relation to its activities. A Gateway will also be subject to annual audits by the Secretary. If the Secretary determines that a Gateway or a state has engaged in serious misconduct with respect to compliance with these requirements, the Secretary may rescind up to one percent of the payments it is otherwise due (per year) unless adequate corrective actions are taken.

The Secretary may implement any measure or procedure deemed necessary to prevent fraud and abuse. Payments made by, through, or in connection with a Gateway are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any federal funds. Civil penalties imposed under the False Claims Act will be increased by a factor of between three and six times the amount of damages sustained by the government. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Gateway shall be a material condition of an issuer's entitlement to receive payments, including subsidy payments, through the Gateway.

The Government Accountability Office (“GAO”) will provide oversight of the Gateways. The Comptroller General is required to conduct an ongoing study of Gateway activities and their enrollees. The study will review: 1) the operations and administration of Gateways, including surveys and reports of qualified health plans offered through Gateways and on the experience of such plans (including data on enrollees in Gateways and individuals purchasing health insurance outside of Gateways), the expenses of Gateways, claims statistics relating to qualified health plans, complaints data relating to

such plans, and the manner in which Gateways meet their goals; 2) any significant observations regarding the utilization and adoption of Gateways; 3) recommendations for improvements in the operation or policies of Gateways; and 4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in federal government health care programs and the adequacy of provider networks of federal government health programs.

Program Design

The Secretary must establish essential health care benefits, the criteria that coverage must meet in order to be considered minimum qualifying coverage, and the conditions under which coverage will be considered affordable and available for individuals and families at different income levels.

Essential Health Care Benefits

The Secretary shall establish the essential health care benefits eligible for credits. These benefits must be equal in scope to the benefits provided under a typical employer plan and must include: 1) ambulatory patient services; 2) emergency services; 3) hospitalization; 4) maternity and newborn care; 5) mental health and substance abuse services; 6) prescription drugs; 7) rehabilitative and habilitative services and devices; 8) laboratory services; 9) preventive and wellness services; and 10) pediatric services, including oral and vision care.

In establishing the essential health benefits, the Secretary shall: 1) consider the recommendations of the National Independent Commission on Essential Health Care Benefits; 2) ensure that the benefits reflect an appropriate balance of medical care; 3) not discriminate against individuals based on their age, disability, or expected length of life; 4) take into account the health care needs of diverse segments of the population; and 5) ensure that benefits are not denied to individuals on the basis of the individual's age, expected length of life, disability, medical dependency, or quality of life.

The benefits must be reviewed at least once annually and the Secretary must submit a report of the findings of this review to Congress and to the public. The report must include an assessment of whether enrollees are facing any difficulty accessing needed services, an assessment of whether the essential benefits package needs to be modified or updated, and an assessment of the potential for additional or expanded benefits.

Minimum Qualifying Coverage

The Secretary shall establish criteria that coverage must meet for it to be considered minimum qualifying coverage. In establishing these criteria, the Secretary shall exclude from meeting such criteria any coverage that either provides reimbursement for the treatment or mitigation of a single disease or condition or an unreasonably limited set of diseases or conditions, or has an out of pocket limit that exceeds a specified amount. The Secretary also may provide for the application of different criteria with respect to young adults, except that coverage must be still be excluded that has an out of pocket limit exceeding the specified amount.

Affordable Coverage

The Secretary shall establish the conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels. Coverage will be defined to be unaffordable only if the premium paid by the individual is greater than 12.5 percent of the adjusted gross income (“AGI”) of the individual involved. This percentage will be adjusted according to the Consumer Price Index for all urban consumers (U.S. city average) during the preceding calendar year.

Non-Discrimination in Health Care

Essential health benefits must include a non-discrimination requirement such that the Administrator of the Gateway or of a qualified health plan offered through a Gateway is prohibited from denying benefits for religious or spiritual health care to eligible individuals, except that such religious or spiritual health care shall be an expense eligible for deduction as a medical care expense.

National Independent Commission on Essential Health Care Benefits

A temporary advisory commission will be created called the National Independent Commission on Essential Health Care Benefits (“Commission”). It will be required to review and analyze the benefits offered under typical employer-sponsored health plans and state laws requiring specified items and services in the individual and group insurance markets. The Commission must hold public hearings and make recommendations to the Secretary regarding items and services that should be included in the essential health benefits package. In making determinations regarding benefits, the Commission must consider clinical appropriateness and effectiveness, affordability, the financial protection of enrollees, access to primary and preventive services, state laws requiring coverage of services in the individual and group markets, and the potential of additional or expanded benefits. A report must be submitted to the Secretary for publication in the Federal Register and on a website established by the Secretary.

The Commission will be composed of 17 members appointed by the Secretary and will include individuals with national recognition for their expertise in clinical medicine, primary and preventive health care, integrative medicine, and actuarial science and health plan benefit design. It will receive assistance from federal agencies, such as cost estimates and technical assistance, as the Commission determines to be necessary to carry out its duties.

Allowing State Flexibility

States have flexibility in establishing Gateways and are given a few options from which to choose from. States may either establish a Gateway itself, request that the Secretary operate the Gateway (for a minimum of 5 years) in their state, or the state may elect to do neither. If a state elects to either establish a Gateway or to request that the Secretary do so, that state must also adopt specified insurance reform provisions and agree to make employers that are state or local governments subject to certain provisions regarding the notification on the availability of affordable health choices and regarding shared responsibility of employers.

Establishing States

If a state elects to establish a Gateway, any resident of that state who is an eligible individual will be eligible for credits beginning 60 days after the date of that determination. States electing to establish their own Gateway are called “establishing states.”

Participating States

If a state requests that the Secretary establish a Gateway in that state, the Secretary will determine whether the state has enacted and has in effect specified insurance reforms. If the reforms are enacted, the Secretary will establish a Gateway and deem the state a “participating state.” The Secretary will not establish a Gateway unless and until the state has enacted the specified reforms. Residents who are eligible individuals of a participating state will be eligible for credits 60 days after the establishment of the Gateway.

Federal Fallback

If a state is not otherwise a participating or establishing state within the first four years, the Secretary will establish and operate a Gateway in that state. Insurance reform provisions will become effective in the state, notwithstanding any contrary provision of state law and the state will be deemed a “participating state.” Residents who are eligible individuals will be eligible for credits 60 days after the Gateway is established as long as the state agrees to make employers that are state or local governments subject to two new provisions: regarding notification of the availability of affordable health choices, and regarding the shared responsibility of employers. If a state refuses to establish a Gateway and fails to request that the Secretary establish a Gateway, the residents will not be eligible for credits until such the state becomes a participating state through this process.

Navigators

The Secretary will award grants to states (or Gateways operating in those states) in order to enable them to enter into agreements with private and public entities which will serve as Gateway navigators. To be eligible to enter into such an agreement with the Secretary, an entity must demonstrate that it has relationships with employers, employees, consumers (including uninsured and underinsured), and self-employed individuals.

Navigators may include trade, industry and professional associations, commercial industry organizations, nonprofit groups, chambers of commerce, unions, small business development centers, and other licensed insurance agents and brokers. They will be charged with several duties such as conducting public education activities to raise awareness of the Gateways, providing fair and impartial information concerning enrollment in qualified health plans and the availability of credits and referring enrollees to the appropriate state agency for grievances, complaints, or questions. Navigators must provide information in a manner determined by the Secretary to be culturally and linguistically appropriate to the needs of the population served by the Gateway.

Navigators may not be health insurance issuers and they must not have any conflicts of interest with any health insurance issuer.

Community Health Insurance Option

The Community Health Insurance Option, a public option, will be established by the Secretary in order to provide value, choice, competition, and stability of affordable, high quality health care throughout the United States. The Community Health Insurance Option is defined as health insurance that: 1) complies with the requirements for being a qualified health plan; 2) provides high value for the premium charged; 3) reduces administrative costs and promotes administrative simplification for beneficiaries; 4) promotes high quality clinical care; 5) provides high quality customer service to beneficiaries; 6) offers a wide choice of providers; and 7) complies with state laws. Individuals enrolled in a Community Health Insurance Option shall be eligible for credits in the same manner as an individual who is enrolled in a qualified health plan.

To provide recommendations to the Secretary on the operations and policies of a Community Health Insurance Option operating in the state, a state shall establish or designate a public or non-profit private entity to serve as the State Advisory Council. This council will make recommendations on how to integrate quality improvement and cost containment mechanisms into the delivery system, mechanisms to facilitate public awareness of the option, and alternative payment structures for health care providers that encourage quality improvements and cost control. The members of the State Advisory Council shall be representatives of the public. The Secretary may apply the recommendations to a community health insurance option in that state or in any state.

A Community Health Insurance Option will provide coverage only for the essential health benefits. A state may offer additional benefits as long as the state pays for those additional benefits and the state's requirement to offer additional benefits does not affect an individual's eligibility for credits. Individuals may still pay out-of-pocket and medical providers may still accept the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. The Community Health Insurance Option will also be prohibited from limiting end of life care.

A Community Health Insurance Option must offer coverage at each of the specified levels of cost sharing. The Secretary will set premium rates in an amount sufficient to cover expected costs (including claims and administrative costs). All provisions regarding assuring portability, availability, and renewability of health insurance coverage will apply to community health insurance options, including modified community rating provisions.

Regarding provider reimbursement, the Secretary will negotiate rates for the reimbursement of health care providers for benefits covered under a Community Health Insurance Option. Such rates shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Gateway. In addition, a State Advisory Council may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers. However, no provision regarding reimbursement rates shall prohibit the application of a state law that permits physicians to jointly negotiate with health plans. In

such states, physicians may jointly negotiate with a Community Health Insurance Option concerning rates paid by the option.

In terms of consumer protections, the Secretary shall establish a federal solvency standard to be applied to Community Health Insurance Options. In setting this standard, the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred, but not reported, claims of a Community Health Insurance Option. On an annual basis, the Secretary shall conduct a study on the solvency of a Community Health Insurance Option and submit to Congress a report describing the results. If, in any year, the result of this study is that a Community Health Insurance Option is insolvent, such result shall be treated as a Community Health Insurance Solvency warning, and in response, the President shall submit to Congress proposed legislation, which is to be considered using the same procedures used for a Medicare funding warning. In addition, the Secretary, in collaboration with the NAIC, may promulgate regulations to establish additional requirements for a Community Health Insurance Option, which will be applicable to such an option beginning 90 days after the date on which the regulation involved becomes final. A Community Health Insurance Option shall also be subject to the solvency standards as well as the consumer protection laws of each state in which it is offered. In addition, in a facility controlled by the federal government, or by a state, where marketing or promotional materials related to a Community Health Insurance Option are made available to the public, making available marketing or promotional materials relating to private health insurance plans – such as informational pamphlets, guidebooks, enrollment forms, or other materials deemed reasonable for display – shall not be prohibited. Finally, in establishing community health insurance options, the Secretary shall establish an ombudsman or similar mechanism to provide assistance to consumers with respect to disputes, grievances, or appeals.

To pay for the establishment of a Community Health Insurance Option, loans will be provided for by the “Health Benefit Plan Start-Up Fund” of the U.S. Treasury, which will be appropriated available funds in amounts requested by the Secretary. These funds shall be available to: 1) pay the start-up costs associated with its initial operations; 2) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered; and 3) make risk corridor payments to contracting administrators. During the first two years of contract, such risk corridor payments will be based on the risk corridors in effect during fiscal years 2006 and 2007 for making risk corridor payments under Section 1860D-15(e) of the Social Security Act (Portion of Total Payments to a Sponsor or Organization Subject to Risk (Application of Risk Corridors)). Following the first two-year period, the Secretary may increase or extend the risk corridor payments. The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions. The Secretary shall make such payments subject to the requirement that any Community Health Insurance Option must repay the Secretary of the Treasury for any payments received within ten years of the date on which the payment was made (along with interest that does not exceed the market interest rate). In addition, a Community Health Insurance Option determined to be a for-profit entity by the Secretary must immediately repay any monies received from the Health Benefits Plan Start-Up

Fund and is thereafter permanently ineligible to offer a qualified health plan. The Secretary shall deposit any payments received from a contracting administrator regarding risk corridor payments into the Health Benefit Plan Start-Up Fund.

To administer the Community Health Insurance Option, the Secretary may enter into 5- to 10-year contracts with qualified entities, called “contracting administrators,” similar to contracts set up with Medicare administrative contractors. At the end of each term, the Secretary will conduct a competitive bidding process to either renew existing contracts or select new qualified entities with which to contract.

Contracting administrators must meet established criteria, be non-profits, meet certain solvency and quality standards, and have fraud, waste and abuse procedures in effect. They must: 1) meet the criteria established under 1874A(a)(2) (regarding the eligibility of entities in contracts with Medicare administrative contractors) of the Social Security Act; 2) be a non-profit entity for purposes of offering such option; 3) meet the applicable solvency standards; 4) be eligible to offer health insurance or health benefits coverage; 5) meet quality standards specified by the Secretary; 6) have in place effective procedures to control fraud, abuse, and waste, including the implementation of procedures to use beneficiary’s identifiers to identify individuals entitled to benefits so that such an individual’s social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payments under Title I of this Bill to identify and investigate unusual billing or order practices under Title I of this Bill that could indicate fraud or abuse; and 7) meet such other requirements as the Secretary may impose. The Inspector General shall conduct periodic audits with respect to contracting administrators to ensure that the administrator involved is in compliance with these requirements.

In terms of payment, the Secretary shall pay the contracting administrator a fee for the management, administration and delivery of the benefits. The Secretary may increase such fee by no more than ten percent, or reduce the fee by no more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas: 1) maintaining low premium costs and low cost sharing requirements; 2) reducing administrative costs and promoting administrative simplification for beneficiaries; 3) promoting high quality clinical care; and 4) providing high quality customer service to beneficiaries. The Secretary may not renew a contract to offer a community health insurance option with any contracting entity that has been assessed more than one such reduction by the Secretary.

Application of Same Laws to Private Plans and Community Health Insurance Option

Certain federal and state laws will apply equally to private health insurance as to community health insurance options: 1) guaranteed renewal; 2) rating; 3) pre-existing conditions; 4) non-discrimination; 5) quality improvement and reporting; 6) fraud and

abuse; 7) solvency and financial requirements; 8) market conduct; 9) prompt payment; 10) appeals and grievances; 11) privacy and confidentiality; 12) licensure; and 13) benefit plan material or information.

Participation of Professional on Certain Health-Related Commissions

Membership of any council, committee, or other advisory committee that the Secretary uses to inform official decision-making related to coverage of, or payment for, medical procedures, conditions, or care, shall have as its participants professionals who hold medical degrees from accredited American universities or colleges and have active clinical practices. Such advisory entities shall be composed of not less than one-third of such professionals.

Health Insurance Consumer Assistance Grants

The Secretary will award grants to establishing or participating states to enable them to establish, expand, or provide support for offices of health insurance consumer assistance. To be eligible to receive a grant, a state must designate an office of health insurance consumer assistance that, directly or in coordination with state health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and under state law. A state that receives such a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant. The state-designated office of health insurance consumer assistance shall: 1) assist with the filing of complaints and appeals, including filing appeals with a qualified health plan's appeal or grievance process and providing information about the external appeal process; 2) track consumer complaints, quantify such complaints, and regularly report such complaints to the State Gateway or the Secretary, as necessary; 3) educate consumers on their rights and responsibilities with respect to qualified health plans; and 4) assist consumers with enrollment in a qualified health plans by providing information, referral, and assistance, in collaboration with navigators. There is authorized to be appropriated to carry out this section, \$20,000,000 for fiscal year 2010, and such sums as may be necessary for each fiscal year thereafter.

Freedom Not to Participate in Federal Health Insurance Programs

All Members of Congress and congressional staff will enroll in a federal health insurance program: 1) created under this Act (or an amendment made by this Act); or 2) offered through a Gateway established under this Act (or an amendment made by this Act).

Subtitle C – Affordable Coverage for All Americans

Tiers of Cost Sharing for Individuals Eligible for Credits

The Secretary will establish at least three tiers of cost sharing for individuals eligible for credits for health insurance coverage accessed through a Gateway. The first tier for a basic plan will, on average, provide reimbursement for 76 percent of the total allowed costs of the benefits provided and the out-of-pocket limitation will not be greater \$5,000 for self-only coverage and \$10,000 for family coverage. The second and third tiers will have an average reimbursement percentage increased by 8 and 17 percentage points of

the basic plan, respectively. The out-of-pocket limitation for the second and third tiers will not be greater than 50 percent and 20 percent of the dollar value of the out-of-pocket limitation of the basic plan, respectively.

“Out of Pocket”

“Out of Pocket” includes all expenditures for covered qualified medical expenses for an account beneficiary and amounts paid by such beneficiary for medical care for his/her self, spouse, or dependent, but only to the extent such amounts are not compensated by insurance or otherwise.

Payment of Credits

The Secretary shall, with respect to an eligible individual, pay a premium credit to the Gateway through which the individual is enrolled in a qualified health plan. Such Gateway shall remit the amount equal to the credit to the qualified health plan in which the individual is enrolled.

Amount of Credit

Subject to an indexing provision and limitation requirement, the amount of an eligible individual’s annual credit will be determined by the Secretary so that the individual is not required to pay an amount that exceeds 12.5 percent of the individual’s income for the year involved. The amount the individual is required to pay will be ratably reduced to 1 percent of income in the case of an eligible individual with an adjusted gross income equal to 150 percent of the poverty line for a family of the size involved for the year. The Secretary may establish a schedule of premium credits to simplify administration of the credits in dollar amounts in line with these limits.

Reference Premiums

A credit may not exceed the lesser of the amount of either the reference premium or the premium of the qualified health plan. Reference premiums will equal the weighted average annual premium of the three lowest cost qualified health plans that meet the cost sharing and out-of-pocket limits and are offered in the community rating area in which the individual resides. In determining the lowest cost plans, the community health insurance option will not be considered. In any case in which there are less than three qualified health plans offered, the determination shall be based on the number of qualified plans that are offered in the area. The reference premium shall be determined without regard for reimbursement of benefits that are not included in the essential health benefits. The reference premium shall be adjusted to account for premium differences based on age, family size, and geographical variation. Beginning in 2014, the indexing percentages that specify the portion of the reference premium that an individual or family is responsible for paying shall be annually adjusted by the percentage increase or decrease in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) during the preceding calendar year.

State Flexibility

A state may make payments to or on behalf of an eligible individual that are greater than the amounts required by this Act.

Rules and Procedures for Eligibility Determinations

The Secretary shall, by regulation, establish rules and procedures for: 1) the submission of applications for payments, including the electronic submission of documents necessary for application and enrollment; 2) making eligibility determinations and informing individuals of such determinations, including verifying income through the use of data contained in applicants' tax returns; 3) making determinations of AGI in cases where the individual applicant was not required to file a tax return for the taxable year involved; 4) resolving appeals of such determinations; 5) redetermining eligibility on a periodic basis; and 6) making payments. The Secretary shall also establish rules that permit eligibility to be determined based on: 1) the applicant's AGI for the second preceding taxable year; or 2) in the case of an individual who is seeking payment based on claiming a significant decrease in AGI, the applicant's AGI for the most recent period or the applicant's declaration of estimated AGI.

Authority of the Secretary in Determining Eligibility

The Secretary shall have the authority to make determinations with respect to the eligibility of individuals submitting applications for credits. The Secretary shall verify, through the Internal Revenue Service or the income and eligibility verification system utilized for purposes of the Medicaid program, the income data received from individuals submitting applications for credits. To be eligible to receive a credit, an individual shall either authorize the disclosure of tax return information or if the individual did not file a tax return for the year involved, provide satisfactory documentation of AGI, which may include a prior year federal income tax return. Such individual must also authorize disclosure of information to the Secretary as may be required from the Internal Revenue Service to verify that a tax return was not filed.

Delegation of Authority

The Secretary shall delegate to a Gateway the authority to make determinations with regard to eligibility. The Gateway may consult with the Internal Revenue Service to verify income data received from individuals submitting applications for credits. A Gateway shall carry out activities with regard to eligibility in a manner that is consistent with the regulations promulgated by the Secretary. If the Secretary determines that a Gateway is carrying out eligibility determination activities in a manner that is substantially inconsistent with the regulations promulgated, the Secretary may, after notice and opportunity for a hearing, revoke the authority.

Requirement to Report Change in Status

An individual who has been determined to be eligible for credits shall notify the Gateway of any changes that may affect such eligibility in a manner specified by the Secretary. Upon receipt of a notice from an individual, the Gateway shall promptly redetermine the individual's eligibility. If the individual fails to provide information regarding changes that affect eligibility on a timely basis or the Gateway determines the individual is no longer eligible for payments, the Gateway shall terminate payments after providing notice to the individual.

Form, Contents, and Manner of Submission for Applications

Submission of applications of credits shall be permitted in person, by mail, telephone, or the Internet. An application shall be in such form and manner as specified by the Secretary, and may require documentation. An application may be submitted to the Gateway, or to a state agency for a determination. A Gateway, or a state agency, shall assist individuals in filing applications.

Reconciliation Statements

In the case of an individual who has received payments for a year and is claiming a significant decrease in AGI from such year, the individual shall file with the Secretary an income reconciliation statement. Based on the statement, the Secretary shall compute the amount of payments that should have been provided on behalf of the individual for the year involved. The Secretary shall make determinations based on income data from the most recent tax return filed by the individual. The Secretary shall ensure that the poverty line data used relates to the same taxable year for which the AGI is determined. In the case of an individual who fails to file an income reconciliation statement for a year required, the individual shall not be eligible for payments until such statement is filed. The Secretary can waive application of this requirement for good cause established by the individual.

Overpayment of Credit Payments

If the amount of payments provided on behalf of an individual for a year was significantly greater than the Secretary's computation of the amount that should have been provided, the individual shall be liable to the Secretary for such excess amount. The Secretary may establish methods under which such liability may be assessed through a reduction in the amount of any credit otherwise applicable to the individual. The amount of any repayment for overpayment shall not exceed \$250 for an individual who filed an individual tax return or \$400 for an individual who filed a joint tax return for such year. Any individual with an AGI that exceeds 400 percent of the poverty line for a family of the size involved for such year must repay the entire amount. The Secretary shall coordinate with the Secretary of the Treasury to develop procedures to enable the Internal Revenue Service to administer collection of overpayments.

Underpayment of Credit Payments

If the amount of payments provided to an individual for a year was less than the Secretary's computation of the amount that should have been provided, the Secretary shall pay the individual the amount of such deficit. The Secretary may establish methods under which payments may be provided through an increase in the amount of any credit otherwise applicable to the individual.

Cultural and Linguistic Outreach

The Gateway shall conduct culturally and linguistically appropriate outreach activities to provide information regarding the application process to individuals who may be eligible for payments.

Credits Excluded from Income

Amounts received by an individual as credits shall not be considered as income, and shall not be taken into account in determining eligibility for benefits or assistance, under any federal, state, or local program financed in whole or in part with federal funds.

No Federal Funding for Individuals not Lawfully Present in the U.S.

Nothing in this title, the new Title XXXI of the Public Health Service Act, shall allow federal payments for individuals who are not lawfully present in the United States.

Small Business Health Options Credit

For each year beginning in 2010, the Secretary shall make a general credit amount payment to qualified small employers. The general credit amount shall be the product of: 1) the applicable amount; 2) the employer size factor; and 3) the percentage of year factor. The applicable amount shall be equal to: 1) \$1,000 for each employee who receives self-only health insurance coverage through the employer; 2) \$2,000 for each employee who receives family health insurance coverage through the employer; and 3) \$1,500 for each employee who receives health insurance coverage for two adults or one adult and one or more children through the employer. The applicable amount shall be increased for each additional 10 percent of the qualified employee health insurance expenses exceeding 60 percent which are paid by the employer by: 1) \$200 for each employee receiving self-only health insurance coverage; 2) \$400 for each employee receiving family health insurance coverage; and 3) \$300 for each employee receiving health insurance coverage for two adults or one adult and one or more children.

Employer Size Factor

For purposes of the general credit amount, the employer size factor shall be: 1) 100 percent for employers with ten or fewer employees; 2) 80 percent for employers with 11 to 20 full-time employees; 3) 50 percent for employers with 21 to 30 full-time employees; 4) 40 percent for employers with 31 to 40 full-time employees; 5) zero percent for employers with more than 50 full-time employees. A full-time employee is defined as an employee whose average number of hours worked in the preceding taxable year for such employer was at least 40 hours per week.

Percentage of Year Factor

For purposes of the general credit amount, the percentage of year factor shall be a ratio of the number of months during the year for which the employer paid or incurred at least 60 percent of the qualified employee health insurance expenses and twelve.

“Qualified Small Employer”

A qualified small employer: 1) pays or incurs at least 60 percent of the qualified employee health insurance expenses, or is self-employed; 2) employed an average of 50 or fewer full-time employees during the preceding taxable year; and 3) had an average wage of less than \$50,000 for full-time employees, or a self-employed individual that had not less than \$5,000 and not more than \$50,000 in net earnings, and has elected not to

receive a credit. An employer may not receive a credit for more than one period of not more than three consecutive years.

“Qualified Employee Health Insurance Expenses”

Qualified employee health insurance expenses include any amount paid by an employer or an employee for health insurance coverage to the extent such amount is for coverage provided to any employee or for a self-employed individual. No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account as a qualified employee health insurance expense.

Inflation Adjustment

Beginning 2011, the dollar amounts specified shall be the amounts in effect in the preceding calendar year or, if greater, the product of: 1) the corresponding dollar amount specified; and 2) the ratio of the index of wage inflations (as determined by the Bureau of Labor Statistics) for August of the preceding calendar year to such index of wage inflation for August of 2008.

Application of Aggregation Rule for Employers

All persons currently treated as a single employer under the Internal Revenue Code, such as employees of a controlled group of corporations, employees of partnerships and proprietorships which are under common control, or employees of an affiliated service group shall be treated as one employer.

Employers Not in Existence in Preceding Year

In the case of an employer which was not in existence for the full preceding taxable year, the determination of whether such employer meets the requirements to receive a credit shall be based on the average number of full-time employees that are reasonably expected to be employed on business days in the employer’s first full taxable year. Employers include any predecessor of such employer.

Voluntary Authorization for Income Verification

The Secretary of the Treasury shall provide a mechanism for each tax payer to indicate whether such taxpayer authorizes the Secretary of the Treasury to disclose tax return information to the Secretary (or pursuant to a delegation to a state or a Gateway). If a taxpayer authorizes the disclosure, the Secretary of the Treasury shall disclose to the Secretary, state, or Gateway the minimum amount of information necessary to establish whether such individual is eligible for a credit. Tax return information disclosed may be used by the Secretary, state, or Gateway only for the purpose and extent necessary to establish the amount of any payment of credit for health insurance.

Collection of Amounts

Upon receiving a certification from the Secretary, the Secretary of the Treasury will assess and collect the amounts certified by the Secretary with regard to amounts specified in this Act.

Subtitle D – Shared Responsibility for Health Care

Individual Responsibility

Every individual and each of his or her dependents must be covered under qualifying coverage at all times during the taxable year. Individuals who do not have in effect qualifying coverage for any month during the taxable year, shall be assessed a shared responsibility fee for the taxable year. The amount of the fee will be set each year by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services and the states.

Dependents

Any fees for a dependent who did not have qualifying coverage in effect for any month during the taxable year shall be imposed: 1) upon the taxpayer on whom such individual is a dependent; or 2) in any case of a joint tax return, jointly upon the taxpayer and the spouse of the taxpayer.

Maximum Shared Responsibility Payment Imposed

The maximum shared responsibility payment amount imposed with respect to any taxpayer shall not exceed four times the limitation (\$750) subject to an inflation adjustment. In establishing the amount to be imposed, the Secretary of the Treasury shall seek to establish the minimum practicable amount that can accomplish the goal of enhancing participation in qualifying coverage.

Beginning with taxable years after 2011, the \$750 amount shall be adjusted each year by the medical care component of the Consumer Price Index for all urban consumers from the preceding calendar year.

Exemptions

The shared responsibility payment requirement shall not apply to any individual: 1) who lacked qualifying coverage for a period of less than 90 days; 2) who is a resident of a state that is not a participating or establishing state; 3) who is an Indian; 4) for whom affordable health care coverage is not available; or 5) who has income below 150 percent of the federal poverty line.

Relation to Tax Code

The amount imposed shall not be treated as a tax imposed for purposes of determining: 1) the amount of any credit allowable under normal taxes and surtaxes; or 2) the amount of the minimum tax imposed. The amount imposed by this requirement shall be treated as a tax for the purpose of Internal Revenue Service procedures.

Amounts collected under the shared responsibility payment requirement shall be dedicated to premium credits established to support for affordable health coverage. The Secretary of the Treasury may prescribe such regulations as may be appropriate to carry out the purposes of this tax requirement. These amendments shall apply to taxable years beginning after December 31, 2011.

Reporting of Health Insurance Coverage Through Tax Returns

Every person, including employers, who provides health insurance that is qualifying coverage shall report health insurance coverage on their tax return, identifying the covered individuals and the time period of that coverage. That information must also be provided to the covered individual each year.

IRS Notification to Individuals Not Enrolled in Qualifying Coverage

Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in qualifying coverage. Such notification shall contain information on the services available through the Health Benefit Gateway (if any) operating in the state in which such individual resides.

Notification on the Availability of Affordable Health Choices to Employees

In accordance with regulations promulgated by the Secretary, an employer to which the Fair Labor Standards Act applies shall provide to each employee at the time of hiring (or with respect to current employees, within 90 days of the date on which a state becomes an establishing or participating state) written notice informing the employee of the existence of the Health Benefit Gateway, including a description of the services provided by such Gateway and the manner in which the employee may contact the Gateway to request assistance.

Shared Responsibility of Employers for Employees Not Offered Coverage

Employers shall make payments to the Secretary in the amount of \$750 (subject to an inflation adjustment) for each full-time employee, pro-rated for each month in which the employee: 1) was not offered qualifying coverage; or 2) on behalf of whom the employer is not contributing at least 60 percent of the monthly premiums for qualifying coverage.

This requirement shall apply with respect to part-time employees employed by the employer, except that the annual payment amount shall be reduced to \$375 for each part-time employee. These requirements shall only apply with respect to the employees of employers with more than 25 employees. The Secretary shall develop procedures for making determinations with respect to qualifying coverage and for making the payments required. Such procedures shall provide for the making of payments on a quarterly basis.

Inflation Adjustment

Beginning with calendar years after 2013, the \$750 and \$375 amounts shall be adjusted annually by the medical care component of the Consumer Price Index for all urban consumers from the preceding calendar year.

Exemption for Small Employers

An employer shall not be considered to employ more than 25 employees if: 1) the employer's workforce exceeds 25 employees for 120 days or fewer during the calendar year; and 2) the employees employed during such 120-day period were seasonal workers.

Independent Contractors

For purposes of determining whether an employer is subject to these requirements, any individual who qualifies as an independent contractor under federal law and who is retained by such employer shall not be counted when determining the number of employees employed by the employer.

Authority to Certify and Regulate

The Secretary, in collaboration with the Secretary of the Treasury and the Secretary of Labor, shall establish procedures for determining the number of employees of employers who are not offered qualifying coverage. Additionally, the Secretary, in consultation with the Secretary of Labor, shall promulgate such regulations as may be appropriate to carry out these requirements, which shall apply with respect to an employer beginning in the calendar year in which the state in which the employer is located becomes an establishing state or a participating state (with respect to a Health Benefit Gateway).

Qualified Employers, Individuals, and Health Plans

In order to be considered “qualified,” employers must elect to make all of their full-time employees eligible for a qualified health plan. For employers that wish to make their employees eligible for qualified health plans in either an establishing or participating state, the employer must employ fewer employees than a set number to be determined by the Secretary or the state, which cannot exceed 50 individuals.

For a health plan to be considered “qualified,” the plan must meet the criteria for certification issued or recognized by each Health Benefit Gateway. It must: 1) be offered by a health insurance issuer that is licensed and in good standing; 2) agree to offer at least one plan in two different tiers of cost sharing; 3) comply with regulations developed by the Secretary; and 4) agree to pay any surcharge assessed by the Gateway. Many forms of coverage are already deemed to be qualifying, such as: 1) a group health plan that an individual is already enrolled in on the date of enactment; 2) a group health plan that meets or exceeds the criteria for minimum qualifying coverage; 3) Medicare coverage under Parts A, B, and C; 4) Medicaid and CHIP coverage; 5) TRICARE coverage; 6) coverage under the veterans’ health care program depending on the individual’s priority for services; 7) coverage under the federal employee health benefits program; 8) a state health benefits high risk pool; 9) coverage provided to Peace Corps volunteers; and 10) coverage under a qualified health plan.

Individuals shall be deemed “qualified” if they: 1) reside in a participating or establishing state; 2) are not incarcerated; 3) are not entitled to coverage under Medicare; 4) are not already enrolled in a state Medicaid program, TRICARE or the federal employees health benefits program; and 5) are not enrolled under employer-sponsored coverage (unless the coverage is not considered affordable by the Secretary).

Subtitle E – Improving Access to Health Care Services

Spending for Federally Qualified Health Centers

In order to improve access to health care services, certain amounts will be set aside for grants, in addition to money already appropriated for federally qualified health centers (“FQHCs”). Amounts authorized to be appropriated are specified for fiscal years 2010 through 2016, and an adjustment percentage is set for subsequent fiscal years. FQHCs will be allowed to contract with other rural providers for the provision of health services.

Other Provisions

A FQHC may elect to provide services in another health center’s catchment area, if the FQHC determines that there is an unmet need. FQHCs will face some changes to their governance requirements and they will be granted more flexibility to make budgeting changes, within certain guidelines. FQHCs are also given the right to appeal decisions by the Secretary with regard to grant funding and other issues that would affect operations.

Medically Underserved Populations and Health Professions Shortages

The Secretary is required to develop new criteria for designating medically underserved populations and health professions shortage areas through a rulemaking process.

Equity for Eligible Survivors

The Black Lung Benefits Act is amended to make it easier for the Secretary to challenge claims by an individual that he or she is eligible for coverage under the Act. At the same time, it relaxes the requirements for family members to claim benefits of deceased relatives.

Wakefield Emergency Medical Services for Children Program

The Wakefield Emergency Medical Services for Children Program is reauthorized and is provided with additional funding.

Co-Locating Primary and Specialty Care in Community Based Mental Health Settings

A demonstration project is established in order to encourage qualified community mental health programs to apply for grants that will help co-locate primary and specialty care within the community mental health centers. The demonstration program is to be extended if the centers and the Secretary show that the program is effective.

Subtitle F – Making Health Care More Affordable for Retirees

Reinsurance for Retirees

A program for the reinsurance of retirees (those 55 years and older who are not yet eligible for Medicare) is created in order to cover a portion of cost of providing health benefits for retirees living in states that do not otherwise provide coverage for this population.

Subtitle G – Improving the Use of Health Information Technology for Enrollment

The Secretary is required to work in conjunction with ONCHIT to set forth the electronic enrollment processes. Specifically, the Secretary is required to collaborate with ONCHIT's policy and standards committees to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in these government programs.

The standards and protocols to be developed must include several important elements, including providing individuals with electronic notification of eligibility and electronic verification of eligibility required under such programs. Electronic enrollment process must use existing government data (vital records, employment history, tax records, etc.) for evidence of eligibility. Procedures regarding submission of documentation, retention of individuals in programs, and the capability for individuals to apply, recertify and manage eligibility information online. The federal government is given the authority to provide grants for the health information technology ("HIT") investments necessary to create these systems, as well as the authority to withhold such funding from states and other entities that do not adopt the required standards and protocols for electronic enrollment.

A Key National Indicator System will be established in order to use quality data in a broad range of information areas to track and measure specific issues. To do so, a Commission on Key National Indicators with specific membership requirements is created. This Commission will work closely with the National Academy of Sciences in the creation, implementation, operation, and evaluation of the Key National Indicator System. The Commission is required to undertake and submit reports to the federal government on the progress and success of the system.

The Comptroller General is required to conduct a study on whether "applicable new Medicare enrollees" exhibit higher than expected rates of preventable disease when compared to the entire population of new Medicare enrollees or another appropriate statistical baseline. If applicable new Medicare enrollees exhibit such a higher than expected rate of preventable disease, the study must also determine whether such rate is related to the failure of the enrollee's previous private health insurance issuer to promote, cover, or adequately pay for preventive health benefits. The results of this study must be submitted to Congress and include any recommendations for legislative or administrative action deemed appropriate by the Comptroller General.

The Secretary must publish on a publically accessible website a list of all the authorities provided to the Secretary under this Act. Moreover, this subtitle includes a provision that states that nothing in the Act shall be carried out in a manner that threatens the solvency of Medicare or Social Security programs.

The federal government, state governments or any recipient of federal funding will be prohibited from discriminating against and individual or institutional health care entity on

the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. However, this provision will not effect institutional policies regarding the withholding or withdrawing of medical treatment or medical care, withholding or withdrawing of nutrition or hydration, abortion, or the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason. Such policies can remain in place.

The Secretary shall not promulgate any regulations in support of this Act that limit the availability of health care treatment for the full duration of a patient's medical needs and won't create any unreasonable barriers to the ability of individuals to obtain appropriate medical care. No individual, company, business, nonprofit entity, or health insurer will be required to participate in any federal health insurance program created under this Act.

Subtitle H – CLASS Act

The Community Living Assistance Services and Supports Act (“CLASS”) establishes a new national program for the voluntary purchase of insurance for community-based long-term care. The insurance will provide supports for individuals to maintain personal and financial independence and continue to live in the community, rather than being institutionalized.

Like long-term care insurance, the CLASS plan will be optional to purchase and may be purchased through one's employer or individually. Any non-institutionalized individual over age 18 who is actively employed and generates taxable income will be eligible for the program, as will the spouse of any eligible individual. Benefits will be in the form of cash payments, available to covered individuals who demonstrate a functional limitation that is expected to last more than 90 days and are not subject to lifetime or aggregate limits. The benefit amount will vary based on the individual's level of functional ability, but will not be less than an average of \$50 per day. Additional benefits will include advocacy services and advice and assistance counseling. Benefit packages, premium levels, and other plan requirements will be determined by the Secretary after receiving recommendations from the CLASS Independence Advisory Council, a committee of individuals appointed by the President to advise the Secretary with regard to Plan policies, administration, and regulation, and the majority of whom will be representatives of individuals who participate or are likely to participate in the CLASS program. In general, premiums will remain stable for the length of an individual's enrollment as long as the individual maintains continuous enrollment.

The CLASS Act also establishes a Life Independence Account for each beneficiary, into which cash benefits under the CLASS Independence Benefits Plan are paid. Beneficiaries may access their individual accounts to pay for nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another community residential setting. Cash benefits through the Plan will also be used

to supplement benefits provided through Medicaid, such as home and community based services and services provided through Programs of All-Inclusive Care for the Elderly (“PACE”). Specific reimbursement requirements are provided for Medicaid beneficiaries who are institutionalized.

Beneficiaries will have the option to rollover funds from month-to-month and may receive any unused benefits annually through a lump sum payment, with the Secretary recouping any remaining funds. Beneficiaries will be required periodically to recertify eligibility. Cash benefits provided through the CLASS Independence Benefits Plan supplement, but do not supplant, health care benefits that the beneficiary may receive through other federally-funded programs.

The CLASS Act provides advocacy and counseling services for its beneficiaries, to help with services such as appeals and recertification requirements, long-term care arrangements, determination of eligibility, assistance with decision-making concerning medical care and other related services.

The CLASS Independence Fund will also be established to hold investments on behalf of CLASS enrollees, to pay administrative expenses related to the Fund, and to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan. The Fund will be managed by a board of trustees, which will include the Secretaries of Treasury, Labor, and Health and Human Services, the Commissioner of Social Security, and two members of the public. A lock-box protection will prevent Congress from designating use of CLASS funds for any purpose other than the CLASS program.

The Secretary will be required to submit annual reports to Congress detailing enrollment and benefits provided under the CLASS program, and the Inspector General will be required to submit annual reports on the existence of waste, fraud, and abuse in the program.

Finally, each state will be required to assess its supply of personal care attendant workers who provide services to CLASS beneficiaries and implement certain measures to ensure that each state maintains an adequate supply of such workers to meet the needs of its beneficiaries. A Personal Care Attendants Workforce Advisory Panel composed of a variety of community stakeholders, will be established to examine and advise the Secretary and Congress on workforce issues related to these workers.