Rockefeller Coverage Amendment #1 to America's Healthy Future Act

Rockefeller Amendment #C1 to Title I, Subtitle A (Insurance Market Reforms)

Short Title: Apply health insurance market reforms to the large group and self-insured market.

Description of Amendment:

Chairman's Mark

No insurance market reforms applied to the individual and small group markets would be applied to the self-insured market. Additionally, insurance market reforms would not be applied to the large group market until 2017. In 2017, states must develop and submit to the Secretary a phase-in schedule (not to exceed five years), including applicable rating rules, for incorporating firms with 50 or more employees (or 100 or more employees for those states that already included firms with 51-100 employees) into the state exchanges. The Secretary must develop regulations to address the potential for any risk selection issues associated with allowing larger employers into the state exchanges. Initial phase in for these firms would begin in plan years 2018 and beyond.

Explanation of the Provision

Effective January 1, 2013, all of the insurance market reforms applied in the exchange would be applied immediately to both self-insured and large group plans.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #2 to America's Healthy Future Act

Rockefeller Amendment #C2 to Title I, Subtitle A (Insurance Market Reforms)

Short Title: Immediately require a prohibition on pre-existing condition exclusions for children

Description of Amendment:

Chairman's Mark

Beginning January 1, 2013, all plans offered in the exchange would be prohibited from applying pre-existing condition exclusions to new enrollees. These provisions are not applied to self-insured plans. They are not mandatory to be phased in for large group employers until beginning in 2018 (over a phase-in period of no longer than five years), and they do not apply to existing plans.

Explanation of the Provision

Effective upon enactment, new health insurance policies in every insurance market that cover children would be prohibited from applying pre-existing condition exclusions for those children. Existing or grandfathered policies would be required to implement an immediate phase-in to eliminate pre-existing condition exclusions for children over the course of a year. More specifically, in 2010 these plans would reduce the exclusion period from 12 months to 3 months and the look-back period from 6 months to 30 days in both the individual and group markets. Then in 2011, these plans would be required to implement a full elimination of pre-existing condition exclusions for children. This amendment is based on the concepts in Pre-existing Condition Patient Protection Act of 2009 (S. 623) and the Children's Health Protection Act of 2009 (S.643).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #3 to America's Healthy Future Act

Rockefeller Amendment #C3 to Title I, Subtitle A (Insurance Market Reforms)

Short Title: Immediate elimination of annual and lifetime limits for all new policies offered in the exchange and a phase-in of the elimination of annual and lifetime limits on grandfathered/existing plans

Description of Amendment:

Chairman's Mark

Beginning in January 1, 2013, all plans offered in the exchange could not include lifetime limits on coverage or annual limits on any benefits. These provisions are not applied to self insured plans. They are not mandatory to be phased in for large group employers until beginning in 2018 (over a phase-in period of no longer then five years), and they do not apply to existing plans.

Explanation of Provision

Beginning in January 1, 2010, this amendment would eliminate annual and lifetime limits for all new insurance policies issued. It would also phase-in an elimination of annual and lifetime limits in grandfathered plans over five years. This amendment is based on the concepts in the Annual and Lifetime Health Care Limit Elimination Act (S. 1149).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #4 to America's Healthy Future Act

Rockefeller Amendment #4 to Title I, Subtitle A (Insurance Market Reforms)

Short Title: Universal 24-Hour health coverage

Description of Amendment:

Chairman's Mark

No provision.

Explanation of Provision

The concept of "Universal 24-Hour Health Coverage" involves providing, in a single policy, medical benefits for all of an employee's injuries and diseases, whether work-related or not, as well as the medical portion of auto liability insurance policies. Consolidating the medical payments components of these lines of insurance would result in a reduction in controllable administrative costs for claims and general administration, reserves, and marketing costs.

The average annual rate of growth in medical care prices was almost twice the rate of inflation between 1980 and 2007 - 4.7% - in contrast to 2.5% for the entire consumer price index.[1] In addition, health insurance premiums on average increased 114% from 1999 to 2007.

In the traditional fault-based state-regulated auto insurance system, injured individuals typically seek compensation for their economic and noneconomic losses from the driver who causes the accident. Individuals usually purchase three kinds of injury insurance coverage:

[1] See CRS Report R40517, *Health Care Reform: An Introduction*, by Bernadette Fernandez, Hinda Chaikind and Chris L. Peterson.

(1) bodily injury (BI) liability insurance that compensates a "third party" or the person that is injured; (2) uninsured motorists (UM) insurance to cover themselves for any compensation due them that they cannot obtain from an uninsured motorist; and (3) medical payment (Med Pay) that covers their own medical costs.

The *Med Pay* component of automobile liability insurance policies covers the drivers' medical costs regardless of who is at fault, up to a policy limit. Importantly, employer-provided health and accident insurance may cover most of the same medical bills and the employee's sick pay might cover the time he/she had to take off work. In this context, possible savings under a "Universal 24-hour Health Care System" could arise from the fact that these payments generally do not enter into the determination of what the other driver's insurer, or their own, owe to the driver.

In the traditional workers' compensation insurance system, workers typically receive reimbursement for unlimited costs relative to work-related medical care and rehabilitation without showing fault. The worker also receives lost wages, and a death benefit could be paid to their dependents.

Rockefeller Coverage Amendment #5 to America's Healthy Future Act

Rockefeller Amendment #C5 to Title I, Subtitle B (Exchange and Consumer Assistance)

Short Title: Strike state exchanges, multiple competing exchanges, and regional exchanges, and create one national exchange

Description of Amendment:

Chairman's Mark

States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. After states adopt Federal rating rules and the exchange is functional for at least three years, states could permit other entities to operate an exchange (i.e. multiple competing exchanges) — but only if it met specified requirements, and subject to approval by the Secretary. States could, through interstate compacts, form regional exchanges, subject to approval by the Secretary.

Explanation of Provision

This amendment would strike the provisions to establish state exchanges, multiple competing exchanges, and regional exchanges, and create one national exchange implemented and regulated by the U.S. Secretary of Health and Human Services (HHS). One, single exchange would minimize insurance enrollment churning, lower administrative costs, and improve the value of benefits and coverage while lowering premiums by creating a larger risk pool.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #6 to America's Healthy Future Act

Rockefeller Amendment #C6 to Title I, Subtitle C (Making Coverage Affordable)

Short Title: Consumers Health Care Act (S. 1278), as modified

Description of Amendment:

This amendment would add a strong public health insurance option, the Consumer Choice Health Plan (CCHP), to the exchange to compete directly with private plans. Like private health plans, CCHP would be offered to all individuals and businesses purchasing health insurance through the national health insurance exchange. To guarantee plan availability nationwide, public program provider networks will be used.

The Consumer Choice Health Plan will be financially self-sustaining (subject to an annual third party audit). The plan administrator will establish and fund a contingency reserve for CCHP in a manner similar to that of the contingency reserve established by OPM for the Federal Employees Health Benefits Plan. Funds to operate the plan shall be derived from premiums for individuals enrolled under the plan.

To help enrollees afford the cost of coverage, the same premium subsidies would be provided to enrollees in CCHP as those offered to consumers enrolled in private health plans. Any additional revenue gained under this public plan option would be reinvested in CCHP in the form of reduced premiums and cost-sharing or increased benefits.

At a minimum, the Consumer Choice Health Plan would be required to follow the same insurance regulations as private plans operating in the exchange. CCHP would also be required to offer the same type of plans as private plans participating in the exchange. Minimum benefit requirements for children would be based on the pediatric care guidelines provided by *Bright Futures*, which offers evidenced-based direction on the provision of well-child and other primary health care services. The provider payment rates for the first two years of CCHP would be based on Medicare provider payment rates, including new delivery models enacted as part of health

reform. For subsequent plan years beyond the first two years, CCHP would be required to determine competitive provider payment rates based on public and private best practices, integrated models of care delivery (such as medical home and chronic care coordination), evidence-based practices, quality improvement, and the use of health information technology.

This amendment would also establish America's Health Insurance Trust to give consumers a voice in health insurance oversight. This nonprofit, consumer-driven organization will evaluate and give ratings to all health insurance products offered through the national health insurance exchange based on factors such as affordability, adequacy, transparency, consumer satisfaction, provider satisfaction, and quality.

The CCHP shall not include abortion, except in cases of rape, incest, or the life of the mother. It also prohibits the expenditure of Federal funding for abortion and it requires the segregation of funds to ensure that no Federal dollars pay for abortions.

Rockefeller Coverage Amendment #7 to America's Healthy Future Act

Rockefeller Amendment #C7 to Title I, Subtitle C (Making Coverage Affordable)

Short Title: Establishment and administration of a public health insurance option as an exchange-qualified health benefits plan (Sections 221, 222, 223, 224, 225, and 226 of H.R. 3200, America's Affordable Health Choices Act of 2009)

Description of Amendment: Sec. 221. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan. Requires the Secretary of Health and Human Services to develop a public health insurance option to be offered starting in 2013 as a plan choice within the Health Insurance Exchange. It participates on a level playing field with private plan choices. Like private plans, it must offer the same benefits, abide by the same insurance market reforms, and follow provider network requirements and other consumer protections.

Sec. 222. Premiums and financing. Premiums for the public option are geographically-adjusted and are required to be set so as to fully cover the cost of coverage as well as administrative costs of the plan. This includes a requirement that the public option, like private plans, include a contingency margin in its premium to cover unexpected cost variations. In order to establish the public option, there is an initial appropriation of $2 billion for administrative costs and in order to provide for initial claims reserves before the collection of premiums such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment. These start up funds are amortized into the premiums for the public option to be recouped over the first 10 years of operation. The plan must be self-sustaining after that initial funding.

Sec. 223. Payment rates for items and services. The Secretary of HHS establishes geographically-adjusted provider payment rates for the public option. For the first three years, those rates are based on Medicare rates with a 5% add-on for practitioners who also participate in the Medicare program. This increase also applies to practitioners, like pediatricians, who do not typically participate in Medicare. After the first three years, the Secretary is granted greater flexibility in setting rates, but the general rule is that overall spending should remain consistent with the initial levels. Flexibility is provided to the Secretary to create payment rates for services

not covered by Medicare, pursue delivery system reforms, make adjustments to offset geographic variations and adjust rates as necessary to assure competitiveness with Exchange-participating plans or for excessive or deficient payments. Medicare providers are presumed to also be participating in the public option unless they opt out. There are no penalties for opting out. The Secretary also has authority to negotiate prescription drug prices for the public option.

Sec. 224. Modernized payment initiatives and delivery system reform. The Secretary is empowered to move forward with delivery system reforms to change the way the public option pays for medical services to promote better quality and more efficient use of medical care. Such payment changes must seek to reduce cost for enrollees, improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, and r promote integrated patient-centered care.

Sec. 225. Provider participation. Provides the Secretary of HHS with the authority to develop conditions of participation for the public health insurance option. Providers must be licensed in the state in which they do business. Physician participation comes in two types: preferred physicians are those physicians who agree to accept the public option's payment rate (without regard to cost-sharing) as payment in full; participating non-preferred physicians are those who agree not to impose charges in excess of the balance billing limitations in Medicare. Providers must be excluded from participating in the public option if they are excluded from other federal health programs.

Sec. 226. Application of fraud and abuse provisions. Applies Medicare's anti-fraud and abuse protections to the public health insurance option.

Rockefeller Coverage Amendment #8 to America's Healthy Future Act

Rockefeller Amendment #C8 to Title I, Subtitle C (Making Coverage Affordable)

Short Title: Amendment to more strictly limit total out-of-pocket costs for all individuals

Description of Amendment:

Chairman's Mark

There is no total out-of-pocket limit included in the mark, defined as including both premiums as well as other cost-sharing, like co-payments. Minimum creditable coverage (MCC) would include an out-of-pocket limit up to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010) indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. For those between 100-200 percent of FPL, the benefit will include an out-of-pocket limit equal to one-third of the HSA current law limit. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of the HSA current law limit.

Explanation of Provision

This amendment would adjust the mark to more strictly limit total out-of-pocket costs (including both premiums and all other cost-sharing) for individuals who purchase coverage in the exchange. More specifically, it would limit total out-of-pocket spending to 7.5 percent for those under 200 percent of poverty ($44,050 for a family of four), 10 percent for individuals between 200 and 400 percent of poverty ($88,200 for a family of four), and 12.5 percent for all individuals above 400 percent of poverty.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #9 to America's Healthy Future Act

Rockefeller Amendment #C9 to Title I, Subtitle C (Making Coverage Affordable)

Short Title: Amend the indexing for premium credit.

Description of Amendment:

Chairman's Mark

Beginning in 2013, tax credits would be available on a sliding scale basis for individuals and families between 134-300 percent of FPL to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of FPL. The share of premium that enrollees pay would be held constant over time, and would therefore decrease in value to the eligible individual over time.

Explanation of Provision

This amendment would adjust the mark to hold constant the share of an individual's income that the premium credit subsidizes, so that the premium credit is always equal to between 3 and 13 percent of the eligible individuals' income.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #10 to America's Healthy Future Act

Rockefeller Amendment #C10 to Title I, Subtitle C (Making Coverage Affordable)

Short Title: Increase the actuarial value of benefits for plans offered in the exchange

Description of Amendment:

Chairman's Mark

Four benefit categories would be available: bronze, silver, gold and platinum. The bronze benefit package, which would represent minimum creditable coverage (MCC), would be equal to the actuarial value of 65 percent with an out-of-pocket limit up to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010) indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. The silver benefit package would have an actuarial value of 70 percent with the out-of-pocket limits for MCC. The gold benefit package would have an actuarial value of 80 percent with the out-of-pocket limits for MCC. The platinum benefit package would have an actuarial value of 90 percent with the out-of-pocket limits for MCC.

Explanation of Provision

This amendment adjusts the mark to reflect the following actuarial values for each plan offered in the exchange,:

Bronze: 76 percent

Silver: 82 percent

Gold: 87 percent

Platinum: 93 percent

These values reflect the values first offered for consideration by Chairman Baucus in his policy options paper published by the Committee on May 14, 2009.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #11 to America's Health Future Act

Rockefeller Amendment #C11 to Title I, Subtitle E (Creation of Health Care Cooperatives)

Short Title: Strike Health Care Cooperatives

Description of Amendment:

Chairman's Mark

The Chairman's mark authorizes $6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program.

Explanation of Provision

This amendment would strike all of Title I, Subtitle E.

There has been no significant research into consumer co-ops as a model for the broad expansion of health insurance. What we do know, however, is that this model was tried in the early part of the 20th century and largely failed.

There is a lack of consistent data about the total number of consumer health insurance cooperatives in existence today, and there have been no analyses of the impact of existing health insurance cooperatives on consumers.

All of the consumer health insurance cooperatives identified by the USDA and the National Cooperative Business Association (NCBA) operate and function just like private health insurance companies.

There have been no analyses of the regulatory structure for existing health insurance cooperatives. Consumer health insurance cooperatives are currently regulated by the states, and there have been no studies conducted to evaluate the consumer experience with them.

Health insurance cooperatives simply have not been proven to meet the policy goals of cost-containment, transparency, and innovation that a public plan option guarantees.

Rockefeller Coverage Amendment #12 to America's Healthy Future Act

Rockefeller Amendment #C12 to Title I, Subtitle F (Transparency and Accountability)

Short Title: Insurance transparency and oversight

Description of Amendment: Consumers cannot make meaningful health insurance choices if the details of coverage are obscure or if the definitions of key terms such as "hospitalization", "outpatient care", or "out-of-pocket limit" vary from plan to plan. The lack of health insurance transparency also contributes to administrative waste and complexity. More than half of health insurers do not provide physicians with the transparency necessary for an efficient claims processing system. A recent RAND Corporation study found that making it easier to get information about insurance products and simplifying the applications process would increase insurance purchase rates as much as modest subsidies. This amendment would add the language from the Informed Consumer Choices in Health Care Act (S. 1050) in order to:

- **Promote consistent standards for insurance information**, including standard definitions of key insurance terms to be used in descriptions of plan benefits, so that consumers can make "apples to apples" comparisons of coverage options.
- **Promote transparency in coverage by providing crucial data to consumers and health care providers**, such as covered benefits and cost-sharing, marketing and underwriting practices, claims payment policies and practices, and timeliness of claims payments.
- **Develop information resources, including "Coverage Facts" scenarios for health coverage** to improve the ability of consumers and group health plans to compare the coverage and value provided under different health plans.
- **Provide Health Insurance Consumer Assistance Grants** to consumer assistance organizations in each state, to assist consumers in solving problems and navigating health insurance coverage transitions.
- **Ensure accountability on existing federal minimum standards for health insurance,** such as those enacted by the Mental Health Parity Act, the Genetic Information Nondiscrimination Act, and HIPAA.

- **Create a new Office of Health Insurance Oversight** within the Department of Health and Human Services to administer accountability and transparency initiatives in coordination with state insurance regulators.

This amendment would also establish America's Health Insurance Trust to give consumers a voice in health insurance oversight. This nonprofit, consumer-driven organization will evaluate and give ratings to all health insurance products offered through the national health insurance exchange based on factors such as affordability, adequacy, transparency, consumer satisfaction, provider satisfaction, and quality.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #13 to America's Healthy Future Act

Rockefeller Amendment #C13 to Title I, Subtitle F (Transparency and Accountability)

Short Title: Insurance transparency and oversight

Description of Amendment:

Chairman's Mark

No provision.

Explanation of Provision

Implements the portions of Section 121 and 201 of America's Affordable Health Choices Act of 2009 (H.R. 3200) to establish a new independent federal agency, the Health Choices Administration, headed by a Commissioner, to issue regulations regarding private health insurance, oversee the Exchange, and administer premium and cost-sharing credits.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #14 to America's Healthy Future Act

Rockefeller Amendment #C14 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Elimination of state mandates

Description of Amendment:

Chairman's Mark

Effective January 1, 2014, Medicaid income disregards would no longer apply, and income would be measured based on modified adjusted gross income (MAGI) as defined in the state exchanges. An exception to this rule would be made for those groups that are eligible for Medicaid through another program, like foster children, low-income Medicare beneficiaries, and individuals receiving Supplemental Security Income (SSI), for whom existing income counting rules would continue to apply. Also, beneficiaries who were determined eligible prior to the change to MAGI will remain eligible until March 31, 2014 or their next redetermination date, whichever is later.

As part of the Medicaid expansion, all newly-eligible, non-pregnant adults would receive a benchmark benefit package consistent with section 1937 of the Social Security Act, which was passed as part of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). The benchmark and benchmark-equivalent packages would have to meet the requirements for minimum creditable coverage. For benchmark-equivalent plans, prescription drugs would be added to the list of benefits that must have the same actuarial value as the benchmark. Populations currently exempted from mandatory enrollment in section 1937 plans would remain exempted.

Explanation of Provision

This amendment would strike the language requiring states to implement section 1937 of the Social Security Act for all newly-eligible, non-pregnant adults. This amendment would also strike the language that eliminates Medicaid income disregards. In both instances, current law would continue to apply.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #15 to America's Healthy Future Act

Rockefeller Amendment #C15 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Providing a real choice for low-income populations to keep current Medicaid coverage.

Description of Amendment:

Chairman's Mark

Effective January 1, 2013, the Chairman's Mark would require states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered ESI if it is cost-effective to do so, consistent with current law requirements.

Beginning in 2014, individuals with income below 100 percent of the federal poverty level (FPL) would be eligible for Medicaid and remain ineligible for tax credits in the state exchanges. Non-elderly, non-pregnant adults between 100 and 133 percent of FPL would be able to "choose" between Medicaid and coverage through their state exchange. States would have to ensure that all children of parents who choose the state exchange coverage would continue to receive the benefits, including early and periodic screening, diagnostic, and testing (EPSDT) benefits, to which children are entitled under Medicaid.

Explanation of Provision

The Chairman's mark would result in a mandate on vulnerable populations to accept employer-sponsored insurance (ESI) if it is offered to them, regardless of whether or not it meets their health care needs. This means that vulnerable populations will not have the choice to keep the Medicaid coverage they have today. This amendment would strike the language requiring states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered ESI if it is cost-effective to do so. Current law would continue to apply.

The Chairman's mark would also place a huge burden on low-income individuals and families by requiring them to navigate between private insurance plans and Medicaid in order to piece together their coverage. The mark would also create a false choice for low-income populations, who would undoubtedly be pushed into inadequate and inefficient private coverage by states seeking to reduce their share of Medicaid expenditures. Private plans, including those offered in Medicare, have a long history of inadequately serving vulnerable, low-income populations. This amendment would provide cost-effective and comprehensive coverage to Medicaid-eligible populations by striking the language which offers a false choice between Medicaid and private coverage.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #16 to America's Healthy Future Act

Rockefeller Amendment #C16 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Increase Medicaid eligibility to 150% of poverty

Description of Amendment:

Include language consistent with the concepts included in Subtitle B, Section 141 (2) of S. 1679 to make individuals with income levels up to 150 percent of poverty eligible for Medicaid.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #17 to America's Healthy Future Act

Rockefeller Amendment #C17 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Countercyclical funding for states

Description:

Consistent with the GAO report entitled, *Medicaid: Strategies to Help States Address Increased Expenditures during Economic Downturn (GAO-07-97)*, this amendment would provide an automatic increase in the federal matching rate for the Medicaid program during periods of national economic downturn. The language is similar to the concept in S. 1377.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #18 to America's Healthy Future Act

Rockefeller Amendment #C18 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Addressing Medicare's liability to state Medicaid programs

Description: There is a long-standing partnership between the federal and state governments to supply both cash assistance and medical insurance to individuals with disabilities. The Social Security Administration (SSA) is responsible for administering both the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program for individuals with disabilities. The SSDI program is an insured program that provides benefits to individuals who have paid into the system and meet certain minimum work requirements. The SSI program, in contrast, is a means-tested program that does not have work or contribution requirements, but restricts benefits to aged, blind, and disabled individuals who have very limited income and assets. Persons in the SSDI program are eligible for Medicare, with states paying the Medicare Part B premiums for low-income beneficiaries dually eligible for state Medicaid benefits. Persons in the SSI program are categorically eligible for Medicaid.

Hundreds of thousands of individuals with disabilities have had their health care paid for by Medicaid when it was the legal responsibility of Medicare. Medicare's liability to the states is currently estimated to be nearly $4 billion, but the amount continues to grow as SSA corrects additional cases. This debt is the result of systemic errors over the past 30 years in determining eligibility for SSDI. The errors are acknowledged, and the Social Security Administration is in the process of correcting the cash insurance payments that were due to disabled individuals. Medicare's liability is also acknowledged by the trustees of the Medicare Trust Funds. However, the federal government has not acted to establish a means of satisfying Medicare's liability.

This amendment, which is similar to the concept in the SDW Liability Resolution Act of 2009 (S. 1111) would resolve Medicare's long-standing liability to state Medicaid programs by:

- Providing $4 billion in repayment funding to the states, to be appropriated from the Treasury (not the Medicare Trust funds). Resolving this federal debt would inject critical funds into state and local economies and help maintain state jobs.

- Requiring the Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS) to develop a payment methodology to reimburse states within six months of the bill's enactment.

- Outlining the specific factors to be considered in the development of the payment methodology, including the number of SDW cases in the state and the periods of Medicare eligibility of those cases; the non-federal share of Medicaid expenditures made for SDW cases; and such other factors that the Secretary, Commissioner, and states determine are appropriate.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #19 to America's Healthy Future Act

Rockefeller Amendment #C19 to Title I, Subtitle G (Role of Public Programs)

Cosponsor: Menendez

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Restore Medicaid for individuals who are lawfully present in the U.S.

Description: Ensures that individuals who are lawfully present in the U.S. and are otherwise eligible for Medicaid can secure coverage under Medicaid without a waiting period or other [sponsor-related] barriers.

Offset: Costs savings derived by ensuring legal immigrants have access to Medicaid and not the exchange.

Rockefeller Coverage Amendment #20 to America's Healthy Future Act

Rockefeller Amendment #C20 to Title I, Subtitle G (Role of Public Programs)

Part I – Medicaid Coverage For the Lowest Income Populations

Short Title: Repeal of the Deficit Reduction Act

Description:

This amendment would repeal Public Law 109-171.

Offset: This amendment saves money.

Rockefeller Coverage Amendment #21 to America's Healthy Future Act

Rockefeller Amendment #C21 to Title I, Subtitle G (Role of Public Programs)

Part II – Children's Health Insurance Program

Co-Sponsor: Senator Hatch

Short Title: Remove the Children's Health Insurance Program (CHIP) from the exchange

Description:

A full description of the amendment will be provided when it is offered.

Offset: Elimination of Title I, Subtitle E (Creation of Health Care Cooperatives)

Rockefeller Coverage Amendment #22 to America's Healthy Future Act

Rockefeller Amendment #C22 to Title I, Subtitle G (Role of Public Programs)

Part II – Children's Health Insurance Program

Short Title: Universal coverage for children

Description:

This amendment would achieve near universal coverage (with the exception of undocumented immigrant children) for children by building on what currently works for children, rather than replace the successful Children's Health Insurance Program (CHIP) program with a new and untested combination of tax credits and "wrap-around" coverage.

Specifically, this amendment would extend CHIP from September 30, 2013, through September 30, 2019, with additional funding as estimated by the Congressional Budget Office (CBO) as needed to provide for the changes to the program noted below. It would also strike the language in the Chairman's Mark on pages 46-47 that effectively ends how CHIP currently operates as of September 30, 2013 (CBO estimates that 14.1 million children and pregnant women will be covered by the program in 2013). The amendment would prevent that disruption in coverage and seek to make additional improvements to the program for children.

The amendment would do so and strive to obtain universal coverage for children who are U.S. citizens or legally resident immigrants with income below 300% of poverty by taking the following additional steps:

- Provide for the requirement of 12-month continuous eligibility for children in Medicaid and CHIP.
- Provide for the extension of the one-time funding for outreach and enrollment grants included in the Children's Health Insurance Program Reauthorization Act of 2009 CHIPRA, including the set-aside of 10% for outreach to Native American children, on an annual basis in the amount of $80 million annually to non-profit, community-based, and faith-based organizations as well as to states to cover the administrative costs of system and policy improvements that expedite enrollment and retention.
- Provide the Secretary the authority through the promulgation of regulations to further improve and streamline enrollment of children that have proven their income eligibility for Medicaid and CHIP through other means-tested programs and federal or state income tax records, along the general lines provided through Express Lane Eligibility under CHIPRA.

- The income disregards eliminated in Medicaid for adults in the Chairman's Mark would not apply to children. However, the Secretary shall modify income methodologies used to determine children's eligibility under Medicaid and CHIP so that that when families submit applications for health coverage subsidies to the Exchange, their children's eligibility for Medicaid, CHIP, and tax credits can all be determined, without any need for families to complete additional forms to establish Medicaid and CHIP eligibility.
- Families can be enrolled using federal income tax forms to identify their uninsured children and to request disclosure of their tax return information to determine their children's eligibility for subsidized coverage, including Medicaid, CHIP, and tax credits, as is provided in the Chairman's Mark for the tax credit on page 21. The Secretary shall develop eligibility methodologies and procedures that, as much as possible, eliminate the need for families to provide additional information, beyond that on the federal income tax return, before the children's eligibility for Medicaid and CHIP can be determined.
- Require the Secretary to evaluate the effectiveness of simplification strategies in use in Medicaid and CHIP programs, including electronic establishment or verification of income-eligibility and automatic renewals. The Secretary shall have the authority through the promulgation or regulations to disseminate the best practices in simplification if they are determined to be cost-effective, increase enrollment, reduce administrative costs, and lower error rates.
- Phase-in mandatory coverage of children through CHIP with full federal financing of the expansion population of 225% of poverty for all states in 2010, 250% of poverty in 2011, 275% of poverty in 2012, and 300% of poverty in 2013. The Secretary would be required to adjust state allocations annually to provide full funding to cover children in the expansions, defined as children with incomes between 200 and 300 percent of the federal poverty level (FPL). Also, as is provided for on page 43 of the Chairman's Mark for the Medicaid expansion population, between 2014 and 2018, the additional assistance to expansion states and other states would be adjusted downward and upward, respectively, so that in 2019 all states would receive the same level of additional assistance for covering children with incomes between 200 and 300 percent of FPL.

The Secretary would study and then submit a report to Congress by December 31, 2011, that would explore the feasibility and best options by which children enrolled in CHIP could, at their option, buy into family coverage in the exchanges or allow parents eligible for tax credits to use the credit to buy into coverage offered by CHIP. This could include requiring states to provide for the option of purchasing CHIP coverage through the state exchanges.

Nothing in this amendment would modify the restrictions that were included in CHIPRA to deny the possibility that undocumented immigrant children would be covered within either Medicaid or CHIP.

Background:

Much progress has been made in terms of coverage of our nation's children due in large part to the creation of CHIP on a bipartisan basis in 1997 and the gradual expansion of Medicaid to serve America's poorest children. An estimated 14.1 million children and pregnant women

will be enrolled in CHIP in 2013 and children will be very close to having obtained a standard of universal coverage at that time.

The Chairman's Mark would end this existing system of CHIP coverage, which has served children well. Instead, children would receive a combination of highly diverse health plans, offered through the exchange, supplemented with "wrap-around" coverage of services not covered by the exchange plans. In terms of out-of-pocket costs, wrap-around coverage would, in theory, give children the minimum legal requirements under the CHIP statute—but almost every state has gone far beyond these federal minimums in limiting children's out-of-pocket costs. The Chairman's Mark would thus cause a massive increase in copayments and deductibles for low-income children who currently receive CHIP, potentially endangering their access to essential care. Further, it is not clear how a single, statewide wrap-around could effectively dovetail with multiple, highly diverse benefits packages offered through the exchange. Most fundamentally, even if the wrap-around were strengthened to retain all current cost-sharing protections, and even if the problem of fitting a statewide wrap-around with diverse exchange plans could be overcome, rigorous research has never evaluated the adequacy of care that children receive from wrap-around arrangements. The proposed amendment would thus prevent millions of low-income children from having their current, successful health coverage upended in favor of a novel, untested system of fragmented coverage that is unsupported by any reasonable evidence of adequacy.

Rather than creating massive dislocation of coverage for 14.1 million children in 2013, the amendment would seek to, as President Obama has called for, "build upon what works." The amendment may even lower the cost of the bill, since per capita CHIP costs should be lower than exchange coverage plus the service and administrative costs of wrap-around benefits. The amendment would build on the successful coverage initiatives already in place for children and make four modifications/improvements to CHIP to ensure near universal coverage for children, fitting smoothly with broader health reforms proposed in the Chairman's Mark. This would be far more likely to serve children well than to repeal a program that has made such a dramatic improvement in children's coverage and access to essential health care during the 12 years since the initial enactment of CHIP.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #23 to America's Healthy Future Act

Rockefeller Amendment #C23 to Title I, Subtitle G (Role of Public Programs)

Part IV – Medicaid Services

Short Title: Require Medicaid managed care provisions to accept in-network payment rates

Description:

Currently out-of-network providers in Medicaid managed care can charge any rate and get reimbursed. Some hospitals and providers are taking advantage of this by refusing to be an in-network provider so they can get higher reimbursement. This leads to increased costs for both the plan and individuals, and leads to access problems if a covered individual is seeking in-network care. There is already Federal statute requiring all Medicare managed care providers to accept in-network rates and some states have instituted this policy as well. One managed care provider estimates this would save $2 billion over 10 ten years if enacted.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #24 to America's Healthy Future Act

Rockefeller Amendment #C24 to Title I, Subtitle G (Role of Public Programs)

Part IV – Medicaid Services

Short Title: Require the Department of Justice to do an annual evaluation of state compliance with federal Olmstead laws

Description:

The Supreme Court decision in Olmstead v. L.C. established that Title II of the Americans with Disabilities Act (ADA) requires states to transfer individuals with disabilities into community settings rather than institutions when 1) a state treatment professional has determined such an environment is appropriate, 2) the community placement is not opposed by the individual with a disability, and 3) the placement can be reasonably accommodated.

The Court also found that states maintain the right to argue that a "reasonable modification" for a person with physical or mental limitations who is able to live in a less restrictive setting would be a "fundamental alteration" of the program and therefore not required under the ADA. Even so, "fundamental alteration" arguments do not allow states to avoid targeted efforts to transfer qualified and willing individuals from institutional care to Home and Community-Based Services under Medicaid. At a minimum, states have to demonstrate an effective working plan with evidence of steady progress. But progress is uneven among states. The purpose of this amendment is to hasten that progress through regular state-specific assessments.

This amendment requires the Department of Justice (DOJ) to annually evaluate and issue a summary report to Congress of each state's compliance with Title II of the ADA as interpreted in the Olmstead decision. This report will include each state's status, progress, and plans in compliance. It will also include evaluations of "fundamental alteration" arguments as claimed by individual states or as anticipated by the DOJ. These findings will be reported to Congress at the end of each calendar year, starting calendar year 2010.

Additionally, these reports will include a recommended set of actions that states out of compliance can take to come into compliance. Reports will also include a recommended set of federal policy additions or changes that can be taken to facilitate compliance.

Offset: This amendment should have no scoring impact.

Rockefeller Coverage Amendment #25 to America's Healthy Future Act

Rockefeller Amendment #C25 to Title I, Subtitle G (Role of Public Programs)

Part VII – Dual Eligibles

Short Title: Improve the coverage and care-coordination for individuals eligible for both Medicare and Medicaid

Description:

This amendment would add provisions to the mark consistent with the concepts included in Section 101 of the Medicare Prescription Drug Coverage Improvement Act of 2009 (S. 1634).

Rockefeller Coverage Amendment #26 to America's Healthy Future Act

Rockefeller Amendment #C26 to Title I, Subtitle G (Role of Public Programs)

Short Title: Allow early retirees between ages 55 and 64 to buy into Medicare

Description of Amendment:

This amendment would add the option for early retirees between ages 55 and 64 to buy into Medicare using language consistent with the concepts included in the Medicare Early Access Act (S. 960).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #27 to America's Healthy Future Act

Rockefeller Amendment #C27 to Title I

Short Title: Addition of a new Subtitle J – Advance Care Planning and Compassionate Care

Description of Amendment:

This amendment would add language consistent with the concepts included in the Advance Planning and Compassionate Care Act of 2009 (S. 1150).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #28 to America's Healthy Future Act

Rockefeller Amendment #C28 to Title I

Short Title: Addition of a new Subtitle J – Advance Care Planning and Compassionate Care

Description of Amendment:

This amendment would add language consistent with the concepts included in Section 211 of the Advance Planning and Compassionate Care Act of 2009 (S. 1150).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #29 to America's Healthy Future Act

Rockefeller Amendment #C29 to Title II, Subtitle A (Prevention and Wellness: Medicare)

Short Title: Medicare benefit improvements

Description of Amendment:

This amendment would add dental, vision, and hearing coverage to the list of mandatory benefits for Medicare recipients.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Coverage Amendment #30 to America's Healthy Future Act

Rockefeller Amendment #C30 to Title II, Subtitle A (Prevention and Wellness: Medicare)

Short Title: Allowing patients to have more control over their own care

Description of Amendment:

This amendment would add advance care planning to the Medicare prevention and wellness risk assessment.

Offset: This amendment should save money.

Rockefeller Coverage Amendment #31 to America's Healthy Future Act

Rockefeller Amendment #C31 to Title I, Subtitle G (Role of Public Programs)

Part IV – Medicaid Services

Short Title: Clarifying the Definition of Medical Assistance

Description: This amendment would clarify the original intent of Congress that the term "medical assistance" as used in various sections of the Act encompasses both payment for services that are provided and the services themselves, by amending section 1905(a) of the Social Security Act (42 U.S.C. section 1396d(a)) by inserting "or the care and services themselves, or both" before "(if provided in or after)".

Offset: No offset is necessary. CBO has determined (provision for the House E&C Committee) that this provision does not produce any costs.

Conrad Amendment #C1 on Reducing Health Insurance Premiums

Short Title: Immediate Premium Relief in the Small Group Market

Description of Amendment:

This amendment would establish a $20 billion Federal Reinsurance Fund that would be available in the small group market prior to 2013. Specifically, $9 billion would be available in 2010, $7 billion in 2011, and $4 billion in 2012.

The Secretary of HHS would develop a prospective, limited list of 50-100 high-risk conditions (such as organ transplants, neonatal intensive care, cancer, accidents, etc.) eligible for reinsurance payments and specific dollar amounts that will be paid for each of those conditions.

The formula for reinsurance payments must be designed on a per condition basis or other comparable method that encourages use of care coordination and care management programs for high-risk conditions. The formula shall equitably allocate the available funds through year-end reconciliation.

Insurers that take advantage of the Federal Reinsurance Fund would be required to certify to the Secretary of HHS that they have reduced insurance premiums by an amount equal to the actuarial equivalent amount of the reinsurance payments.

Offset: TBD

Bingaman Amendment # C-1 to America's Healthy Future Act of 2009

Efficient and Effective Eligibility Determination

Summary:
The amendment establishes a coordinated system of eligibility determination for Medicaid, tax credits, and CHIP. This will prevent multiple subsidy programs from creating pointless red-tape for families, high administrative costs for government, erroneous eligibility decisions, and reduced program participation.

Score: Unknown, may be budget neutral or reduce costs.

Offset: A commensurate increase in the annual insurance fee.

Description:

The amendment directs the Secretary of Health and Human Services, working in conjunction with the Secretary of the Treasury, to establish a system of application, enrollment, and retention for Medicaid, CHIP and tax credits that meets the following requirements:

1. A single, streamlined form can be used to apply for all three subsidy programs (Medicaid, CHIP, and tax credits) with one exception: the Secretary is authorized to allow use of a supplemental or alternative form when individuals apply for a category of Medicaid eligibility that is not determined based on MAGI.
2. The form can be filed on line, in person, by mail, or by telephone.
3. The form can be filed with the Exchange, Medicaid, or CHIP.
4. After the form has been satisfactorily filed, the applicant, without any need to complete additional paperwork, receives a notice of his or eligibility for Medicaid, CHIP, and tax credits.
5. Exchanges and state Medicaid and CHIP agencies operate satisfactory systems to ensure a secure electronic interface sufficient to allow a determination of eligibility for all three programs based on the single, streamlined form (described above) or reliable third-party data (described below).
6. Whenever possible, reliable, third-party data (such as income reports from employers to State Workforce Agencies and income tax data) are used to establish, verify and update eligibility.
7. Taxpayers filing federal income tax returns may use such returns to apply for tax credits, Medicaid, and CHIP, if on such a return the taxpayer affirmatively authorizes disclosure of his or her tax return data to determine eligibility for subsidized health coverage. If data on the return is more recent than the information that would otherwise establish eligibility

for tax credits, the tax return information shall supersede the older information. [A similar provision was included as a state option using state income tax data in CHIPRA 2009].

8. To safeguard program integrity, the state exchanges will regularly engage in data matches with the Internal Revenue Service, the Social Security Administration, the National Directory of New Hires, the applicable State Workforce Agency, or any other source of data that, under current law, may be used to verify eligibility for Medicaid or CHIP. Data matches for this purpose shall be limited to individuals receiving tax credits (and, at state option, Medicaid or CHIP). When such data match show a change in income or other relevant household circumstances, eligibility for tax credits (and, at state option, Medicaid or CHIP) is automatically adjusted, with notice to the household.

To accomplish these goals, the Secretary may promulgate model agreements and enter into interagency agreements concerning data-sharing, consistent with safeguards of privacy and data integrity. Nothing in the legislation shall be construed to either (a) prevent the exchange and a state Medicaid agency from entering into a contract through which the latter agency determines eligibility for Medicaid, CHIP, and tax credits for state residents, so long as that contract meets requirements promulgated by the Secretary of HHS (after consulting with the Secretary of the Treasury) ensuring that such a contract lowers overall administrative costs and reduces the likelihood of eligibility errors and disruptions in coverage; or (b) change the requirement in current law that Medicaid eligibility must be determined by public agencies.

Bingaman Amendment # C-2 to America's Healthy Future Act of 2009

Protection for Children Receiving Health Insurance through Health Exchange

Summary:
Requires that health insurance provided through the health exchange is adequate to meet the needs of children including assurances that adequate processes have been established by state Medicaid agencies and exchanges to provide EPSDT wrap-around and cost-sharing protections.

Score: Unknown

Offset: If necessary, a commensurate increase in the annual insurance fee

Description:

This amendment requires the Secretary of Health and Human Services to establish by regulation requirements that must be met to ensure that health insurance offered in the new exchanges provides adequate benefits for children.

Specifically, the Secretary must ensure that:

- Coverage offered to children in the exchange is at least comparable to the level of benefits and cost-sharing (including premium, deductible, copayment, and out-of-pocket limits) as the national average state CHIP plan; and
- Insurance plans offered through the exchange and state Medicaid agencies have established adequate processes to ensure access to EPSDT wrap-around and cost-sharing protections (already included in the Chairman's Mark).

The requirements that must be met would be established by the Secretary through regulation. Before any state can eliminate existing Medicaid/CHIP eligibility for children and move them to the exchanges, the Secretary would be required to certify that the requirements have been met. If such a certification could not be made, the Maintenance of Effort requirements already included in the Chairman's Mark for Medicaid and CHIP coverage would be extended for children until the requirements have been met and the certification is provided. The Secretary would be

required to recertify the adequacy of benefits, cost-sharing, and wrap-around services for children every five years.

Background:

Currently, 31% of children in the country are covered by Medicaid and CHIP. The success of these programs in providing affordable coverage options to children can be seen in the latest Census data, which show that the uninsured rate for children has reached its lowest level in over two decades despite the difficult economic times. It is critical that health care reform build upon their successes, and that children are not inadvertently left worse off as a result of health care reform.

Under Medicaid, states are required to cover children five and under and pregnant women up to at least 133% of poverty under Medicaid. In addition, states must cover children age 6 through 18 up to 100% of poverty under Medicaid. They also have the option to expand Medicaid for children beyond these federal minimum levels, and 42 states have opted to do so.

CHIP covers children above a state's eligibility threshold for Medicaid. States may operate CHIP as an expansion of their Medicaid program, a stand-alone program, or some combination of the two approaches. As a result of CHIP and Medicaid, 31 states and D.C. now cover (or have adopted plans to cover) children at or above 250% of the federal poverty level (FPL). Twenty-two states cover children at 300% of the FPL or above.

Children covered under Medicaid are entitled to EPSDT services (early and periodic screening, diagnosis, and treatment). Through EPSDT, children receive comprehensive screening and preventive services, including immunizations. In States that operate CHIP through their Medicaid program, CHIP enrollees also receive EPSDT services. Children in Medicaid have little or no cost sharing. Federal law requires that children in CHIP have a 5% (of family income) aggregate cap on cost-sharing, though states routinely have opted to provide significantly stronger cost-sharing protections.

In most states, CHIP is currently a comprehensive benefit with affordable cost-sharing that does not need a wrap. The decision to effectively phase out the existing CHIP program and transform it into a supplement to insurance plans offered through the exchange presents an entirely new challenge. To avoid harm, before any child is moved to the exchange we must be certain that the

new structure is fully functional, including that the wrap will provide children with comparable benefit and cost-sharing protections, as well as ensure access to age-appropriate care, an adequate pediatric network, and culturally-competent providers.

Bingaman Amendment # C-3 to America's Healthy Future Act of 2009

Ensuring Children Receive Same Levels of CHIP Cost-sharing Protections after Reform

Summary: Requires states to provide the average level of CHIP cost-sharing provided by states.

Score: Likely nominal cost

Offset: If necessary, a commensurate increase in the annual insurance fee

Description:

The Chairman's Mark includes a requirement that states provide cost-sharing protections for children established in the CHIP program up to 250% of poverty. The Mark specifies that states would be required to provide existing Federal CHIP cost-sharing protections of five percent of family income. States generally provide higher cost-sharing protections in CHIP than the five percent floor. This amendment would require that states provide the average level of CHIP cost-sharing protections.

Bingaman Amendment # C-4 to America's Healthy Future Act of 2009

To Ensure that States Take Appropriate Action to Enroll Medicaid Expansion Populations

Summary:
Requires the Secretary of Health and Human Services to establish benchmarks tied to the receipt of enhanced federal payments for Medicaid expansion population.

Offset: Budget Neutral

Description:

The Chairman's Mark includes enhanced federal payments or "FMAP" for new expansion populations in Medicaid. This amendment would require the Secretary of Health and Human Services to establish:

1. Process benchmarks such as those included in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, including: express lane eligibility, 12-month continuous eligibility, elimination of asset tests/allow administrative verification of assets, no face-to-face interview, presumptive eligibility, etc.; and

2. Outcome benchmarks.

In order to receive an enhanced FMAP, states must meet either process or outcomes benchmarks established by the Secretary.

Bingaman Amendment # C-5 to America's Healthy Future Act of 2009

Ensuring access to Ombudsman Services

Summary:

Allows individuals to seek ombudsman services: (1) if their internal appeal lasts more than three months or (2) if their appeal involves a life threatening issue.

Cost: Budget Neutral

Description:

The Chairman's Mark requires states to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets. It authorizes policyholders "whose health insurers have rejected claims and who have exhausted internal appeals to be able to access the ombudsman office for assistance." This amendment would authorize a policy holder to access ombudsman services: (1) if their internal appeal lasts more than three months or (2) if their appeal involves a life threatening issue.

Bingaman Amendment # C-6 to America's Healthy Future Act of 2009

Provides for Alternative Income Documentation for Non-filers

Summary:
Clarifies that the Secretary of Health and Human Services will establish alternative income documentation that may be provided to determine income eligibility for individuals and families who have not filed a tax return in the prior tax year.

Offset: Anticipated to be budget neutral

Description:

Page 21 of the Chairman's Mark describes the use of IRS data to establish income eligibility for health care tax credits and Medicaid. This amendment clarifies that the Secretary of Health and Humans Services will establish alternative income documentation that may be provided to determine income eligibility for individuals and families who have not filed a tax return in the prior tax year.

Bingaman Amendment # C-7 to America's Healthy Future Act of 2009

Protection for Individuals Seeking an Affordability Waiver from Employer Sponsored Insurance

Summary:
Removes the requirement that individuals must "present" affordability waivers to employers.

Cost: Budget Neutral

Description:

As a general matter under the Chairman's Mark, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 13 percent of the employee's income. In such circumstances, the employee is required to seek an affordability waiver from the state exchange. Employees would then present the waiver to the employer. The employer assessment would apply for any employee(s) receiving an affordability waiver.

Since the employer assessment would apply under these circumstances, there is a concern that requiring an employee to submit a waiver to their employer may deter employees from seeking an affordability exception. This amendment would strike the requirement that an employee submit the waiver to the employer and require instead that the exchange provide the waiver directly to the employer.

Bingaman Amendment # C-8 to America's Healthy Future Act of 2009

Providing Health Insurance Enrollees with Additional Protections from Insurance Companies and Providing Flexibility in Benefit Design

Summary: Ensures that benefit categories described in statute are further defined by the Secretary of Health and Human Services to protect against insurance industry abuses in interpreting benefit categories. In addition, the amendment would allow the Secretary to vary benefit categories over time but within fiscal constraints.

Offset: Budget Neutral

Description:

The Chairman's Mark currently includes a list of benefit categories that must be included in insurance plans offered in the exchange (e.g., "preventative and primary care", "outpatient services", "emergency services", etc…,). However, the Mark does not provide further information about how such benefit categories will be interpreted by insurance companies. Thus, insurance companies would still have the ability to define categories in a manner that is inequitable for beneficiaries. This amendment would require the Secretary of Health and Human Services to provide through regulation further definition of the benefit categories. In addition, it would require the Secretary to certify that insurance plans offered through the exchange meet the benefit category definitions in regulation.

The amendment would also provide the Secretary with the authority to vary the list of required benefit categories over time. Such flexibility will allow the Secretary, for example, to adapt benefits provided in the exchange to advancements in medicine. However, such authority would be restricted by fiscal constraints provided for within the Chairman's mark and would not allow the Secretary to vary the actuarial value of the insurance plans.

The framework currently provides a list of required benefit categories. This list appears to be a "floor" of benefit categories available within the exchange and, therefore, eligible for subsidies. There does not appear to be a clear limit on the benefits (and therefore the total value of benefits) available for federal subsidies. This amendment would also limit the value of the scope of benefits that may receive subsidized coverage within the health insurance exchanges in the following ways:

1. Limits the value of the scope of benefits subsidized in the exchange to that of "a typical employer plan, as determined by the Secretary" and certified by the CMS Chief Actuary; and

2. Excludes state mandated benefits (which are not otherwise included in the required benefit package) from being considered in providing federal subsidies but require states to defray the cost of these non-federally subsidized mandates.

This protection was included in the Affordable Health Choices Act reported by the Senate HELP Committee.

Bingaman Amendment # C-9 to America's Healthy Future Act of 2009

Option for Single-source Eligibility Determination

Summary:

Allows exchanges to enter into contracts with Medicaid agencies in determining eligibility.

Offset: Budget neutral or possibly reduces spending

Description:

This amendment clarifies that exchanges and state Medicaid agencies may enter into a contract through which the latter agency determines eligibility for Medicaid, CHIP, and tax credits for state residents, so long as that contract meets requirements promulgated by the Secretary of HHS (after consulting with the Secretary of the Treasury) ensuring that such a contract lowers overall administrative costs and reduces the likelihood of eligibility errors and disruptions in coverage.

Background:

An important factor behind Massachusetts' success in covering 97% of state residents is that, through interagency agreements with the Connector and other state offices, Massachusetts' Medicaid agency determines eligibility for multiple subsidy programs, including Medicaid, CHIP, Commonwealth Care (the new subsidy for residents with incomes up to 300% of FPL created by 2006 legislation), the state's program for reimbursing uncompensated care provided by hospitals and health centers, and a state-funded program covering immigrant children ineligible for federal matching funds. This has lowered administrative costs, increased participation, and reduced errors.

Bingaman Amendment # C-10 to America's Healthy Future Act of 2009

Protections for New Medicaid Expansion Populations

Summary: Strikes "Section 1937" provisions, which would permit states to discriminate in providing benefits to new Medicaid expansion populations.

Cost: $8-10 billion

Offset: Commensurate increase in annual fee on health insurance providers.

Description:

The Chairman's Mark proposes to apply "Section 1937" benchmark coverage to new mandatory expansion populations, which includes parents and other adults. The Section 1937 policy was enacted as of the Deficit Reduction Act (DRA) of 2005 (which was passed on reconciliation with a 51:50 vote).

In general, Section 1937 allows states to offer a smaller benefit package (i.e., "benchmark") to specific groups of Medicaid beneficiaries. This directly contradicts the fundamental "statewideness" and "comparability of benefits" requirements that have existed in Medicaid for decades, which prevent states from distinguishing among beneficiaries with regard to benefit design (unless they have received a waiver from the federal government). Note that the expansion population is, by definition, among the poorest individuals in society. Section 1937 flexibility would likely be used by states to deny to this population optional Medicaid benefits such as transportation, mental health services, etc…, services of which this population may be most in need.

This amendment would strike from the Mark the application of Section 1937 provisions to the new Medicaid expansion population to ensure that states could not discriminate against this population in providing benefits. Note that states have a great deal of authority under current law to vary Medicaid benefits irrespective of Section 1937. This Amendment would not restrict the states ability to vary benefits under other Title XIX authority.

Bingaman Amendment # C-11 to America's Healthy Future Act of 2009

Ensuring Accuracy in providing health insurance tax credits and Medicaid eligibility

Summary:
Clarifies that individuals are permitted to update eligibility information for the purposes of receiving federal healthcare tax credits or Medicaid during the year due to a change in household circumstances within the limits established by the Secretary of Health and Human Services.

Score: Likely budget neutral

Offset: If necessary, a commensurate increase in the annual insurance fee.

Description:

Page 21 of the Chairman's Mark provides, "Individuals (or couples) who experience a change in marital status or experience a decrease in income of more than 20 percent can request a redetermination of their tax credit eligibility." This amendment clarifies that individuals are permitted to update eligibility information for the purposes of receiving federal healthcare tax credits or Medicaid during the year due to any change in household circumstances. For example, this change would permit a childless couple who has a baby or adopts a child to submit updated information because their household size increases from 2 to 3 people. Because household expenses rise, the federal poverty level of the household drops, even if income and marital status are unchanged and this couple could receive a larger health insurance tax credit. Similarly, the amendment would permit individuals whose income has increased to provide updated information to ensure that they do receive excess tax credits, which would have to be repaid. The amendment would also provide the Secretary of Health and Human Services with the authority to narrow the circumstances in which information may be updated to avoid unnecessary administrative expense (e.g., *de minimis* changes in income).

Bingaman Amendment # C-12 to America's Healthy Future Act of 2009

Ensuring Americans Have Access to Affordable Health Insurance

Summary:
Improves actuarial value of plans, cost sharing protections, and premium tax credits.

Cost: To be determined

Offset:

Proportionately increase the annual fees on health insurance providers; manufacturers and importers of branded drugs; manufacturers and importers of medical devices; and clinical laboratories in the Chairman's Mark by an amount commensurate with the cost associated with this amendment

Description:

This amendment would improve actuarial value of plans, cost sharing protections, and premium tax credits.

Bingaman Amendment # C-13 to America's Healthy Future Act of 2009

Ensuring Federal Fiscal Responsibility by Limiting the Value of the Benefit Package provided within the Health Exchange.

Summary:
Limits the value of the scope of benefits that may receive subsidized coverage within the health insurance exchanges.

Offset: Potential to reduce spending.

Description:

The framework currently provides a list of required benefit categories. This list appears to be a "floor" of benefit categories available within the exchange and, therefore, eligible for subsidies. There does not appear to be a clear limit on the benefits (and therefore the total value of benefits) available for federal subsidies. This amendment limits the value of the scope of benefits that may receive subsidized coverage within the health insurance exchanges in the following ways:

1. Limits the value of the scope of benefits subsidized in the exchange to that of "a typical employer plan, as determined by the Secretary" and certified by the CMS Chief Actuary; and

2. Excludes state mandated benefits (which are not otherwise included in the required benefit package) from being considered in providing federal subsidies but require states to defray the cost of these non-federally subsidized mandates.

This protection was included in the Affordable Health Choices Act reported by the Senate HELP Committee.

Kerry/Bingaman Amendment # C-1

Title I- Health Care Coverage
Subtitle D-Shared Responsibility
Employer-Provided Health Insurance Coverage

Short Description: Replace the Free Rider Provision with an Employer Mandate

Employers who do not offer insurance would be subject to an excise tax. An employer would be required to offer qualified coverage to full time employees and pay at least 60 percent of the monthly premiums. For an employer that does not offer coverage, the excise tax is $750 for each full time employee equivalent and the excise tax is $375 for each part-time employee. The amount of the excise tax will be pro-rated with respect to each month an employee is without coverage. The provision of this subsection exempts the first 25 employees. The amounts of the excise tax would be adjusted to CPI beginning in 2013.

The amendment strikes the provision requiring payments for employees receiving premium credits.

This amendment will not result in decreased revenue.

Kerry/Snowe/Schumer/Lincoln/Cantwell Amendment # C-2

Title I- Health Care Coverage
Subtitle C-Making Coverage Affordable
Amendment to Small Business Tax Credit Employer-Provided Health Insurance Coverage

Short Description: Modify the small tax business credit to allow non-profits to be eligible.

Non-profit entities that meet the eligibility requirements of the small business credit would be eligible to receive the credit.

An offset will be provided when the amendment is offered.

Kerry Amendment C-3

Title I- Health Care Coverage
Subtitle G- Role of Public Programs

Section: New Section: Medicaid Global Payments Demonstration Project

Description of Amendment: Would allow for the establishment of a "Medicaid Global Payments" demonstration project in those states that are currently providing premium assistance to low-income individuals through a Section 1115 waiver.

The Secretary shall, working through the CMS Innovation Center established under Part III, authorize a "Global Payments System" demonstration project in up to five states, under which a large, safety net hospital system serving a Medicaid, uninsured and subsidized low income population established under an existing Medicaid 1115 waiver in the state shall be allowed to move from a fee for service payment structure to a capitated, global payment structure for that population. Said demonstration shall be in effect for FY 10-12.

The Center would be required to conduct an evaluation of each project, including an analysis of the extent to which the project results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.
In order to facilitate the timely design, implementation, and evaluation of payment models by the Center, the Mark exempts the Center from budget-neutrality requirements for an initial testing period. The Center would be given the authority to terminate or modify the design of models at any time during a testing period.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-4

Title I- Health Care Coverage
Subtitle H- Addressing Health Disparities

Section: Privacy and Security
Short Title: Providing an Option for Medical Power of Attorney for Children Aging Out of Foster Care

Description of Amendment: Include the following provision to ensure children aging out of the foster system have the opportunity to designate a medical power of attorney prior to emancipation:

- as part of the transition process for children expected to age out of the foster system, states must supply information about and an opportunity for the child to designate another individual to make medical decisions on their behalf should they not be able to participate in such decision making process,
- the opportunity to designate an individual to make such decisions must be made in compliance with state law in the form of a health care power of attorney, health care proxy, or other such similar document as recognized by state law,
- the importance of designating another individual to make medical treatment decisions shall be incorporated into the curriculum of Independent Living Education programs for adolescents preparing to age out of the foster system.

This amendment will not result in increased cost.

Kerry Amendment C-5

Title III- Improving the Quality and Efficiency of Health Care
Subtitle B- Improving Medicare for Patients and Providers

Section: Ensuring Beneficiary Access to Physician Care and Other Services
Short Title: Medicare Patient Access to Home IVIG Treatment

Description of Amendment: Include the following provisions based on the Medicare Patient IVIG Access Act of 2009 (S.701):

- Amends Section 1842(o)(1)(E), which provides a home infusion benefit under Part B specific to beneficiaries with primary immunodeficiency diseases, to require coverage for related items and services.

- Requires the Assistant Secretary of Planning and Evaluation (ASPE) to:

  (1) collect data and review available data, including and updating the February 2007 ASPE report entitled "Analysis of Supply, Distribution, Demand and Access Issues Associated with Immune Globulin Intravenous (IGIV)", on the differences, if any, between payment to physicians and hospital outpatient departments for immune globulins under the Medicare program and the costs incurred by physicians and hospital outpatient departments for furnishing these products;
  (2) collect data or review existing data from providers related to the practice of IVIG infusion and report to Congress regarding which of the current infusion complexity codes is most appropriate for IVIG; and
  (3) conduct an analysis of the appropriateness of implementing a new methodology for payment for IVIG and of the feasibility of reducing the lag time with respect to data used to determine the average sales price and report to Congress recommendations for legislative and administrative action.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-6

Title I- Health Care Coverage
Subtitle B-Exchange and Consumer Assistance

Section: State Exchanges and Marketing Requirements
Short Title: Building a Successful Public/Private Partnership to Assist Exchanges

Description of Amendment: Exchanges shall have the choice to enter into an agreement with a Sub-Exchange, a state or regionally incorporated and governed organization with demonstrated experience in the small business and non-group health insurance and benefit market. A Sub-Exchange shall not be owned or controlled by a health insurance issuer.

Sub-Exchange responsibilities would include, but not be limited to, marketing and sale of health insurance products offered by the Exchange, enrollment activities, broker relations, customer service, customer education about reform, premium billing and collection, member advocacy with health insurance plans, maintain call center support, determine/audit eligibility. A Sub-Exchange may charge an additional fee to be used only to pay for additional administrative and operational expenses of the Sub-Exchange.

Amendment will be offset by closing corporate tax loopholes.

Kerry/Stabenow Amendment C-7

Title I- Health Care Coverage
Subtitle A-Insurance Market Reforms

Section: Pooling Requirements for Individual and Small Group Markets
Short Title: Reinsurance for Early Retirees

Description of Amendment: A new reinsurance program for early retirees would be created at HHS. The reinsurance program shall begin immediately and apply only to employer-sponsored retiree coverage. As determined by the Secretary, eligible coverage must offer "appropriate coverage" for a mature population between 55 and 64; offer preventative benefits; have demonstrated programs to generate cost-savings for those with chronic and high-cost conditions; and can show actual cost of medical claims.

Under the program, the government would reimburse any eligible employer or insurer that applies for the reinsurance. It would structure the reinsurance as a risk corridor that begins at $15,000 and ends at $90,000, with the reinsurance covering 80 percent of claims in this range. The thresholds would rise each year based on the Medical Care Component of the CPI-U, rounded to the nearest multiple of $1,000. It would reinsure only the claims for individual between the ages 55 to 64 year old who are not active workers nor dependents of active workers and who are not Medicare-eligible.

The Secretary shall have such sums as necessary to implement this policy up to $10 billion. The Secretary has the authority to stop taking applications to comply with this funding limit.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-8

Title I- Health Care Coverage
Subtitle B-State Exchanges and Consumer Assistance
Section: State Exchanges and Marketing Requirements

Short Title: Empowering State Exchanges to be Prudent Purchasers

Description of Amendment: This amendment would allow the state exchanges to engage in prudent, selective purchasing of insurance. Exchanges could negotiate with plans for lower bids, encourage plans to form select networks, and exclude plans that do not offer good value and cost-effectiveness. The state exchanges shall be required to offer all nationally licensed health plans that are (a) available in its own state and in states covering at least 90% of the US population and (b) reasonably price/value competitive with other plans selected by the exchange. States shall develop policies to encourage the participation of Medicaid managed care organizations in the Exchange that are comparable in quality and networks to other plans.

Savings from the amendment will be used to improve the premium subsidy in future years.

Kerry/Menendez Amendment C-9

Title I- Health Care Coverage
Subtitle C-Making Coverage Affordable
Section: Health Care Affordability Tax Credits

Short Title: Making Health Coverage More Affordable to Low- and Moderate-Income Individuals and Families

Description of Amendment: This amendment would make the premium tax credits more affordable. The credits would be based on the percentage of income the cost of premiums represents, rising from one percent of income for those at 100 percent of poverty to 10 percent of income for those at 300 percent of poverty. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual‘s share of the premium at a flat 10 percent of income.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-10

Title I- Health Care Coverage
Subtitle C-Making Coverage Affordable
Section: Health Care Affordability Tax Credits

Short Title: Ensuring that Premium Tax Credits Continues to Make Health Insurance Affordable

Description of Amendment: This amendment would replace the indexing of the premium contribution levels for individuals and families between 100 percent and 400 percent of the federal poverty level and instead maintain the premium contribution levels defined as a percentage of income required in 2013 for 2014 and subsequent years.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-11

Title I- Health Care Coverage
Subtitle G-Role of Public Programs
Section: Medicaid Program Payments

Short Title: Adjustment to FMAP Language to Include Individuals Covered Under Section 1115 Waivers.

Description of Amendment: The amendment would define "newly eligible" as a (1) non-elderly, non-pregnant individuals below 133 percent of FPL who were not previously eligible for a full or benchmark benefit package under the Medicaid State Plan, or (2) who were eligible for such a package through a capped waiver but were not enrolled, as of the date of enactment. For services provided to existing State Plan eligibility groups, the Federal and state governments would share in the costs as established under the FMAP formula

Amendment will be offset by closing corporate tax loopholes, if necessary.

Kerry Amendment C-12

Title I- Health Care Coverage
Subtitle C-Making Coverage More Affordable
Section: Benefit Options

Short Title: Creating an Open, Transparent, and Inclusive Process for Establishing Benefit Standards

Description of Amendment: The Secretary would establish standards for the required benefits, including the covered items, treatments, and services within the categories of benefits. Standards would be developed through a transparent and public process that allows for public input, including public comment periods. The Secretary would allow some flexibility in plan design but shall ensure plan design does not encourage adverse selection.
A temporary commission would be created to advise the Secretary in the development of a definition of items, treatments, and services.

In preparation for making recommendations to the Secretary, the Commission would be charged with reviewing and analyzing the benefits offered under typical employer-sponsored health plans and State benefit mandates. The Commission would consider the clinical appropriateness, effectiveness and affordability of the benefits covered; the financial protection of enrollees against high healthcare expenses; access to necessary healthcare services, including primary and preventive health services; existing State benefit mandates; and the potential of additional or expanded benefits to increase costs. The Commission membership would consist of experts in actuarial science and health plan benefit design, as well as representatives of key health care stakeholders, including consumer and patient advocates. The Commission will also adopt procedures to receive public input from any interested party.

Not later than 1 year after the date of enactment, the Commission would submit a report to the Secretary and Congress containing a detailed statement of its recommendations, findings, and conclusions. Following submission of the report the commission would cease operation. The Secretary would publish the report in the Federal Register and post it on an appropriate Internet website.

The Secretary would review the items and services covered by plans in the individual and small group market no less than annually, and provide a report to Congress and the public that assesses: (1) whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost and (2) whether the benefits covered need to be updated or modified to account for changes in medical evidence or scientific advancement. The Secretary would provide information on how benefits will be modified to address any gaps in access or changes in the evidence base.

This amendment will not result in increased cost.

Kerry Amendment C-13

Title I- Health Care Coverage
Subtitle F-Transparency and Accountability
Section: Health Insurance Consumer Assistance Grants

Short Title: Community Based Outreach for Fishermen, Farmers, and Ranchers

Description of Amendment: Grantee organizations may include commercial fishing organizations, ranching and farming organizations, and other organizations capable of conducting community based health care outreach and enrollment assistance for hard to reach and rural workers.

This amendment will not result in increased cost.

Kerry/Hatch Amendment C-14

Title I- Health Care Coverage
Subtitle B-State Exchanges and Consumer Assistance
Section: Establishment of State Exchanges

Short Title: Religious Non-Discrimination in Health Care

Description of Amendment: There shall be a requirement that there be non-discrimination in health care in a manner that, with respect to an individual who is eligible for medical or surgical care under a qualified health plan offered through a State Exchange, prohibits the Administrator of the State Exchange, or a qualified health plan offered through a State Exchange, from denying such individual benefits for religious or spiritual health care, except that such religious or spiritual health care shall be an expense eligible for deduction as a medical care expense as determined by Internal Revenue Service Rulings interpreting section 213(d) of the Internal Revenue Code of 1986 as of January 1, 2009.

This amendment will not result in increased cost.

Kerry Amendment C-15

Title I- Health Care Coverage
Subtitle A-Insurance Market Reforms

Section: Rating Rules in the Individual Market
Short Title: Narrow the Age Rating Band

Description of Amendment: The amendment will replace the 5:1 age rating band in the Chairman's Mark with a 2:1 age rating band. Taking together all permissible risk factors, premiums within a family category could not vary by more than a 3:1 composite ratio.

This amendment will not result in increased cost.

Kerry Amendment C-16

Title I- Health Care Coverage
Subtitle G- Role of Public Programs

Section: Long Term Services and Supports
Short Title: Improved Access to Home and Community Based Services Under Medicaid

Description of Amendment: Include the following provisions from the Empowered at Home Act (S. 434) which expand access to home and community based services under Medicaid:

- allow states to seek approval from the Secretary of HHS to offer additional services under the Medicaid Home and Community Based-Services State Plan Amendment option;
- allow states under the State Plan Amendment option to provide home and community-based services to persons with income above 150% of the federal poverty level, but no greater than 300% of the Supplemental Security Income (SSI) level (placing it on-par with nursing home and home and community-based services waiver eligibility criteria;
- protect against spousal impoverishment in all Medicaid Home and Community-Based Services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents on Medicaid; and
- allow states to exclude up to 6 months of average cost of nursing facility services from assets or resources for purposes of eligibility for home and community-based services.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-17

Title III- Improving the Quality and Efficiency of Health Care
Subtitle C- Medicare Advantage

Section: Medigap
Short Title: Expand Access to Medicare Advantage for ESRD Patients

Description of Amendment: Include the provision from the Equal Access to Medicare Options Act (S.1669) which allows ESRD beneficiaries to enroll in Medicare Advantage plans.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment C-18

Title III- Improving the Quality and Efficiency of Health Care
Subtitle C- Medicare Advantage

Section: Medigap
Short Title: Expand Access to Medigap for Individuals with Disabilities and ESRD

Description of Amendment: Include the provision from the Equal Access to Medicare Options Act (S. 1669) which requires the guaranteed issue of Medigap policies to those with disabilities and ESRD beneficiaries.

Amendment will be offset by closing corporate tax loopholes.

Kerry/Schumer Amendment C-19

Title I- Healthcare Coverage
Subtitle A- Insurance Market Reforms

Section: National Plans
Short Title: Protecting State Consumer Protections

Description of Amendment: Strikes the provision to create national plans offered across state lines.

This amendment will not result in increased cost.

Lincoln Amendment #C1 to The America's Healthy Future Act

Short Title: To strike the provision in the Chairman's Mark that would allow for multiple exchanges operating in the same state.

Description of Amendment:

The Chairman's Mark includes the following provision, which this amendment would strike:

> ***"Multiple Exchanges.*** After states adopt Federal rating rules and the exchange is functional for at least three years, states could permit other entities to operate an exchange — but only if it met specified requirements, and subject to approval by the Secretary."

The health exchange model provides a "one stop shop," or marketplace, through which people can shop for health insurance products from a wide array of options. The Secretary or state insurance commissioner as described in the Chairman's Mark, would perform a number of functions, including standardizing the enrollment application for eligible individuals and small businesses seeking health insurance through the state exchange, whether done electronically or on paper; providing a standardized format for presenting insurance options in the state exchange, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers); developing standardized marketing requirements; operating a call center to provide consumer assistance; providing a tax credit calculator so individuals and small businesses can determine their true cost of coverage; informing individuals of eligibility for public programs; establishing procedures for appeals of eligibility decisions for subsidies; and other critical responsibilities.

Some people suggest that multiple exchanges would increase competition. However, having only one exchange in each state through which many insurers can offer their plans already does foster competition between plans which should help to lower costs and improve quality. Having multiple exchanges would add layers of complexity that are simply not necessary. Choosing a health insurance plan is complex, and a health insurance exchange provides one reliable portal which helps to streamline that decision into one location.

Without allowing for multiple exchanges, the Chairman's Mark would still allow state-based exchanges to contract with private entities on a competitive basis to perform functions of the exchange, such as a call center, if they wish. This should address the concern of ensuring there is competition for quality services provided by the exchange.

Offset: To be determined

Lincoln Amendment #C2 to The America's Healthy Future Act

Short Title: Modification of Small Business Tax Credit Wage Threshold

Description of Amendment:

Chairman's Mark

Employers whose employees have average annual full-time equivalent wages from the employer of less than $20,000 would qualify for the full credit. The credit would phase out for an employer for whom the average wages per employee is between $20,000 and $40,000 at a rate of five percent for each $1,000 increase of average wages above $20,000.

Proposed Change

This amendment would modify the Chairman's Mark so that employers whose employees have average annual full-time equivalent wages from the employer of less than $30,000 would qualify for the full credit. The credit would phase out for an employer for whom the average wages per employee is between $30,000 and $40,000 at a rate of five percent for each $500 increase of average wages above $30,000.

A revenue offset will be provided when the amendment is offered.

Lincoln Amendment #C3 to The America's Healthy Future Act

Short Title: Seasonal Worker Exclusion

Description of Amendment:

Chairman's Mark

For purposes of the small business tax credit, a qualified small employer would be an employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's taxable year. An employer's FTEs would be calculated by dividing the total hours worked by all employees during the employer's tax year by 2080.

For purposes of shared responsibility payments, all employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through the exchange.

Proposed Change

This amendment would exclude hours worked by seasonal workers from calculation for small business tax credit eligibility. It would also provide for an exclusion of seasonal workers from shared responsibility payments if: (1) the employer's workforce exceeds 50 employees for 120 days or fewer during the calendar year; and (2) the employees employed during that 120 day period were seasonal workers.

A seasonal worker is defined as an individual who performs labor or services on a seasonal basis where, ordinarily, the employment pertains to or is the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year.

A revenue offset will be provided when the amendment is offered.

Wyden Amendment #C1 to the Chairman's Mark of America's Healthy Future Act of 2009 Title I Subtitle A

Short Title: To ensure affordable access to health insurance exchange plans for all Americans

Description:

This amendment adds the following to the Chairman's Mark.

This amendment gives every American the ability to either choose to keep the coverage they have or pick a plan that works better for them and their family. It guarantees both choice and portability by creating a path for employers to insure their workers through the state-based insurance exchange. This amendment also recognizes that employers play an important role in ensuring that their employees have health coverage and gives employers a choice in how they fulfill that role. This amendment honors President Obama's pledge that everyone can keep the coverage they have while making it possible for individuals and families who don't like their current coverage to get a good quality, affordable alternative at an insurance exchange.

Employer Coverage Options: Under this amendment, employers that offer group health coverage meeting the minimum requirements under the Act would have the following options:

1. The employer would offer all individuals eligible for coverage under their plan a voucher equal to the amount that the employer would pay for their coverage under the plan that they sponsor. These workers would have the choice to:

- Forfeit the voucher to take the health plan offered by employer; or

- Decline the employer plan and use the voucher to take coverage through the local exchange. If workers select a plan that costs less than the voucher amount, they can keep the unspent amount as cash.

2. The employer can offer two or more health plans where at least one has a premium that is less than or equal to the average of the premiums for the two lowest cost "gold level" health plans in the area exchange. The amount of the employer contribution must be the same regardless of the plan selected by the worker. If the employer contribution amount exceeds the premium for the lower cost health plan, the worker retains the difference as cash.

Tax Treatment of Benefits: Under both approaches, the employer contribution for health insurance, including the voucher amount, is exempt from taxation except to the extent that they do not exceed the employer tax exclusion caps under the Act (i.e., $8,000 individual, $21,000 family). However, if the voucher amount exceeds the cost of insurance purchased in the exchange, the difference is taxable income to the employee. The employer will continue to be able to deduct the full amount of their costs including voucher payments.

Risk Adjustment: All employers electing the voucher option would be required to participate in a reinsurance pool encompassing the plan offered by the employer and the plans in the exchange. The

reinsurance is fully funded with an assessment applied uniformly to affected employers and exchange plans. Employers that decide to offer a choice of plans rather than offer vouchers are exempt from participation in the reinsurance pool.

More Choice for Workers: Workers who don't like their employer plans can choose to go to the exchange and choose any plan available through the exchange. If their employer currently provides health coverage, the workers will get a voucher equal to the money their employer currently pays to help pay the cost of an exchange plan. The voucher amount would be excluded from the employee's income and the cost of the voucher would be deductible by the employer. If the workers choose a plan that costs less than they have currently, they get rewarded with extra money in their pockets.

More Choice for Employers: Employers also have more choices: they can give their workers the ability to buy health coverage in the exchange or bring their entire group to the exchange and get a discount. This choice could be phased in for the mid-sized and large employers over a few years after the exchange gets going.

Employers with good health plans will be able to maintain their plans because they will offer their workers better value. Employers with high cost, low value plans can cut their costs by letting their workers go to the exchange.

Cost Containment: The plan would reward consumers for selecting more efficient lower cost plans by enabling them to retain the full amount saved by electing a lower-cost option.

Transition to the Free Choice System

Year 1— People who are currently in the individual market plus small employers with up to 25 workers and the uninsured have access to the exchange.

Year 2-- Add employers with up to 100 workers to the exchange.

Year 3 – Open exchanges to all employers.

Offset: The Lewin Group has estimated that the Free Choice proposal would reduce national health spending by $360 billion over the next 10 years and this reduced health spending would reduce the amount of revenue foregone through the health tax exclusion by $129.8 billion over that 10-year period. Thus, the amendment should raise revenue. It should complement and enhance the "stick" provided by the excise tax on high cost plans by providing a "carrot" to encourage selection of low cost, high value plans.

Wyden Amendment #C2 to the Chairman's Mark of America's Healthy Future Act of 2009 Title I Subtitle C Section "Health Care Affordability Tax Credits"

Short Title: To increase low-income subsidies to 400% of the Federal Poverty Level and lower cost-sharing

Description:

Without access to affordable health care coverage either through the employer based system or an insurance exchange, millions of Americans may continue to be uninsured or underinsured. Affordable health care coverage is also a necessary component to make sure that the insurance market reforms such as an individual mandate and guarantee issue work. Without all Americans in the health insurance system, there will continue to be problems with adverse risk selection and cherry picking.

Replacing the language in the Chairman's mark on low-income subsidies with a 400% FPL upper limit to the sliding scale would ensure affordability of coverage, help to reduce the number of uninsured in the country, and protect the interest of American families, particularly in harsh economic times. Additional revenues from the offset shall go toward lowering out of pocket costs for individuals between 200% and 400% of the Federal Poverty Level.

Offset: Tax revenues related to Internet gaming authorized to be collected under the Internet Gambling Regulation, Consumer Protection and Enforcement Act (H.R. 2267) or similar legislation authorizing such activities.

Wyden Amendment #C3 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle C

Short Title: Exchange Plans As Good As Members of Congress

Description:

This amendment adds the following to the Chairman's Mark.

All states must ensure that there are available in every exchange plans that are actuarially equivalent to the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C4 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle A

Short Title: Seamless Portability: Exchange Plans for Life.

Description: Under the Chairman's Mark, a person who goes in and out of the job market will have to change insurance plans multiple times. After losing a job, a person may go to the exchange and receive a low-income subsidy. Then if she gets a new job that offers what is defined as "affordable" coverage, she has to change plans yet again.

This amendment adds language to the Chairman's Mark that would **allow people to keep their exchange plans indefinitely**.

Employers that offer coverage will be required to offer every new employee who has an exchange plan a tax-free voucher worth at least 70% of the average of the three lowest cost plans in the exchange. Workers with vouchers will not be eligible for the low-income subsidies in the exchange.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C5 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle A

Short Title: Seamless Portability – No Need for COBRA

Description: To amend the State Exchange and Marketing Requirements and Health Care Affordability Tax Credits sections of the Mark to assist Americans who have lost their employment, particularly due to the recent economic recession. Application for unemployment insurance is to be considered as qualifying as a "change in circumstance" that allows Health Care Affordability Tax Credits to be reassessed, not having them based simply on the prior year's Federal income tax return. The amendment will also to require that the Secretary and/or states come up with guidelines on how to use unemployment insurance applications as part of an automatic enrollment process for Health Care Affordability Tax Credits. As in all other cases, income eligibility will be reconciled retrospectively on the individual's forthcoming Federal income tax return.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C6 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle C

Short Title: Equal Access to Congressional Health Benefits for Working Families to Guarantee Affordability

Description: The amendment would allow all individuals who meet the requirements of the bill to be exempted from the personal responsibility requirement for health insurance to purchase any health plan offered through the Federal Employees Health Benefit Plan in their region. For workers who are offered coverage through their employer where the employee contribution exceeds 10% of the employee's AGI the employer must provide their contribution to the employee's health benefits in the form of a voucher which may be used to purchase any FEHBP plan offered in their region. Individuals would be included in the existing risk pool that includes all federal employees including Members of Congress. Individuals eligible under this amendment shall not receive premium subsidies from the FEHBP except as provided by their employer voucher. Certification that an individual is exempt from the personal responsibility requirement or the receipt of a premium notice that would exceed 10% of previous year's income will be a qualifying event for purposes of FEHBP enrollment. OPM, in consultation with HHS shall establish a national exchange to connect eligible workers with the FEHBP system. All revenues from the Administrative fee for non-government enrollees shall go to the management of the non-government exchange. .

Offset: This amendment will not result in increased cost.

Wyden Amendment #C7 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle A

Short Title: Slashing Administrative Costs of Health Insurance

Description:

This amendment adds the following to the Chairman's Mark.

All insurance companies offering plans in the individual, small, and large group markets that have not been grandfathered will have to abide by an 85% minimum loss ratio, meaning that of total costs, 85% must be spent on delivery of medical care. The Secretary is directed to include profits in administrative costs, and to exclude the cost of coordinating care, particularly in chronic care management services. The Secretary of Health and Human Services will define what other costs are defined as administrative costs.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C8 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle A

Short Title: Empowering States to be Innovative

Description:

This amendment adds the following to the Chairman's Mark.

A State may be granted a waiver if the state applies to the Secretary to provide heath care coverage that is at least as comprehensive as required under the Chairman's Mark. States may seek a waiver through a process similar to Medicaid and CHIP. If the State submits a waiver to the Secretary, the Secretary must respond no later than 180 days and if the Secretary refuses to grant a waiver, the Secretary must notify the State and Congress about why the waiver was not granted.

a) IN GENERAL.—A State that meets the requirements of this Act such that all residents have affordable, quality insurance coverage shall be eligible for a waiver of applicable Federal health-related program requirements.
b) ELIGIBILITY REQUIREMENTS.—A State shall be eligible to receive a waiver under this section if—
(1) the State approves a plan to provide health care coverage to its residents that is at least as comprehensive as the coverage required under an exchange plan;
(2) the State approves a plan that will ensure all residents have coverage; and,
(3) the State submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a comprehensive description of the State legislation or plan for implementing the State-based health plan.
(c) DETERMINATIONS BY SECRETARY.—
(1) IN GENERAL.—Not later than 180 days after the receipt of an application from a State under subsection (b)(2), the Secretary shall make a determination with respect to the granting of a waiver under this section to such State.
(2) GRANTING OF WAIVER.—If the Secretary determines that a waiver should be granted under this section, the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.
(3) REFUSAL TO GRANT WAIVER.—If the Secretary refuses to grant a waiver under this section, the Secretary shall—
(A) notify the State involved of such determination, and the reasons therefore; and
(B) notify the appropriate committees of Congress of such determination and the reasons therefore.
(d) SCOPE OF WAIVERS.—The Secretary shall determine the scope of a waiver granted to a State under this section, including which Federal laws and requirements will not apply to the State under the waiver.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C9 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I Subtitle A

Short Title: To limit insurance rating based on age in the individual and group markets.

Description:

The chairman's mark allows age rating up to 5:1. This means that a 55 year old could be charged five times the premium than a 20 year old. The policy of allowing age-rating makes health coverage unaffordable for older individuals. Successful risk pooling will allow risks to be spread across populations and community rating would result in administrative ease, due to the fact that everyone in a health plan would be charged the same premium.

Replace the language in the Chairman's mark that allows age rating on a 5:1 scale with a limit on age rating of no more than 2:1.

Offset: Allow increased the limit on variation of premiums for tobacco use to be increased as necessary.

Wyden Amendment #C10 to the Chairman's Mark of America's Healthy Future Act of 2009

Short Title: Expanding States Access to Home and Community-Based Care

Description:

If a State decides to do a waiver similar to the Vermont waiver which allows individuals to have access to home and community based services, so long as the State meets criteria specified, the State may automatically implement the program. See section 311 in the Healthy Americans Act.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C11 to the Chairman's Mark of America's Healthy Future Act of 2009 Title I, Subtitle G, Part 4

Short Title: Helping States with Extraordinary Long Waiting Lists for Medicaid

Description: To clarify that Medicaid beneficiaries in states with waiver-approved waiting lists will be considered "newly eligible" and will qualify for additional Federal financial assistance.

Offset: This amendment will not result in increased cost.

Wyden Amendment #C12 to the Chairman's Mark of America's Healthy Future Act of 2009

Short Title: Employer Fair Share Contribution

Description: The "Employer Offer of Health Insurance Coverage" section of Subtitle D of Title 1 of the Chairman's Mark does not require employers to offer insurance. It only requires a financial penalty for employers whose workers receiving low-income "Health Care Affordability Tax Credits." This could result in bias for hiring low-income workers.

This amendment strikes and replaces the "Employer Offer of Health Insurance Coverage" provision with an employer responsibility payment for employees failing to offer at least minimal credible coverage.

Replace "Employer Offer of Health Insurance Coverage" and "Required Payments for Employees Receiving Premium Credits" sections of Subtitle D of the Chairman's mark with the following:

Every employer must make an employer shared responsibility payment (ESR) for each calendar year in the amount equal to the number of full time equivalent employees who are not offered coverage by the employer during the previous year multiplied by a percentage of the average lowest cost plan premium amount on the exchange. The first 25 full-time equivalent employees will be excluded from this requirement. The percentage used is determined by size and revenue per employer.

Once in effect, the percentages employers would pay are:

Large employers:

0-20th percentile 17%

21st - 40th percentile 19%

41st - 60th percentile 21%

61st-80th percentile 23%

81st-99th percentile 25%

Small employers:

0-20th percentile 2%

21st - 40th percentile 4%

41st - 60th percentile 6%

61st-80th percentile 8%

81st-99th percentile 10%

At the beginning of each calendar year, the Secretary in consultation with the Secretary of Labor shall publish a table based on a sampling of employers to be used in determining the national percentile for revenue per employee amounts.

Offset: This amendment will result in savings to the Federal government.

SCHUMER # C1

Schumer Amendment #C1 to Title I, Subtitle E-

Short Title: Level Playing Field Public Option

Description of Amendment:

Strike Title I, Subtitle E, Health Care Cooperatives and replace with a national "level playing field" public health insurance option with negotiated reimbursement rates to enhance competition for consumers within the Exchange.

The new national level playing field public option must adhere to the same rules (actuarial reporting, community rating and guaranteed issue) as all other plans in the Exchange and must be self-sustaining with premiums and copayments covering claims. Like private plans, the "level playing field" public option would also be required to establish a reserve fund. Aside from covering some initial start-up costs, general revenues or annual appropriations may not support the ongoing operation of the plan.

The government must not use existing programs like Medicare as a stick to compel providers to participate in the public option. Instead, doctors and hospitals should be able to voluntarily opt-in to participate in the public option.

Offset:

Increase annual fee on for-profit health insurance providers by amount necessary to offset the increase in spending.

SCHUMER-CANTWELL # C2

Schumer-Cantwell Amendment #C2 to Title I, Subtitle E-

Short Title: Public Option as passed by HELP Committee

Description of Amendment:

Strike Title I, Subtitle E, Health Care Cooperatives and replace with public option proposal included in the Senate Health, Education, Labor, and Pensions Committee:

The Secretary will establish a community health insurance option that complies with the health plan requirements established by this title and provides only the essential health benefits established in section 3103, except in States that offer additional benefits. There are no requirements that health care providers participate in the plan or that individuals join the plan. The premiums must be sufficient to cover the plan's cost. The Secretary shall negotiate rates for provider reimbursement. Reimbursement rates will be negotiated by the Secretary and shall not be higher than the average of all Gateway reimbursement rates. A "Health Benefit Plan Start-up Trust Fund" will be created to provide loans for the initial operations of the community health insurance plan, which the plan will be required to pay back no later than 10 years after the payment is made. After the first 90 days of operation, the community health plan will be subject to a Federal solvency standard, established by the Secretary, and will be required to have a reserve fund that is at least equal to the dollar value of incurred claims. Each state will establish a State Advisory Council to provide recommendations to the Secretary on the policies and procedures of the community health insurance plan.

The Secretary shall contract with qualified nonprofit entities to administer the community health insurance plan in the same manner as Medicare program contracting. The contractor will receive a fee from the Department of Health and Human Services, which may be increased or reduced depending on the contractor's performance in reducing costs and providing high-quality health care and customer service. Contracts will last between 5 and 10 year-terms, at the end of which there will be a competitive bidding process for new and renewed contracts.

SCHUMER #C3

Schumer Amendment #C3 to Title I, Subtitle C-

Short Title: Hardship Waiver at 7 Percent

Description of Amendment:

The amendment would change the affordability level at which the hardship waiver kicks in to 7 percent. In other words, if a taxpayer cannot find an affordable plan in the Exchange for which the premium is less than 7 percent of their income, they are exempt from paying any penalty.

Offset:

No cost anticipated. Any savings should be directed to improving affordability in the Exchange.

SCHUMER #C4

Schumer Amendment #C4 to Title I, Subtitle C-

Short Title: Hardship Waiver at 5 Percent

Description of Amendment:

The amendment would change the affordability level at which the hardship waiver kicks in to 5 percent. In other words, if a taxpayer cannot find an affordable plan in the Exchange for which the premium is less than 5 percent of their income, they are exempt from paying any penalty.

Offset:

No cost anticipated. Any savings should be directed to improving affordability in the Exchange.

SCHUMER #C5

Schumer Amendment #C5 to Title I, Subtitle C-

Short Title: Hardship Waiver at 3 Percent

Description of Amendment:

The amendment would change the affordability level at which the hardship waiver kicks in to 3 percent. In other words, if a taxpayer cannot find an affordable plan in the Exchange for which the premium is less than 3 percent of their income, they are exempt from paying any penalty.

Offset:

No cost anticipated. Any savings should be directed to improving affordability in the Exchange.

SCHUMER #C6

Schumer Amendment #C6 to Title I, Subtitle D-

Short Title: Modifications to the Penalty for Not Maintaining Insurance

Description of Amendment:

The amendment would reduce the penalty for failing to obtain coverage from $750 to $500 for all individuals above 100 percent FPL and reduce the maximum penalty on a family from $3,800 to $1,000. Extend this penalty section without regard to income.

Offset:

Increase annual fee on manufacturers and importers of branded drugs by amount necessary to offset the increase in spending.

SCHUMER #C7

Schumer Amendment #C7 to Title I, Subtitle A-

Short Title: Protecting State Consumer Protections

Description of Amendment:

Strikes the provision to create national plans offered across state lines.

This amendment will not result in increased cost.

SCHUMER-MENENDEZ-BINGAMAN # C8

Schumer-Menendez-Bingaman Amendment #C8 to Title I, Subtitle B-

Short Title: Inclusion of Puerto Rico and the Territories in the Exchange

Description of Amendment:

The amendment would include Puerto Rico and the Territories in all aspects of Title I of the bill, the insurance market reforms, the Healthcare Exchanges, the coverage affordability provisions, and the shared responsibility provisions.

Offset:

Increase annual fee on for-profit health insurance providers by amount necessary to offset the increase in spending.

SCHUMER # C9

Schumer Amendment #C9 to Part I, Subtitle 6-

Short Title: Changes to Medicaid DSH Reductions and Addition of Medicaid DSH Report

Description of Amendment:

This amendment would replace the existing Medicaid DSH language with the following. Not later than January 1, 2016, the Secretary of Health and Human Services must submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out in Title I in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH. In preparing the report, the Secretary must consult with community-based health care networks serving low-income beneficiaries. The report must include recommendations regarding the appropriate targeting of Medicaid DSH within States and the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to a State to the number of uninsured individuals in such States. The report will also include the DSH Health Reform methodology as described in the next paragraph. The Secretary must coordinate this report with the report on Medicare DSH under Title III, Subtitle D.

Beginning in 2017, the Secretary must implement adjustments to Medicaid DSH allotments if a trigger is met. State DSH allotments would remain intact as under current law until a state trigger is tripped. The trigger would be tripped once a state's uninsured rate, as measured by the Census Bureau's American Community Survey, decreases by at least 50 percent, compared to an initial uninsured rate on the date of enactment and once a state's dollar amount of uncompensated care, including Medicaid losses as defined in Section 1923(g)(1) of the Social Security Act, decreases by at least 50 percent, compared to its uncompensated care dollar amount in calendar year 2010, as determined by data
collected by the secretary.

If the trigger is met, then the Secretary must reduce Medicaid DSH so as to reduce total Federal payments to all States for such purpose by up to $1.5 billion in FY2017, up to $2.5 billion in FY2018, and up to $6 billion in FY2019. The Secretary must carry out these reductions through use of a DSH Health Reform methodology issued by the Secretary that imposes the largest percentage reductions on the States that: have the lowest percentages of uninsured individuals during the most recent year for which such data are available; or do not target their DSH payments on hospitals with high volumes of Medicaid inpatients (as defined in section 1923(b)(1)(A) of the Social Security Act) and hospitals that have high levels of uncompensated care (excluding bad debt).

The Secretary must publish in the Federal Register a notice specifying the DSH allotment to each State under 1923(f) of the Social Security Act, consistent with the application of the DSH Health Reform methodology, for the following fiscal years by these deadlines: January 1, 2016 for DSH allotments for FY2017; January 1, 2017 for DSH allotments for FY2018; and January 1, 2018 for DSH allotments for FY2019.

The Social Security Act would be amended to require that no hospital may be defined or deemed as a disproportionate share hospital (or as an essential access hospital under Section 1923(f)(6)(A)(iv) Security Act), under a State Medicaid plan or Section 1923(b) of the Social Security Act (including any waiver under section 1115) unless the hospital: provides services to Medicaid beneficiaries without discrimination on the ground of race, color, national origin, creed, source of payment, status as a Medicaid beneficiary, or any other ground unrelated to the beneficiary's need for the services or the availability of the needed services in the hospital; and makes arrangements for, and accepts, reimbursement under Medicaid for services provided to eligible Medicaid beneficiaries.

Offset:

Increase annual fee on manufacturers and importers of branded drugs by amount necessary to offset the increase in spending.

SCHUMER #C10

Schumer Amendment #C10 to Title I, Subtitle G-

Short Title: Changes to Definition of "Newly Eligible" Populations to be Covered Under Medicaid Program Payments

Description of Amendment:

Beginning in 2014, states would continue to receive Federal financial assistance as determined by FMAP. Beginning in 2014, additional Federal financial assistance would be provided to all states to defray the costs of covering newly-eligible beneficiaries. The Federal government would pay a greater share of the costs for individuals ―newly eligible for Medicaid based on the proposed eligibility changes. Newly eligible would be defined as (1) non-elderly, non-pregnant individuals below 133 percent of FPL who were not previously eligible for a full or benchmark benefit package, or (2) who were eligible for such a package through, or eligible for medical assistance under Title XIX of the Social Security Act under, a demonstration waiver approved under section 1115 of such Act or with state funds as of the date of enactment.

Those states that offer minimal or no coverage of the newly-eligible population currently would receive more assistance initially than those states that currently cover at least some non-elderly, non-pregnant individuals. Expansion states would be defined as states with coverage of parents and childless adults at or above 100 percent of FPL that is not based on employer or employment, whether through Medicaid or under an 1115 waiver or with state funds. Such coverage may be less comprehensive than Medicaid, but must be more than premium assistance, hospital-only benefits, or health savings accounts (HSA). Between 2014 and 2018, the additional assistance to expansion states and other states would be adjusted downward and upward, respectively, so that, in 2019, all states would receive the same level of additional assistance for covering newly eligibles.

Offset:

Increase annual fee on manufacturers and importers of branded drugs by amount necessary to offset the increase in spending.

SCHUMER # C11

Schumer Amendment #C11 to Title I, Subtitle C-

Short Title: Eligibility Verification

Description of Amendment:

Eligibility Verification. In order to prevent illegal immigrants from accessing the state exchanges obtaining federal health care tax credits, the bill shall require verification of lawful presence in the United States. For individuals claiming to be U.S. Citizens, citizenship status will be verified by either: (1) comparing the name, date of birth, and social security account number provided in an inquiry against such information maintained by the Commissioner of Social Security in order to confirm the validity of the information provided regarding an individual whose identity and citizenship must be confirmed; or (2) authentication of identity and citizenship through any biometric verification system administered by the Secretary of Homeland Security, the Attorney General, or the Commissioner of Social Security that is in existence, operational, and mandatory for all persons seeking employment at the time verification is required.

For individuals who do not claim to be U.S. citizens, but claim to be otherwise lawfully present in the United States, the claim of lawful presence shall be substantiated by authentication through any verification system administered by the Secretary of Homeland Security, the Attorney General, or the Commissioner of Social Security that is existence and operational at the time of verification.

Individuals whose status is expected to expire in less than a year are not allowed to obtain the tax credit. Individuals whose claims of citizenship or lawful status cannot be verified with federal data must be allowed substantial opportunity to provide documentation or correct federal data related to their case that supports their contention.

Within 2 years of enactment, the Government Accountability Office (GAO) shall conduct a study regarding: (1) the rate of erroneous non-confirmations of lawful presence; (2) solutions for remedying systemic difficulties causing erroneous non-confirmations; and (3) the economic impact caused by erroneous non-confirmations and the cost of remedying any systemic difficulties causing erroneous non-confirmations.

All personal information submitted to the state exchange can only be used for purposes of providing insurance coverage through the state exchange, eligibility for and determination of the amount of the health care tax credit, or other administrative functions related to the efficient operation of the state exchange. Appropriate penalties will apply to the use of fraudulent information or stolen identity information in the state exchange. Applicants for insurance coverage or for health care tax credits shall be required to provide only the information that is necessary to determine eligibility for access to the exchange or tax credits. Information provided to the exchange by the applicant or by the IRS, shall not be disclosed or shared with other agencies, entities or individuals for any purpose that is not directly connected with the administration of the health insurance program.

Offset:

Offset to be determined.

SCHUMER #C12

Schumer #C12 to Title I, Subtitle C -

Short Title: Ensuring Availability of Innovative Health Insurance Plans

Description of Amendment:

This amendment requires the Secretary to take into consideration current health insurance plans which offer affordable coverage as described in the Chairman's Mark to ensure that they are not negatively impacted by any provisions in the Mark.

Offset:

To be determined when offered.

SCHUMER #C13

Schumer Amendment #C13 to Title I, Subtitle G-

Short Title: Community First Choice Option

Description of Amendment:

Add the Community First Choice Option to the end of Title I, Subtitle G, Part IV (Medicaid Services) or at an appropriate place within this Title.

The Community First Choice Option would create a state plan option under Section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living and health related tasks. States who choose the Community First Choice Option would be eligible for enhanced federal matching funds for reimbursable expenses in the program.

The Community First Choice Option would require data collection to help determine how states are currently providing home and community based services, the cost of those services, and whether states are currently offering individuals with disabilities who otherwise qualify for institutional care under Medicaid the choice to instead receive home and community based services, as required by the U.S. Supreme Court in Olmstead v. L.C. (1999).

The provision would also modify the Money Follows the Person grant program to reduce the amount of time required for individuals to qualify for that program.

Offset:

To be determined when offered.

Stabenow Amendment C-1 to the Chairman's Mark

Short title/purpose: To make insurance affordable for middle-class families

Description of Amendment: Numerous studies illustrate how price sensitive many families and individuals—particularly in the working and middle class—are to purchasing insurance. To ensure that there are affordable products for our nation's middle-class families, this amendment would replace the current tax-credit structure in the Chairman's mark with the following:

- For individuals and families between 100% to 200% FPL, there would be a sliding scale tax credit that would from 3% to 6.5%

- For individuals and families between 200% to 400% FPL, there would be a premium "cap" established so that no one in this income range would pay more than 6.5% of household income on insurance premiums for the lowest-cost silver plan.

- Additionally the out-of-pocket maximum between 300% and 400% FPL would be held at two-thirds the current out-of-pocket maximum for a Health Savings Account.

Offset: To the extent necessary, the offset would both expand the individual portion of the Medicare tax to cover limited investment income, defined as capital gains (no losses); interest (taxable); dividends; estate and trust income; schedule E net income (no net losses) [rents, royalties, Sub-S, and partnerships (unearned portion only)]. It exempts the first $10,000 of investment income for singles ($20,000 for joint filers).

Contact: Oliver Kim (health)/Colleen Briggs (tax)

Stabenow-Wyden-Kerry Amendment C-2 to the Chairman's Mark

Short title/purpose: To ensure parity for mental health services within the exchange

Description of Amendment: The Chairman's mark authorizes a minimum benefit basic package – including mental and substance abuse services– that must be offered by health insurance plans participating in the State Exchanges. While the mark states that services offered through the four benefit categories must "meet minimum standards set by Federal and state laws," it is unclear whether The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) applies to mental health and substance abuse services offered through State Exchange plans. The amendment would clarify the application of mental health and addiction parity to these new plans in all four benefit categories.

This amendment would clarify the application of the federal Wellstone/Domenici mental health and addiction parity requirement to plans offered through State Exchanges by including a specific statutory cross reference to P.L. 110-343.

Offset: Since P.L. 110-343 is a minimum insurance standard set by Federal law, no offset is needed.

Contact: Oliver Kim

Stabenow Amendment C-3 to the Chairman's Mark

Short title/purpose: To give states the option of including family planning as part of their Medicaid programs

Description of Amendment: This amendment would add a new optional categorically-needy eligibility group to Medicaid. This new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per section 1905(a)(4)(C)) and would also include related medical diagnosis and treatment services.

This amendment would also allow states to make a "presumptive eligibility" determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies.

Any savings from this amendment shall be diverted to a reserve fund for a health care purpose to be determined.

Offset: This amendment is budget neutral. The Medicaid family planning option has been scored as a saver.

Contact: Oliver Kim

Stabenow Amendment C-4 to the Chairman's Mark

Short title/purpose: To help our nation's most vulnerable children have access to health and human services

Description of Amendment: This amendment is designed to facilitate the enrollment of several vulnerable and underserved populations in Medicaid or CHIP. These groups include children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

This amendment would require the Secretary of Health and Human Services to issue guidance to states regarding standards and best practices that would help vulnerable populations enroll in Medicaid or CHIP. The guidance would be required to address three specific issues. First, the guidance would detail effective ways to inform eligible individuals about coverage available under Medicaid and CHIP. Second, the guidance would identify ways to assist vulnerable populations to enroll in the programs. Third, the guidance would identify ways that application and enrollment barriers can be eliminated.

Examples of methods that the Secretary must address in the guidance include "outstationing" of eligibility workers, express lane eligibility, residence requirements, documentation of income and assets, presumptive eligibility, continuous eligibility, and automatic renewal. In issuing the guidance, the Secretary may use all available legal authority and work with appropriate groups to ensure that the guidance is implemented effectively.

Within two years after the legislation is enacted, and annually after that, the Secretary is required to report to Congress on progress made in implementing those measures provided for in the guidance.

Offset: The same language was adopted by the House Energy and Commerce Committee and did not score.

Contact: Oliver Kim

Stabenow Amendment C-5 to the Chairman's Mark

Short title/purpose: To ensure every American purchasing a plan through the exchange has access to a health care provider

Description of Amendment: This amendment would require the Secretary of Health and Human Services to establish minimum network adequacy standards for safety-net providers for any area designated as a health professional shortage area or a medically underserved area.

The Secretary of Health and Human Services would establish a list of what entities or providers could be considered a safety-net provider, including but not limited to such factors as providing medical services on a sliding scale, participation in the 340b program, or insufficient public transportation.

Offset: This amendment is not expected to score. In the event that it does score, the fee on brand-name drug companies would be increased an appropriate amount.

Contact: Oliver Kim

Stabenow Amendment C-6 to the Chairman's Mark

Short title/purpose: To ensure high quality, specialized care for children and youth with special medical, psychological, social and emotional needs who can accept and respond to the close relationships within a family setting, but whose special needs require more intensive or therapeutic services than are found in traditional foster care

Description of Amendment: This amendment would create a rule of construction that nothing in section 1905(a) of the Social Security Act shall be construed as limiting a State from covering therapeutic foster care for eligible children in out-of-home placements.

The amendment would also provide a statutory definition of therapeutic foster care as a foster care program that provides to the eligible child structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communications, and behavioral skills; crisis intervention and crisis support services; medication monitoring; counseling; and case management services. Additionally, therapeutic foster care would include specialized training for the foster parent and consultation with the foster parent on the management of children with mental illnesses and related health and developmental conditions.

Offset: To be determined if this language does score. Similar language was included in the House Energy and Commerce legislation.

Contact: Oliver Kim

Stabenow Amendment C-7 to the Chairman's Mark

Short title/purpose: To allow stand-alone dental and vision plans to offer the required pediatric dental and vision services and to be offered in the individual and small group markets including within the insurance exchanges.

Description of Amendment: The Chairman's mark states that no policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described and that all plans in the individual and small group markets, at a minimum, would be required to offer coverage in the silver and gold categories. Furthermore, all plans must offer pediatric services, including dental and vision. The current language precludes stand-alone dental plans, which currently provide 97 percent of the dental benefits in the United States, from competing with medical plans for pediatric dental coverage in the Exchange.

This amendment would ensure that people who like their dental plans would be able to keep them. To accomplish this, stand-alone dental plans must be allowed to offer the required pediatric dental and vision benefits directly and to offer coverage through the Exchange and must comply with any relevant consumer protections required for participation in the Exchange.

Required pediatric dental and vision benefits in the non-group and small group markets (in and outside an Exchange) may each be separately offered and priced from other required health benefits. Coverage for these required pediatric dental and vision benefits may be provided by any state-licensed stand-alone dental-only and stand-alone vision-only carrier that meets the requirements of section 2791(c)(2)(A) of the Public Health Service Act. Stand-alone dental-only and stand-alone vision-only coverage together with a qualified health plan that provides all of the other required benefits satisfies the required benefits standards. Tax credits and cost-sharing assistance for the required pediatric dental and vision and for other required health benefits would be designed to ensure they do not total more than they would have otherwise been under the Chairman's Mark.

Stand-alone dental and vision plans would be allowed to be offered in the individual and small group markets, including through the exchanges, if they meet the requirements of section 2791 (c)(2)(A) of the Public Health Service Act.

Offset: We do not believe this amendment will score as the person or family exercising this option would not be entitled to any larger a credit than if that person or family purchased.

Contact: Oliver Kim

Stabenow Amendment C-8 to the Chairman's Mark

Short title/purpose: To ensure all insurance plans conform to the same consumer protections and market rules

Description of Amendment: This amendment would require that any state law that imposes more stringent regulatory requirements on health insurance issuers shall impose such requirements in the same manner and to the same extent on all associations, MEWAs and health insurance issuers that issue such coverage.

The provisions ensure that all other entities offering health insurance would be subject to any state requirements that exceed federal requirements. This will ensure all consumers are appropriately protected in each state.

Twenty four states exempt associations from some element of their insurance reforms. Other states treat MEWAs as large group coverage that would be exempt from small group reform laws.

Offset: We do not believe this amendment will score.

Contact: Oliver Kim

Stabenow-Menendez Amendment C-9 to the Chairman's Mark

Summary: Requires that the more than 13 million children enrolled in the Children's Health Insurance Program (CHIP) in 2013 are not moved to the exchanges unless it is clear that they will secure coverage that is at least comparable or better to what they have in CHIP so that they are not left worse off by health reform.

Description of Amendment: The Secretary would be required to submit a report to Congress by December 31, 2011, which would compare the coverage in the exchanges to the coverage offered by the Children's Health Insurance Program (CHIP). In making this coverage comparison, the Secretary would review the benefits, cost sharing (including premiums, deductibles, copayments, and out-of-pocket limits), differences in eligibility, legal protections, adequacy of provider networks, and ease of enrollment and other barriers to coverage between CHIP and the exchanges with the CHIP wrap around.

The Secretary shall make recommendations to Congress as to how both CHIP and the exchanges would need to be improved or modified in order to provide comparable coverage to the alternative system.

Prior to the expiration of CHIP and movement of children into the exchanges, the Secretary must make a finding that coverage in the exchange plans are at least comparable to the coverage offered by the average CHIP plan.

If the Secretary does not make that certification by September 30, 2013, the states would be required to extend the requirement on page 46 of the Chairman's Mark "to maintain income eligibility levels for currently eligible children" within CHIP until one year after the Secretary could certify that the coverage in the exchanges is comparable or better than that in CHIP. Only at that point where it was been established that children would not be left worse off would children be allowed to move from CHIP to the exchanges.

A very similar version to this amendment was passed by the House Energy and Commerce Committee by unanimous consent in its health reform mark-up in July.

Contact: Oliver Kim

Offset: To the extent necessary, the insurers' fee will be increased.

Cantwell Amendment #C1 to America's Healthy Future Act of 2009

Short Title: Incentives for States to Offer Home and Community Based Services (HCBS) as a Long-Term Care Alternative to Nursing Homes for the Medicaid Population.

Description of Amendment: This amendment provides a modest, targeted, 5-year-limited increase in federal matching payments (FMAP) for Medicaid covered home and community based services (HBCS). This FMAP increase will be available only to those states willing to undertake certain structural reforms in their Medicaid long-term care programs that have been proven to increase nursing home diversions and access to HCBS. The targeted FMAP increase is offered on a scale based upon the percentage of a state's long-term care that is offered through HCBS, with lower FMAP increases going to states that will need to make fewer reforms.

This amendment also includes provisions which make it easier for states to provide HCBS under existing Medicaid waiver and option authorities. States will be able to offer HCBS through state plan amendments for targeted populations, including HCBS populations up to 300 percent of the maximum Supplemental Security Income payment.

This amendment reflects S. 1256, the Home and Community Balanced Incentives Act of 2009.

Offset: A 1.45% surtax on short-term capital gains.

Cantwell Amendment #C-2 to America's Healthy Future Act of 2009

Short Title: Pharmacy Benefit Manager (PBM) Transparency for Health Plans Operating in the Health Insurance Exchanges

Description of Amendment: The amendment requires pharmaceutical benefit managers (PBM) to share basic information with the commissioners of the exchanges and with any plans the PBMs contracts with in the exchanges. This information will be considered confidential and must be protected by the commissioners and the plans. The PBM will be required to confidentially disclose information on: (1) the percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the generic dispensing and substitution rates in each location; 2) the aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor; 3) the average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy. There are no mandates that these rebates are passed through, only that they be reported to plans.

Offset: This amendment is not expected to require an offset, however, a sufficient offset to ensure that it is revenue neutral will be provided, if needed.

Cantwell Amendment #C-3 to America's Healthy Future Act of 2009.

Title: Increase authorized funding to allow for full national implementation of Aging and Disability Resource Centers (ADRC).

Description: The amendment modifies the Aging and Disability Resource Center (ADRC) section in the Chairman's Mark to increase the total ADRC authorization to a total of $727 million for the years 2010 through 2020 years. This funding expands the Mark's current proposal to allow for full national implementation of the ADRC pilot project.

ADRCs are a model tested and proven by demonstration projects under the Administration on Aging (AoA) and the Centers for Medicare and Medicaid (CMS). The amendment modifies the Mark to reflect current policy and ensure that the Secretary of Health and Human Services has the authority and resources to make grants to the states for ADRCs through the Administration on Aging, which administers the program. Demonstrations have achieved savings by diverting Medicaid eligible clients who qualify for institutional care to the Medicaid home and community based service (HCBS) waivers.

Offset: The amendment authorizes funding and therefore does not require an offset.

Cantwell Amendment #C-4 to America's Healthy Future Act of 2009.

Title: Provide mandatory funding to allow for full national implementation of Aging and Disability Resource Centers (ADRC).

Description: The amendment modifies the Aging and Disability Resource Center (ADRC) section in the Chairman's Mark to provide mandatory funding for ADRCs. The funding totals $727 million for the years 2010 through 2020 years. This funding expands the Mark's current proposal to allow for full national implementation of the ADRC pilot project.

ADRCs are model tested and proven demonstration projects under the Administration on Aging (AoA) and the Centers for Medicare and Medicaid (CMS). The amendment modifies the Mark to reflect current policy and ensure that the Secretary of Health and Human Services has the authority and resources to make grants to the states for ADRCs through the Administration on Aging, which administers the program. Demonstrations have achieved savings by diverting Medicaid eligible clients who qualify for institutional care to the Medicaid home and community based service (HCBS) waivers.

The amendment reflects Subtitle A of S. 1217, Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009.

Offset: The needed, the necessary offsets will be provided to ensure budget neutrality.

Cantwell Amendment #C-5 to America's Healthy Future Act of 2009

Title: Authorize funding for national implementation of evidence-based wellness and disease prevention programs for older Americans to reduce the necessity of institutional care.

Description: The amendment would authorize $1.14 billion over 10 years to allow full implementation of demonstration projects currently authorized under the Older Americans Act. Wellness promotion and disease prevention programs are cost-effective, non-clinical programs. Currently, 26 Centers for Disease Control and Prevention approved pilot projects are operating across the nation. States that have piloted these programs see documented savings by helping participants avoid hospitalizations and unnecessary physician visits. Workforce training is provided to ensure the various evidence-based programs have sufficient staff. Under this amendment, all states would be eligible to receive funding for programs of this type.

The amendment reflects Subtitle B of S. 1217, Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009.

Offset: The amendment authorizes funding and therefore does not require an offset.

Cantwell Amendment #C-6 to America's Healthy Future Act of 2009

Title: Provide for mandatory funding for national implementation of evidence-based wellness and disease prevention programs for older Americans to reduce the necessity of institutional care.

Description: The amendment would provide $1.14 billion over 10 years in mandatory funding to allow full implementation of demonstration projects currently authorized under the Older Americans Act. Wellness promotion and disease prevention programs are cost-effective, non-clinical programs. Currently, 26 Centers for Disease Control and Prevention approved pilot projects are operating across the nation. States that have piloted these programs see documented savings by helping participants avoid hospitalizations and unnecessary physician visits. Workforce training is provided to ensure the various evidence-based programs have sufficient staff. Under this amendment, all states would be eligible to receive funding for programs of this type.

The amendment reflects Subtitle B of S. 1217, Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009.

Offset: The needed, the necessary offsets will be provided to ensure budget neutrality.

Cantwell Amendment #C-7 to America's Healthy Future Act of 2009

Title: National implementation of current Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) nursing home diversion projects.

Description: The amendment authorizes $11.49 billion over 10 years to nationally implement current non-Medicaid nursing home diversion projects which prevent institutionalization and asset spend down to Medicaid eligibility. These programs prevent impoverishment and provide for a consumer-directed option allowing consumers to purchase services and supports that help them to remain independent. Such services including homemaker support, assistive technology, and minor adaptive and rehabilitative home repairs.

The amendment reflects Subtitle C of S. 1217, Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009.

Offset: The amendment authorizes funding and therefore does not require an offset.

Cantwell Amendment #C-8 to America's Healthy Future Act of 2009

Title: National implementation of current Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) nursing home diversion projects.

Description: The amendment provides for $11.49 billion over 10 years in mandatory funding to nationally implement current non-Medicaid nursing home diversion projects which prevent institutionalization and asset spend down to Medicaid eligibility. These programs prevent impoverishment and provide for a consumer-directed option allowing consumers to purchase services and supports that help them to remain independent. Such services including homemaker support, assistive technology, and minor adaptive and rehabilitative home repairs.

The amendment reflects Subtitle C of S. 1217, Project 2020: Building on the Promise of Home and Community-Based Services Act of 2009.

Offset: The needed, the necessary offsets will be provided to ensure budget neutrality.

Cantwell Amendment #C-9 to America's Healthy Future Act of 2009

Short Title: Provide for coverage in a direct primary care medical home plan, provided that plan is coupled with a quality wrap-around insurance program to cover non-primary care services.

Description: Direct primary care medical homes (DPM) practices offer patients comprehensive primary care coverage outside of traditional insurance and include preventive and primary care as well as chronic disease management. Care is coordinated with specialists and hospitals. Beneficiaries in a DPM program pay a flat monthly fee in lieu of a premium to cover primary care and preventive services. Specifies that enrollees in a DPM must also obtain wrap-around insurance to cover non-DPM provided services.

Offset: This amendment requires no funding and therefore does not require an offset.

Cantwell Amendment #C-10 to America's Healthy Future Act of 2009.

Title: Allow states with "mature co-ops" to apply for federal start-up funding currently authorized in the Mark.

Description: The amendment would allow states with "mature co-ops," to be defined by the amendment, to apply for federal start-up funding available through the new co-op program, and use such to expand access to care and make health care more affordable in the most efficient and effective way for that state. Such funds may be used in partnership with the mature co-ops at the discretion of the states.

Offset: No new funding is required for this amendment.

Cantwell Amendment #C-11 to America's Healthy Future Act of 2009.

Title: Requires national plans to abide by all state insurance regulations.

Description: Any national insurance plans that wish to sell health care coverage across state lines would be required to abide by all existing state laws and regulations governing the health insurance market in the state in which the coverage is sold.

Offset: The amendment requires no new funding.

Cantwell Amendment #C-12 to America's Healthy Future Act of 2009.

Title: To allow manufacturers to provide assistance to individuals enrolled in a Medicare Part D plan.

Description: The Amendment allows manufacturers to provide assistance to individuals enrolled in a Medicare Part D plan with substantial out-of-pocket costs through the use of coupons, co-payment cards, and other non-cash instruments. This manufacturer cost sharing assistance will count toward "true out-of-pocket" (TrOOP) expenses, so the assistance afforded by this program will not impede the beneficiary from reaching the annual out-of-pocket threshold. Manufacturer cost sharing assistance is only available for categories or classes of drugs that were found to result in lower spending per enrollee in the Medicare Replacement Drug Demonstration that was authorized by section 641 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173), or other products that the Secretary determines will result in lower Medicare expenditures or improve access to treatment. The Amendment will create an exception to the anti-kickback statute for manufacturer cost sharing assistance provided under the amendment and exempt the assistance from inclusion in the determination of "best price" under the Medicaid statute.

Offset: This amendment requires no new funding.

Cantwell Amendment #C-13 to the American's Health Future Act of 2009

Short Title: Clarify the definition of full-time employee for purposes of determining the employer assessment.

Description of Amendment: This amendment would clarify that full-time employees are those working at least 390 hours per calendar quarter. In addition, for the purposes of determining the employer assessment, fees would be assessed quarterly at $100 multiplied by all full-time employees of the employer during such quarter (capped as under the mark at $400 per year).

Offset: Assumed in Chairman's Mark.

Cantwell Amendment #C-14 to the American's Health Future Act of 2009

Short Title: Reduce the amount of the "Free-Rider" Penalty by Employer Contributions into a Health Reimbursement Arrangement

Short Description: The amendment would allow an employer who is otherwise required to pay a fee for employees receiving premium credits to reduce the amount of that payment by any amounts contributed by the employer to an individually controlled HRA.

Offset: Cost should be negligible; but an appropriate offset will be provided if needed.

Cantwell Amendment #C-15 to America's Healthy Future Act of 2009.

Title: Basic Health Plan

Description: The Secretary of Health and Human Services shall establish a basic health plan that will provide affordable coverage to individuals below 200 of the federal poverty level. Individuals below 200 percent of the federal poverty level will not be eligible to receive tax credits to purchase coverage through the health insurance exchanges, and will instead be able to access affordable coverage this basic health plan.

Offset: An appropriate offset will be provided if necessary.

Nelson-Kerry Amendment #C-1 to the America's Healthy Future Act of 2009

Short Title: Strike Interstate Sale of Insurance

Description of Amendment: Strike provisions in Chairman's mark (pages 12-13) to allow states to form "health care choice compacts."

Offset: This amendment is expected to be budget neutral.

Nelson Amendment #C-2 to the America's Healthy Future Act of 2009

Short Title: Medicaid Disproportionate Share Hospital Payments

Under the Chairman's mark, to trigger a Medicaid Disproportionate Share Hospital (DSH) cut, a state's uninsured population must have been reduced by 50%. This amendment would add two additional criteria to the trigger: under this amendment, the trigger is only met when a state's uninsured population 1) has been reduced by 50%, and either 2) its ratio of federal DSH allotment to its uninsured population exceeds $100 per uninsured individual; or 3) it's uninsured population is below 1 million individuals.

Within the underlying budgetary assumption in the Chairman's mark for Medicaid DSH cuts, the Secretary will annually allocate DSH cuts among those states that have met the trigger on a proportional basis such that the greater the state's number of uninsured the lower the cut except that no state would receive less than 35% of its 2012 DSH allotment level. To the extent feasible, the Secretary would allocate the cuts to those states that have reached the trigger as outlined above on an inverse proportional basis based on the ratio of remaining uninsured lives in each trigger state relative to the remaining uninsured lives in all the trigger states (such that the greater a state's number uninsured the lower the cut). However, the Secretary would retain sufficient flexibility to implement such cuts in a manner that meets the principle of allocating DSH cuts taking into account the number of uninsured individuals in the trigger states but also consistent with the underlying budgetary assumption in the Chairman's mark for Medicaid DSH cuts.

Offset: Amendment is expected to be budget neutral.

Nelson (for himself, Senator Snowe, and Senator Grassley) Amendment # C-3 to America's Healthy Future Act of 2009

Short Title: An amendment to clarify how certain provisions in the Chairman's Mark apply to Professional Employer Organizations

Description of Amendment: Professional Employer Organizations (PEOs) provide human resource services to small business clients—paying wages and employment taxes, and improving compliance with state and federal laws. PEOs provide access to 401(k) plans, health insurance, dental coverage, and other benefits not typical for many small businesses. The average PEO client has 19 employees. It is unclear how certain provisions in the Chairman's Mark will apply to PEOs. For example, will small businesses lose eligibility for the small business tax credit if they contract with a PEO for certain human resource services? Will small businesses otherwise exempt from the shared responsibility provisions become liable as a result of the small business-PEO relationship? The lack of certainty in the draft legislation could result in higher taxes or the loss of tax benefits for small businesses that contract with PEOs.

In the case of health plans sponsored by a certified PEO for the benefit of workers at a PEO customer organization (or health plans sponsored by such a client organization):

(1) responsibility for the "Required Payments for Employees Receiving Premium Credits",
(2) eligibility for the "Small Business Tax Credit", and
(3) eligibility for the "Cafeteria Plan Rules for Small Employers"

shall be applied to each PEO customer organization separately with any benefits provided through the PEO taken into account. For purposes of the amendment, a certified PEO shall be defined by applying the definitions and requirements previously reported by the Senate Finance Committee and approved by the Senate in 2007 in H.R. 2. The amendment would not alter payroll tax responsibilities, as they apply under current law. The Secretary of the Treasury shall prescribe such regulations as are necessary to carry out the purposes of this amendment.

Offset: The sponsors believe the amendment is revenue neutral. If the amendment is not revenue neutral, an offset will be provided when the amendment is offered.

Menendez/Kerry/Bingaman/Schumer Amendment C# 1 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: Making premiums more affordable

Description of Amendment:

The credits would be based on the percentage of income the cost of premiums represents, rising from one percent of income for those at 100 percent of poverty to 10 percent of income for those at 300 percent of poverty. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 10 percent of income.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez/Bingaman Amendment C# 2 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Description: To allow citizen and lawfully present immigrant children to get affordable health coverage while ensuring that undocumented immigrants do not benefit from the tax credit subsidy.

Description of Amendment:

Consistent with eligibility for mixed-status families in the Medicaid program, the amendment would count all income and all members of a household in determining eligibility for tax credits, but would provide a tax credit subsidy only to household members who meet citizenship or legal immigrant eligibility requirements for the tax credit along with all other eligibility requirements. The amendment ensures that only eligible citizens and lawfully present immigrants get the benefit of a tax credit subsidy.

Offset: No cost anticipated.

Menendez Amendment C# 3 to Chairman's Mark of America's Healthy Future Act
Title I, Subtitle C

Short Title: Ensuring that Federally-Qualified Heath Centers (FQHCs) would not lose revenue when treating newly insured patients gaining coverage through the new Health Insurance Exchanges.

Description of Amendment:

Insurers participating in the state exchanges would be required to provide payment for services furnished to enrollees of the insurer by any electing federally-qualified health center at levels no less than such center would receive under Section 1902(bb) of the Social Security Act for such services.

Background:

Federally-Qualified Health Centers currently serve more than 18 million low-income patients in more than 7,000 communities across the country, in every state and territory. Patients at FQHCs receive comprehensive primary care services, including mental health, dental, pharmacy and other case management services. FQHCs save the health care system more than $18 billion annually through reduced Medicaid expenditures and unnecessary use of emergency rooms.

FQHCs' current payment structure under Medicaid and CHIP (under SSA Section 1902(bb)) ensures that health centers receive adequate payment through an all- inclusive per- visit payment rate for comprehensive primary and preventive care services, in contrast to the fee- for- service reimbursement system which pays on a per- service basis. The PPS also ensures that discretionary grant funding needed to support other vital purposes (operation and expansion of health center services, care for those who remain uninsured, health- improving services that are not reimbursed, etc.) will not have to be siphoned off to cover inadequate payment rates.

This amendment would ensure that Federally-Qualified Heath Centers (FQHCs) would not lose revenue when treating newly insured patients gaining coverage through the new Health Insurance Exchanges. This would be accomplished by extending the PPS payment rate to insurance plans participating in the Exchange. Full participation and appropriate payment will assure the continued emphasis on preventive care, patient education, and effective case management of chronic conditions.

Offset: No cost anticipated.

Menendez Amendment C# 4 to Chairman's Mark of America's Healthy Future Act

Title I

Short Title: Ensure and clarify that children qualify as exchange eligible individuals and that there shall be the option of a child-only health insurance option and subsides in the exchanges.

Description of Amendment:

Ensure that minor children qualify as exchange eligible individuals, such as children in foster care, children in kinship care, children in families when parents are covered by employers who do not offer dependent coverage, children in families whose parents are uninsured, and other citizen and lawfully present U.S. resident children. This amendment would also provide for the availability of child-only health insurance coverage in the exchanges.

Furthermore, the amendment would direct the Secretary to determine whether alternative means, such as direct subsidies to the exchanges, and refinements to tax credit eligibility determinations, are necessary to provide support for the purchase of such coverage for children.

The Secretary would also be directed to determine and be given authority, if necessary, to exempt the child-only coverage option from age-rating requirements.

Offset: No cost anticipated.

Menendez Amendment C# 5 to Chairman's Mark of America's Healthy Future Act
Title I

Short Title: Strengthening the insurance appeals process in order to better protect consumers.

Description of Amendment:

Each health care plan and health care insurance issuer offering coverage in the exchange shall provide an internal claims appeal process. Each state shall provide an external review process for plans in the individual and small group markets that, at a minimum, includes the consumer protections set forth in the NAIC Uniform External Review Model Act. States are required to allow the enrollee to review their file and to present evidence and testimony as part of the appeals process, and plans must provide for continued coverage pending the outcome of a review. Each health plan and health insurance carrier shall provide notice in clear language and in the subscriber's primary language of available internal and external appeals processes and the availability of the ombudsman to assist them with appeals. The external review shall be binding on the health plan. Enrollees can seek judicial review through available state or federal procedures.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez Amendment C# 6 to Chairman's Mark of America's Healthy Future Act

Title I

Short Title: Protecting consumers in an emergency.

Description of Amendment:

Each health care plan and health care insurance issuer offering coverage in the exchange shall provide enrolled individuals coverage for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the health plan. Further, enrollees may not be charged co-payments or cost-sharing for emergency services furnished out-of-network that are higher than in-network rates.

Offset: No cost anticipated.

Menendez Amendment C# 7 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle F

Short Title: Providing help with internal appeals.

Description of Amendment:

Allow policyholders to access the ombudsman for assistance in pursuing internal appeals with their health plans.

Offset: No cost anticipated.

Menendez Amendment C# 8 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle F

Short Title: Providing help with tax credit appeals.

Description of Amendment:

Allow policyholders to access the ombudsman for assistance in resolving problems with their premium and cost-sharing credits, and with assistance in filing appeals as needed.

Offset: No cost anticipated.

Menendez Amendment C# 9 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: Ensuring quality health care for those with autism and other behavioral health conditions.

Description of Amendment:

Specify that all plans must provide behavioral health treatment as part of mental health and substance abuse services.

Offset: No cost anticipated.

Menendez Amendment C# 10 to Health Care Reform Bill

Title II, Subtitle A

Short Title: Consolidating Medicare coverage of adult vaccines into Part B.

Description of Amendment:

The amendment consolidates Medicare coverage of adult vaccines into Part B. Vaccines are currently covered under both Part B and Part D. The amendment will change the Medicare payment for Part B vaccines to conform with payment for other Part B covered drugs and biologicals – using the Average Sales Price methodology. (Influenza vaccine payment would remain unchanged.). This provision is identical to Section 1310 of the House bill, which was scored by CBO as costing $1.5 billion over ten years.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez Amendment C# 11 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: To guarantee access to maternity care for young adults who are enrolled in Young Invincible Plans.

Description of Amendment:

Because Young Invincible Plans would only have to offer catastrophic coverage, this amendment would provide a fallback option that permits a woman enrolled in such plan to seamlessly enroll in a comprehensive plan if she becomes pregnant without any barriers such as waiting periods, affiliation periods, or any other obstacle to obtain comprehensive maternity coverage. Therefore, pregnancy shall be included as a qualifying life event for individuals enrolled in a Young Invincible Plan.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez/Rockefeller Amendment C# 12 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle G

Short Title: Covering all lawfully present children and pregnant women.

Description of Amendment:

Requiring states to cover lawfully present children and pregnant women in Medicaid and CHIP.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez Amendment C# 13 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: Providing a reduction in the out-of-pocket maximum for those between 300-400% of poverty.

Description of Amendment:

For those between 300-400 percent of FPL, within the same actuarial value, the benefit will include an out-of-pocket limit equal to two-thirds of the Health Savings Account (HSA) current law limit.

Offset: No cost anticipated.

Menendez Amendment C# 14 to Chairman's Mark of America's Healthy Future Act

Short Title: Support, education, and research for postpartum depression.

Description of Amendment:

Provide support services to women suffering from postpartum depression and psychosis and also help educate mothers and their families about these conditions. In addition, this amendment will support research into the causes, diagnoses and treatments for postpartum depression and psychosis.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending.

Menendez Amendment C# 15 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle C

Short Title: Applicability of Systematic Alien Verification for Entitlements (SAVE) and Ensuring Data Accuracy To Protect U.S. Citizens and Legal Residents.

Description of Amendment:

For any eligibility determination that an individual is a legal United States resident under this Act, the federal government shall provide, in consultation with the Secretary of Homeland Security, for the applicability of Systematic Alien Verification for Entitlements described in section 1137 of the Social Security Act, in the same manner as such section applies with respect to a State in implementing title XIX of the Social Security Act. U.S. Citizenship and Immigration Services and any other agency charged with management of the system shall establish appropriate safeguards necessary to protect and improve the integrity and accuracy of data by establishing a process through which such individuals are provided access to, and the ability to amend, correct, and update, their own personally identifiable information contained within the system. U.S. Citizenship and Immigration Services and any other agency charged with developing a verification system shall provide a written response, without undue delay, to any individual who has made such a request to amend, correct, or update records. The U.S. Citizenship and Immigration Service and any other agency charged with developing a verification system shall develop a written notice for user agencies to provide to individuals who are denied a benefit due to a determination of ineligibility based on a final verification determination under the system. The notice shall include information about the reason for such notice, a description of the right of the recipient of the notice to contest such notice, a description of the right of the recipient to access and attempt to amend, correct, and update the recipient's own personally identifiable information contained within records of the system, and instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies. Applicants for insurance coverage or for health care tax credits shall be required to provide only the information strictly necessary to determine eligibility for the coverage or the credits. Information provided to the exchange by the applicant or by the Internal Revenue Service shall not be disclosed or shared with other agencies, entities or individuals for any purpose that is not directly connected with the administration of the health insurance program.

Offset: No cost anticipated.

Menendez Amendment C# 16 to Chairman's Mark of America's Healthy Future Act

Title III, Subtitle H

Short Title: To authorize a pilot project for state-based innovations to reduce medical errors.

Description of Amendment:

Authorizes a pilot program for state-based innovations to reduce medical errors.

Offset: Authorization for discretionary sums that are not yet determined.

Menendez/Stabenow Amendment C# 17 to Chairman's Mark of America's Healthy Future Act

Title I, Subtitle G

Short Title: Increasing the CHIP wrap to 275 percent of the poverty level.

Description of Amendment:

Establish a Federal floor for CHIP eligibility at 275 percent of FPL –requiring states to offer CHIP to all children between 134 and 275 percent of FPL.

Offset: Offset to be determined when offered.

Carper Amendment #C1 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To provide workplace wellness tax credits.

Description of Amendment:

Under current law, the expense of an employer-provided wellness program for employees is deductible by the employer as a business expense under section 162.

Under this amendment, a tax credit would be allowed for 50 percent of the costs paid by an employer for providing a "qualified wellness program" during a taxable year. The amount of the credit would be limited to an amount not exceeding $200 for each of the first 50 employees, plus $100 for each additional employee beyond the first 50 employees. This credit is limited to employers with 100 or fewer employees. Only employees generally working more than 25 hours per week are taken into account. For purposes of this credit, any amount paid for food or health insurance could not be included as a cost of the wellness program. The credit would not be refundable and would not be paid in advance and would be available for a maximum of 5 years. The credit would only be available for employers that are not providing qualified wellness programs upon enactment of the Act.

To claim the tax credit for eligible expenditures, an employer would be required to obtain a certification by the Secretary of HHS (in coordination with the Director of the Center for Disease Control and the Secretary of the Treasury) that its program meets the definition of a qualified wellness program.

In order for a program to be a qualified wellness program, all employees would be required to be eligible to participate in the program. A qualified wellness program would be required to be consistent with evidence-based research and best practices, as determined by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs. Further, a qualified wellness program must include the following four components:

1. Health awareness (such as health education, preventive screenings and health risk assessments);
2. Employee engagement (such as mechanisms to encourage employee participation);
3. Behavioral change (elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials); and
4. Supportive environment (such as creating on-site policies that encourage healthy lifestyles, healthy eating, physical health and mental health).

Offset: Under current law, taxpayers may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed a threshold of 7.5 percent of Adjusted Gross Income (AGI). This amendment shall adjust the AGI threshold upwards by an amount necessary to offset the increase in spending.

Carper Amendment #C2 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: Encouraging employer-sponsored wellness programs under HIPAA by increasing the premium discount that employers can use to reward employees for participating in wellness programs.

Description of Amendment: This amendment codifies the current regulatory framework of allowances for premium deduction under HIPAA, immediately raising the allowed percentage reduction in premium (or rebate or a modification of a co-pay or deductible) from 20 percent to 30 percent and allowing the Secretaries of HHS, Department of Labor and Treasury the discretion to take the percentage up to 50% for adherence to or participation in a reasonably designed program of health promotion and disease prevention.

The language defines programs of health promotion of disease prevention to meet certain requirements and to assure that none of the conditions are based on health status factors.

The reward must be available to everyone. There must exist within a program, a reasonable alternative standard (or waiver of otherwise applicable standard) for obtaining the reward for anyone for whom it is medically inadvisable to satisfy the standard, or for anyone for whom it is unreasonably difficult due to a medical condition. All plan materials must state the availability of an alternative standard or waiver within the wellness program.

Offset: No offset is required.

Carper Amendment #C3 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To establish a virtual health coach program for chronic diseases in Medicaid with demonstration grant program.

Description of Amendment: This amendment uses cutting-edge information and communication technology to coordinate and improve the treatment of chronic diseases: diabetes, asthma, heart disease, obesity, and depression. The amendment requires the Secretary of Health & Human Services to develop a demonstration grant program to encourage states to implement pilots that leverage wireless patient self-management technologies. Medicaid grants would be provided to ten states to carry out these demonstration pilots, totaling $120 million for five years.

Studies have shown that using inexpensive, communication technologies to help treat chronic diseases can lead to better, and earlier, treatment, thus avoiding expensive (and life-threatening) complications. This program takes advantage of these technologies through the development of wireless and Internet-based tools that simplify the complex management and treatment of patients with chronic diseases. These tools are developed specifically for use with the commonly available, inexpensive technologies that Americans use every day, including cell phones, e-mail, and text messaging. This program would take lessons learned from previous peer-reviewed studies and apply them to a deserving, but underserved, population – Americans who rely on Medicaid-based health care to keep them healthy.

Offset: Increase market basket reduction for all providers by amount necessary to offset the increase in spending.

Carper Amendment #C4 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To require CMS to increase its public outreach and guidance to states and health care providers regarding Medicaid's coverage of obesity-related services.

Description of Amendment: Obesity is a pervasive chronic condition affecting almost every segment of the U.S. population. Roughly one in every three Americans is obese. A recent GAO study found that almost one of every five Medicaid children is obese and that Medicaid adults are more likely to be obese as compared to adults with private health insurance. Obesity rates are also higher in adults between ages 55 and 64 than they are among adults ages 65 and older, making obesity a significant and growing problem in for seniors as well in the general population.

Obesity and related illnesses are also extremely expensive to treat. Chronic diseases, many of them associated with obesity, lead to 70% of U.S. deaths and represent 75% of the treatment costs. More than 95% of Medicare spending is related to health care for patients with chronic disease. Costs from obesity alone could be as high as $147 billion.

In many states, Medicaid provides obesity-related services to eligible children and adults. To increase public awareness regarding such services, CMS is required to increase public outreach and guidance to states and health care providers regarding the types of obesity-related benefits, such as obesity screening and counseling, available to their Medicaid-eligible populations. CMS will report to the Congress on its public outreach and guidance efforts to states and health care providers in 2011, 2014, and 2017.

Offset: No offset is required.

Carper Amendment #C5 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To conduct a study on methods that health plans within the exchange can use to encourage increased meaningful use of electronic health records by health care providers.

Description of Amendment:

The Chairman's Mark requires states to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market in 2010.

This amendment requires the Secretary or his/her designate to conduct a study on methods that entities offering insurance plans through the exchange can use to encourage increased meaningful use of electronic health records by health care providers, including:

1. Insurance plans offering higher reimbursement rates for meaningful use of electronic health records; 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.

Not later than two years after the date of enactment of the America's Health Future Act, the Secretary or his/her designate must submit to the Congress a report containing the results of the study and recommendations concerning whether insurance plans offered in the exchange should increase reimbursement rates to health care providers in order to increase meaningful use of electronic health records.

Not later than one year after the date the report is submitted to the Congress, the Secretary must disseminate the finding of the report to the state and/or regional exchanges.

Offset: No offset is required.

Carper Amendment #C6 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To allow agents and brokers, including existing health exchanges, to play an immediate complementary role to any state or regional based exchange.

Description of Amendment:

The Chairman's Mark requires states to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market in 2010.

This amendment allows agents and brokers the immediate right to enroll individuals and employers in any health insurance option available in the state exchanges. Individuals or employers obtaining a health plan through an agent or broker would also not be discriminated against for tax purposes. State regulators would maintain their authority over agents and brokers, and the amendment would not change the process established by the Chairman's Mark for verifying a person or employer's eligibility for the subsidies and distributing those to the proper health insurance companies.

The HHS Secretary would be able to regulate the ability of agents or brokers to assist individuals eligible for tax credits or other subsidies in enrolling in qualified health plans utilizing such subsidies and other relevant aspects of subsidy administration.

Offset: No offset is required.

Carper Amendment #C7 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To make references to preventive services and immunizations consistent throughout the Chairman's Mark by replacing the relevant language in Title I Subtitle C (Benefit Options) and Title I Subtitle D (Personal Responsibility Requirement) with language consistent with requirements established in Title II Subtitle B (Medicaid).

Description of Amendment: The Chairman's Mark includes several references to "preventive services" or "preventive services and immunizations" throughout the document. However these references are not consistently described in the various sections of the bill.

This amendment replaces references to preventive services and immunizations in Title I Subtitle C (Benefit Options) and Title I Subtitle D (Personal Responsibility Requirement) with language consistent with requirements established in Title II Subtitle B (Medicaid).

Specifically, in Title I Subtitle C (Benefit Options), the language referring to required coverage for preventive care services should be changed to "In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) **for all USPSTF recommended preventive care services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)**, except in cases where value-based insurance design is used."

In Title II Subtitle B (Personal Responsibility Requirement), the language referring to required first dollar coverage for prevention-related services should be changed to "Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through (1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or (2) in the large group market, in a plan with first dollar coverage for prevention-related services as recommended by the U.S. Preventive Services Task Force **and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)** – except in cases where value-based insurance design is used and cannot have a maximum out-of-pocket limit greater than that provided by the standards established for HSA current law limit."

Offset: No offset is required.

Carper Amendment #C8 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To pay for expanded affordability credits by increasing the total value of employer-sponsored health coverage that is subject to the excise tax on high cost insurance

Description of Amendment:

Title I, Subtitle C of the Chairman's Mark provides health affordability tax credits in the form of a premium credit. Beginning in 2013, premium credits shall be available on a sliding scale basis for individuals and families between 134-**300** percent of the Federal Poverty Level (FPL) to help offset the cost of private health insurance premiums. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 13 percent of income.

This amendment eliminates the sliding scale established in the Chairman's Mark. This amendment inserts the sliding scale adopted by the Senate Health, Education, Labor and Pensions (HELP) Committee on July 15, 2009 in the Affordable Health Choices Act. Specifically, beginning in 2013, premium credits shall be available on a sliding scale basis for individuals and families between 134-**400** percent of the Federal Poverty Level (FPL) to help offset the cost of private health insurance premiums.

This amendment adopts other provisions of Title I, Subtitle C, as appropriate.

Offset: Title VI of the Chairman's Mark imposes an excise tax on high cost insurance. The Chairman's Mark establishes a threshold amount of $8,000 for individual coverage and $21,000 for family coverage for 2013 – indexed to the Consumer Price Index for Urban Consumers (CPI-U) as determined by the Department of Labor beginning in 2014.

This amendment establishes a threshold amount of the excise tax on high cost insurance of $6,800 for individual coverage and $17,500 for family coverage for 2013. This amendment retains the other provisions in the Chairman's Mark relating to the excise tax on high cost

insurance (e.g., inflation index, transition rules). This amendment is intended to be revenue neutral with respect to the Chairman's Mark; the threshold amounts established in this amendment may be adjusted to ensure that it raises an amount of revenue equal to the additional cost of this amendment's expansion of premium credits.

Carper Amendment #C9 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To pay for expanded affordability credits by eliminating the excise tax on high cost insurance and enacting a limit on the value of excludable high-cost employer-provided health premiums

Description of Amendment:

Title I, Subtitle C of the Chairman's Mark provides health affordability tax credits in the form of a premium credit. Beginning in 2013, premium credits shall be available on a sliding scale basis for individuals and families between 134-**300** percent of the Federal Poverty Level (FPL) to help offset the cost of private health insurance premiums. Individuals between 300-400 percent of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 13 percent of income.

This amendment eliminates the sliding scale established in the Chairman's Mark. This amendment inserts the sliding scale adopted by the Senate Health, Education, Labor and Pensions (HELP) Committee on July 15, 2009 in the Affordable Health Choices Act. Specifically, beginning in 2013, premium credits shall be available on a sliding scale basis for individuals and families between 134-**400** percent of FPL to help offset the cost of private health insurance premiums.

This amendment adopts other provisions of Title I, Subtitle C, as appropriate.

Offset: The Chairman's Mark imposes an excise tax on high cost insurance. This amendment would eliminate that excise tax on high cost insurance and would enact the following provisions:

This amendment imposes ordinary income tax on the value of employer-sponsored coverage that exceeds a threshold amount. Any amount above that threshold is subject to the ordinary individual income tax. The value of the employer-provided health coverage excluded from an

employee's gross income shall be limited to $6,800 for individual coverage and $17,500 for family coverage for 2013. The threshold amounts are indexed to the Consumer Price Index for Urban Consumers (CPI-U) as determined by the Department of Labor beginning in 2014.

This amendment retains the other provisions in the Chairman's Mark relating to the excise tax on high cost insurance (e.g., inflation index, transition rules). This amendment also

grandfathers the current law tax exclusion for employer-provided health insurance coverage under a group health plan maintained pursuant to one or more collective bargaining agreements in effect when the change is enacted. In this situation, any change to the tax exclusion would only apply when the last relevant agreement terminates.

This amendment is intended to be revenue neutral with respect to the Chairman's Mark; the threshold amounts established in this amendment may be adjusted to ensure that it raises an amount of revenue equal to the additional cost of this amendment's expansion of premium credits.

Grassley Amendment #C 1

Short Title:
Preventing increases in health insurance costs

Purpose:
To require Health and Human Services' Chief Actuary to study premium rates and provide an exemption from new federal requirements for states with significant premium increases

Background:
The Chairman's Mark proposes new federal regulations for individual and small group health insurance. These new regulations establish new rating and issuance rules, benefit requirements, and minimum actuarial standards. In many states, these new rules will be substantially more restrictive than existing state requirements.

Description:
This amendment would require the Chief Actuary to study premium rates in each state 180 days after enactment and each year after that. If in any year premiums are found to have increased by more than 10 percent for a specific population (minorities, certain age groups, early retirees, etc.), the state may be exempt from the proposed insurance market requirements.

Grassley Amendment #C 2

Purpose:
To guarantee the independence of health care co-ops from federal government interference.

Background:
The Chairman's Mark provides health care cooperatives with the authority to form group purchasing councils. The mark further states that "the council shall be prohibited from setting payment rates for health care facilities and providers."

Description:
This amendment would make that more explicit by including a provision that, just as with Part D, the Secretary may not interfere with the negotiations between a co-op or co-ops and drug manufacturer, pharmacy, hospital or any other health care provider; and may not require or institute a price structure for the reimbursement of any health care service covered by the co-op or co-ops. This amendment clarifies that nothing in this section or in this part shall be construed as authorizing the Secretary to authorize or institute a price structure for benefits, or to otherwise interfere with the competitive nature of providing health insurance benefits through a health care cooperative.

Grassley Amendment #C 3

Short Title:
To require that elected officials and all federal employees purchase coverage through exchanges

Purpose:
To require that elected officials and federal employees purchase insurance in the same manner proposed in the Chairman's mark for private citizens

Background:
The Chairman's Mark establishes state-based exchanges that are designed to provide private health insurance options for consumers to choose from.

Description:
This amendment would require that, not withstanding any other provision of law, beginning in 2013 elected officials and federal employees must purchase coverage through a state-based exchange, rather than using the traditional Federal Employees Health Benefits Plan (FEHBP).

Grassley Amendment #C 4

Short Title:
Providing consumers with the same health insurance options as Members of Congress

Purpose:
To allow health insurance policies that meet the definition of a High Deductible Health Plan (HDHP) under the tax rules for Health Savings Accounts to satisfy the individual mandate to purchase insurance.

Background:
In 2009, under current law, an HSA-qualified HDHP has a deductible of at least $1,150 for self-only coverage and $2,300 for family coverage. However, an HSA-qualified HDHP may cover preventive care before the deductible is met. Qualifying HDHPs must also limit out-of-pocket expenses for covered benefits to certain amounts — for self-only coverage, the 2010 limit on out-of-pocket expenditures for covered benefits must not exceed $5,800; for family policies, the limit must not exceed $11,600. These limits are indexed annually by CPI-U.

Description:
This amendment would allow any HDHP that meets the tax rules for HSAs to qualify as Minimum Creditable Coverage in the Chairman's Mark. This would allow consumers to choose from a wider array of plans, similar to the choices provided to Members of Congress. Any savings achieved by this recalculation would be used to lower the overall cost of the entire proposal.

Grassley Amendment #C 5

Short Title:
Protecting access to Medicare Advantage for rural beneficiaries

Purpose:
To ensure that changes to the Medicare Advantage program do not result in decreased access for beneficiaries living in rural areas

Background:
Title III, Subtitle C of the Chairman's Mark proposes significant changes to the Medicare Advantage program that could result in less access for seniors living in rural areas.

Description:
This amendment would require that prior to implementing any of the changes in Title III, Subtitle C, the Secretary of Health and Human Services must certify that the proposed changes will not result in decreased access to Medicare Advantage plans in rural areas.

Grassley Amendment #C 6

Short Title:
Promoting coverage without the use of a government requirement to purchase insurance

Purpose:
To replace proposed requirement to purchase insurance with a mechanism similar to the open enrollment period and late enrollment penalties in Medicare Part D.

Description:
In place of the individual mandate, health plans in the individual market would provide an annual open enrollment period that would exist between November 1st and December 15th – with certain exceptions similar to those in COBRA continuation coverage. After the open enrollment period, there would be a 90 day grace period before any late-enrollment penalties would be assessed.

If a person enrolled after the 90 day grace period, private health plans could assess an actuarially fair penalty established by the Secretary of Health and Human Services. The late enrollment penalty would increase on a sliding scale each year starting at 10 percent of the full penalty one month after the grace period to a maximum of 100 percent of the penalty after 7 years. Health plans would collect late enrollment penalties and transfer to a general reinsurance fund.

Individuals are responsible for maintaining proof of coverage or documentation that an exception to the requirement to maintain coverage applied. If an individual fails to maintain proof of coverage or an exception, they may be assessed the maximum penalty upon enrollment.

Individuals would be notified of pending late enrollment penalties on an annual basis for each year they go without coverage. If an individual has a gap in coverage of more than 90 days, then they could be subject to pre-existing condition exclusions or waiting periods of no more than 18 months.

Enrollment is a 12-month contract. If enrollee drops coverage or fails to pay premiums during a part of a contract year, premiums continue to be owed per the contract and the plan may seek enforcement through the tax code for nonpayment.

Each state would establish and administer a reinsurance pool. Insurers could obtain retrospective reinsurance payments on individuals enrolled in new individual market policies. Federal reinsurance payments would be equal to 75 percent of the excess above $50,000, but subject to certain limitations to promote efficient use of resources.

Any savings achieved through this amendment are redirected towards other provisions in the Chairman's Mark.

Grassley Amendment #C 7

Short Title:
Promoting coverage without the use of a government requirement to purchase insurance

Purpose:
To replace proposed requirement to purchase insurance with a mechanism similar to the open enrollment period and late enrollment penalties in Medicare Part D and to replace the mandate to expand Medicaid with an incentive for states to expand Medicaid.

Description:
In place of the individual mandate, health plans in the individual market would provide an annual open enrollment period that would exist between November 1st and December 15th – with certain exceptions similar to those in COBRA continuation coverage. After the open enrollment period, there would be a 90 day grace period before any late-enrollment penalties would be assessed.

If a person enrolled after the 90 day grace period, private health plans could assess an actuarially fair penalty established by the Secretary of Health and Human Services. The late enrollment penalty would increase on a sliding scale each year starting at 10 percent of the full penalty one month after the grace period to a maximum of 100 percent of the penalty after 7 years. Health plans would collect late enrollment penalties and transfer to a general reinsurance fund.

Individuals are responsible for maintaining proof of coverage or documentation that an exception to the requirement to maintain coverage applied. If an individual fails to maintain proof of coverage or an exception, they may be assessed the maximum penalty upon enrollment.

Individuals would be notified of pending late enrollment penalties on an annual basis for each year they go without coverage. If an individual has a gap in coverage of more than 90 days, then they could be subject to pre-existing condition exclusions or waiting periods of no more than 18 months.

Enrollment is a 12-month contract. If enrollee drops coverage or fails to pay premiums during a part of a contract year, premiums continue to be owed per the contract and the plan may seek enforcement through the tax code for nonpayment.

Each state would establish and administer a reinsurance pool. Insurers could obtain retrospective reinsurance payments on individuals enrolled in new individual market policies. Federal reinsurance payments would be equal to 75 percent of the excess above $50,000, but subject to certain limitations to promote efficient use of resources.

Further, the Chairman‘s Mark would create a new eligibility category for all non-elderly non-pregnant individuals (childless adults) otherwise ineligible for Medicaid. In 2011, states would have the option to cover childless adults through a state plan amendment (SPA). The Chairman‘s Mark would establish 133 percent of FPL as the new mandatory minimum Medicaid income eligibility level for all non-elderly individuals – parents, children, and childless adults – beginning on January 1, 2014.

This amendment would strike the provision requiring states to cover all childless adults up to 133 percent of FPL as of January 1, 2014.

For states that do expand to cover childless adults after January 1, 2011, those states will receive an enhanced FMAP percentage for coverage of newly eligible childless adults that is 20% higher than the state's regular FMAP not to exceed 95%.

Any savings achieved through this amendment are redirected towards other provisions in the Chairman's Mark.

Grassley Amendment #C 8

Purpose:
An amendment to require presentation of identification in applying for Medicaid benefits

Description of Amendment:
The amendment amends Title 19 of the Social Security Act to require an applicant (or the parent or guardian in the case of a child under the age of 18) to present at the time of application for Medicaid or CHIP benefits government-issued photo identification and that identification must be authenticated with the issuing agency.

Grassley Amendment #C 9

Purpose:
To improve access to care for children in Medicaid

Description:
This amendment requires states to raise reimbursement rates for Medicaid providers (such as pediatricians, children's hospitals, and dentists) providing care for an eligible child to 100% of Medicare levels starting in 2014. States get 100% match for the additional cost of reimbursing providers for two years phasing back to regular matching rate by 2019. The additional cost of this provision is paid for by eliminating subsidies provided in the bill to people over 300% of poverty and lowering the overall subsidy amount to a sufficient amount to make up the difference.

Grassley Amendment #C 10

Purpose:
To guarantee access in Medicaid for children

Description:
This amendment requires the Secretary to certify that a state has at least 90% of providers (such as pediatricians, children's hospital, and dentists) in a state that treat children are participating in the state Medicaid program and are accepting children eligible for Medicaid before the state can be required to expand mandatory eligibility levels in 2014.

Grassley Amendment #C 11

Purpose:
To protect state budgets from the maintenance of effort mandate

Background:
The Chairman's Mark requires that states maintain existing income eligibility levels for all Medicaid populations upon enactment of this bill. This maintenance of effort provision would expire when the state exchange becomes fully operational (expected January 1, 2013), except as it applies to coverage at income levels of 133 percent of FPL and below, for which it would continue through January 1, 2014.

Currently, states are operating under a maintenance of effort for their Medicaid populations. The American Recovery and Reinvestment Act (ARRA) included a provision that requires states to maintain coverage of populations in exchange for additional FMAP assistance. That assistance expires December 31, 2010.

Description:
This amendment would prevent the maintenance of effort from being enforced after from January 1, 2011 through January 1, 2014 if states do not have the additional FMAP matching rate provided in ARRA.

Grassley Amendment #C 12

Short Title:
Providing relief to American businesses

Purpose:
To suspend any employer penalties proposed in Title I Subtitle D of the Chairman's Mark for two years whenever the National Bureau of Economic Research declares an economic recession is occurring.

Background:
Under the Chairman's Mark, employers with more than 50 full-time employees -- 30 hours and above -- that do not offer health coverage would be required to pay a fee for each employee receiving a tax credit for health insurance through an exchange. The assessment would be based on the amount of the tax credit received by the employee, capped at an amount equal to $400 multiplied by the total number of employees at the firm. Employees participating in a welfare-to-work program, children in foster care and workers with a disability would be exempted from this calculation.

Description:
This amendment would suspend any fees for two years following an announcement of an economic recession by the National Bureau of Economic Research. It would be offset by eliminating any subsidies in the Chairman's Mark for individuals and families between 300 and 400 percent of federal poverty level ($66,150 to 88,200 for a family of four).

Grassley Amendment #C 13

Short Title:
Protecting Medicare Benefits

Purpose:
To make sure Medicare beneficiaries do not see a reduction in benefits as a result of the policies proposed in the Chairman's Mark

Background:
Title III, Subtitle C of the Chairman's Mark proposes significant changes to the Medicare Advantage program that could result in a reduction in benefits for seniors.

Description:
This amendment would require that prior to implementing any of the changes in Title III, Subtitle C, the Secretary of Health and Human Services must certify that the proposed changes will not result in a reduction in benefits for Medicare Advantage beneficiaries.

Grassley Amendment #C 14

Short Title:
To reduce federal spending

Purpose:
To lower the overall cost of the bill by prohibiting any individual above 300 percent of federal poverty level (FPL) from receiving federal assistance proposed in the Chairman's Mark for the purchase of private health insurance.

Background:
For individuals/families between 300-400 percent of FPL ($66,150 to 88,200 for a family of four), the Chairman's Mark provides additional subsidies by capping an individual's share of health insurance premiums to a flat 13 percent of income.

Description:
This amendment would eliminate any subsidies for households with incomes in excess of 300 percent of FPL. Any savings achieved as a result of this change would be used to lower the overall cost of the proposal.

Grassley Amendment #C 15

Short Title:
Promoting state flexibility and individual freedom

Purpose:
To make the individual mandate in Title I Section D of the Chairman's Mark a state option

Background:
Under the Chairman's Mark, beginning in 2013, all U.S. citizens and legal residents would be required to purchase health insurance or have health coverage from an employer, through a public program (e.g., Medicare, Medicaid or CHIP), or through some other source that meets the minimum creditable coverage standard. Individuals who kept their current plan would be deemed to have satisfied the requirement. Those who do not comply with the requirement would be subject to a penalty, which increases with income, up to a maximum of $950 per year for an individual and $3,800 per year for a family.

Description:
This amendment would give states the option of pursuing alternative mechanisms to encourage the purchase of health insurance.

Grassley Amendment #C 16

Short Title:
To promote state flexibility and innovation

Purpose:
To allow states to opt-out of certain requirements established in the Chairman's Mark

Background:
The Chairman's Mark establishes a range of new federally mandated insurance market reforms.

Description:
This amendment would allow states to pursue alternative approaches to the reforms outlined in the Mark document. In order for a state to opt-out of the Medicaid expansion, individual mandate, and rating and benefit requirements, the state must have a plan for maintaining health insurance coverage at or above projected levels, not increasing federal costs or total health spending, and improving the quality of care delivered to state residents.

This plan must be presented to the Secretary of Health and Human Services and Office of Management and Budget with a certification from the State Insurance Commissioner. Once submitted, plans are automatically approved after 90 days.

Hatch Amendment #C1 to America's Healthy Future Act of 2009

Short Title: Ensure Americans can keep the coverage they have by keeping premiums affordable.

Description: The implementation of America's Healthy Future Act of 2009 shall be conditioned on the Secretary of Health and Human Services certifying to Congress that this legislation would not increase premiums for more than 1,000,000 Americans.

Offset: Not applicable.

Hatch Amendment #C2 to America's Healthy Future Act of 2009

Short Title: Ensure Americans can keep the coverage they have.

Description: The implementation of America's Healthy Future Act of 2009 shall be conditioned on the Secretary of Health and Human Services certifying to Congress that this legislation would not cause more than 1,000,000 Americans to lose the current coverage of their choice.

Offset: Not applicable.

Hatch Amendment #C3 to America's Healthy Future Act of 2009

Short Title: Ensure health care savings for American families.

Description: The implementation of the America's Healthy Future Act of 2009 shall be conditioned on the Congressional Budget Office reporting that this legislation will result in savings of $2500 per family as envisioned by the President.

Offset: Not applicable.

Hatch Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Strike the new federally imposed individual mandate and replace it with a state option.

Description: The amendment would strike the new federal government imposed mandate (or personal responsibility requirement) under Title I, Subtitle D (page 28) on all US Citizens and legal residents beginning in 2013, where in middle-class families making above 300 percent of federal poverty level could face a maximum penalty of up to $3800, if they fail to purchase one of the defined coverage categories. This amendment would instead leave the decision of having or not having an individual mandate up to states as under current law where they could make the decision for their respective populations as opposed to a federal government imposed and enforced mandate.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #C5 to America's Healthy Future Act of 2009

Short Title: Protect and promote employment for low-income Americans.

Description: The amendment would strike the new federal government imposed requirement that employers with more than 50 employees, who may not currently be able to offer health coverage, but have a full-time employee(s) receiving a low-income tax credit could face an assessment of an amount equal to the average tax credit in the state exchange, capped up to $400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange credit). So an employer with 100 employees could face a penalty of up to $40,000. This amendment would strike this federally-mandated payment for employers.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #C6 to America's Healthy Future Act of 2009

Short Title: Protect and promote employment for low-income Americans.

Description: The implementation of the required payment for employers under Title I, Subtitle D (pages 31-32) in America's Healthy Future Act of 2009, shall be conditioned on the Secretary of Department of Labor certifying that this provision will not disproportionately impact employment and hiring practices for low-income Americans.

Offset: Not applicable.

Hatch Amendment #C7 to America's Healthy Future Act of 2009

Short Title: Strike the Federal Government-funded Health Care Cooperative under Title I, Subtitle E and direct savings to reduce the deficit.

Description: See above.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #C8 to America's Healthy Future Act of 2009

Short Title: Automatic Enrollment of Members of Congress Voting for the Federal Government-funded Health Care Coooperative.

Description: Upon enactment, any Member of Congress voting for the federal-government funded health care cooperatives under Title I, Subtitle E will be dropped from their current plan and automatically enrolled in the healthcare cooperative of their respective state.

Offset: Not applicable.

Hatch Amendment #C9 to America's Healthy Future Act of 2009

Short Title: Create a level-playing field for Health Care Cooperatives.

Description: To ensure a level-playing field for fair competition the government-funded health care cooperatives under Title I, Subtitle E must meet all the requirements imposed on other private insurance providers by the respective states in which the cooperative is located. This would include solvency and licensure requirements, rules on payments to providers, compliance with network adequacy rules, compliance with rate and form filing rules and any applicable State premium assessments.

Offset: Not applicable.

Hatch Amendment #C10 to America's Healthy Future Act of 2009

Short Title: Restoration of funding for Abstinence Education

Description: The amendment would direct $50 million a year through FY 2014 appropriated under Title I, Subtitle I of the Chairman's Mark for Section 510 of Title V of the Social Security Act.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #C11 to America's Healthy Future Act of 2009

Short Title: Strike Medicaid Expansion

Description: This amendment would strike the provisions that would strike the Medicaid expansions included in the mark on page 42.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #C12 to America's Healthy Future Act of 2009

Short Title: Prohibits federal funds under this Mark from being used to pay for assisted suicide and offers conscience protections to providers or plans refusing to offer assisted suicide services

Description:

Protecting Americans And Ensuring Taxpayers Funds in Government Health Care Plans Do Not Support Or Fund Physician-Assisted Suicide

The Federal Government, and any State or local government or health care provider that receives federal financial assistance under this Mark (or under an amendment made by this Mark) or any health plan created under this Mark (or under an amendment made by this Mark), shall not pay for or reimburse any health care entity to provide for any health care item or service furnished for the purpose of causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

Prohibition Against Discrimination on Assisted Suicide

The Federal Government, and any State or local government or health care provider that receives federal financial assistance under this Mark (or under an amendment made by this Mark) or any health plan created under this Mark (or under an amendment made by this Mark), may not subject an individual or institutional health care entity to discrimination 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.

Offset: Not applicable.

Hatch Amendment #C13 to America's Healthy Future Act of 2009

Short Title: Non-discrimination on abortion and respect for right of conscience

Description:

Non-Discrimination on abortion and respect for rights of conscience

(a) NON DISCRIMINATION.—A Federal agency or program, and any State or local government that receives Federal financial assistance under this Act (or and amendment made by this Act), may not-
    1) subject any individual or institutional health care entity to discrimination, or
    2) require any health plan created or regulated under this Act (or an amendment made by this Act), to subject any individual or institutional health care entity to discrimination, on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) DEFINITON.—In this section, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) ADMINISTRATION.—The Office for Civil Right of the Department of Heath and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

Offset: Not applicable.

Hatch Amendment #C14 to America's Healthy Future Act of 2009

Short Title: Prohibits authorized or appropriated federal funds under this Mark from being used for elective abortions and plans that cover such abortions.

Description:

No funds authorized or appropriated under this Mark may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

Nothing in this amendment would preclude an insurance issuer from offering a separate, supplemental policy to cover additional abortions. Such a supplemental policy would be funded solely by supplemental premiums paid for by individuals choosing to purchase the policy.

Rationale:

All other major federal health programs preclude federal funds from being used to support abortion or any benefits package that includes abortion, beyond the limited circumstances of life endangerment and rape/incest. In some programs such as SCHIP (State Children's Health Insurance Program) this is written into permanent law; in others, such as Medicaid, Medicare and

FEHBP (Federal Employees Health Benefits Program) longstanding appropriations riders, the Hyde amendment and parallel provisions, have long prevented federal funds from paying for abortions or from supporting any of the costs of a health plan that includes them. In FEHBP, because federal funds are used to supplement private premium dollars, all the health plans offered to federal employees must completely exclude abortion except for these very limited circumstances. This amendment would respect the same policy in the health care reform legislation, while allowing truly private insurance coverage for elective abortions to continue as long as this is done through a supplemental policy, chosen and funded by the purchaser and kept completely separate from the federally subsidized package of benefits. In this way longstanding federal policy on abortion funding will be preserved, anyone who wants abortion coverage may purchase it, and people will not be forced to pay for other people's abortions.

Offset: Not applicable.

SNOWE AMENDMENT #1 - COVERAGE

Short Title: Provision of Safety Net fallback plan to ensure access to affordable coverage

Description of Amendment: This amendment establishes a non-profit government corporation through which a "safety net" plan would be provided in any state in which *affordable coverage was n*ot available in the Exchange to at least 95% of state residents. An individual would be deemed to have affordable access if either of two conditions is met. First, two or more plans are offered with premiums – the cost of which does not exceed a specified percentage of the individual's adjusted gross income (AGI), after deducting any available tax credit or employer subsidy from the cost of such premium. The percentage contribution shall range from 3 percent of AGI at 133 percent of the Federal Poverty Level, to 13 percent at 300 percent and above.

Assessment of affordability shall follow submission of plan premiums filed one year in advance of the first day of each policy year, and should a state be found to not meet the 95% threshold, plans would be permitted to submit of any revised premium filings, after which a second assessment of affordability shall be performed. If, after that second assessment, a state still be deemed as not meeting the affordability standard, the safety net plan shall be offered within that state, and shall be available at the pending open season enrollment.

Cost: Offset to be provided.

SNOWE AMENDMENT #2 COVERAGE

Short Title: Scale Firewall Affordability Test to Protect Low Income Individuals

Description of Amendment: The Chairman's Mark currently provides that those who are offered employer-sponsored insurance (ESI) may not obtain tax credits in the Exchange. However, the Mark now recognizes that such coverage must be affordable, and provides an exception which permits individuals to obtain the tax credit assistance to which they would otherwise been entitled – were it not for an offer of ESI – if the individual's cost of premiums exceeds 13 percent of income. Such a test vastly exceeds the contribution which many lower income individuals would be required to make for coverage within the Exchange. This amendment modifies the affordability test for granting access to subsidized Exchange coverage, scaling the criteria from 3 percent at 133 percent of poverty to 13 percent at 300 percent of poverty.

Cost: No formal score available. Offset will be provided at a later date.

SNOWE AMENDMENT #3 COVERAGE

Cosponsor: Senator Lincoln

Short Title: Expand Small Business Participation in the SHOP Exchange

Description of Amendment: This amendment would allow small businesses, in all states, with up to 100 employees, to purchase coverage through the SHOP health insurance exchange created in the Chairman's Mark.

Cost: No cost anticipated

SNOWE AMENDMENT # 4 -- Coverage

Short Title: Medicaid Expansion Phase In Option

Description of Amendment: Under this amendment, for parents and childless adults, states have the option to either expand to 133 percent of poverty in 2014 (included in the Chairman's Mark) or expand to 100 percent of poverty in 2014, then phase in Medicaid eligibility to 133 percent of poverty more gradually. States that choose to expand more gradually would follow the lower, expansion state increase schedule.

SNOWE AMENDMENT # 5 -- Coverage

Short Title: Medicaid Early Expansion State Maintenance of Effort

Description of Amendment: States currently have a Medicaid maintenance of effort requirement on eligibility as a condition of receiving the enhanced match under ARRA through December, 2010. Under the Chairman's mark, States would be required to maintain existing income eligibility levels for all Medicaid populations upon enactment. This maintenance of effort provision would expire when the state exchange becomes fully operational (expected January 1, 2013), except as it applies to coverage at income levels of 133 percent of FPL and below, for which it would continue through January 1, 2014.

This amendment modifies the maintenance of effort requirement so that starting in 2011; it only applies to coverage at income levels of 133 percent of FPL and below. States that continue to provide coverage above 133 percent would receive an increase in FMAP for those populations.

SNOWE AMENDMENT #6 - COVERAGE

Short Title: Set maximum deductible for ESI coverage to ensure individuals access to timely care.

Description of Amendment: Under the Chairman's Mark, no maximum deductible is set for either individual or family coverage. Currently, the standard for minimum creditable coverage (MCC) permits annual out-of-pocket spending up to $5950 for individuals, and $11,900 for a family.

Such a limited design requirement, combined with low actuarial value, permits the design of plans which could employ very large deductibles which may significantly impair access to timely care when offered as employer-sponsored coverage. This amendment would require that an employer offering coverage shall not provide a plan with a deductible which exceeds $2,000 for individuals and $4,000 for families, unless offering contributions which offset any increase in deductible above these limits. This specified deductible limit is accommodated with no change in actuarial value, including not affecting the actuarial value of Bronze plans. This amendment specifically would not apply to any "young invincible" plan offered to those 25 and under.

Cost: No score, and no significant cost anticipated

SNOWE AMENDMENT #7 COVERAGE

Short Title: Expedite Insurance Market Reforms in Small Group Market

Description of Amendment: This amendment would expedite the insurance market reforms in the Chairman's Mark for the small group market and SHOP exchanges. This amendment would phase in reforms, including rating reforms, guaranteed issue and renewability, and preexisting condition rules, in the small group market and SHOP exchanges over five years, starting no later than the year after enactment, so that all rating reforms are in place no later than January 1, 2014.

Cost: No cost anticipated

SNOWE AMENDMENT #8 COVERAGE

Short Title: Expediting Larger Employer Participation in the SHOP Exchanges

Description of Amendment: This amendment would allow larger employers in all states, with more than 50 employees, to access the SHOP exchanges, starting in 2013.

Cost: No significant cost anticipated.

SNOWE AMENDMENT #9 COVERAGE

Short Title: Small Business Health Education and Awareness Grants

Description of Amendment: This amendment would allow Small Business Development Centers (SBDCs), a resource partner of the Small Business Administration, to participate in the competitive grant program established in the Chairman's Mark and would allow these participating SBDCs to assist small businesses in navigating the complex health insurance landscape.
Cost: None

SNOWE AMENDMENT #10 COVERAGE

Short Title: Continuation of Small Business Participation

Description of Amendment: This amendment would allow small businesses that grow beyond the upper employee limit in the SHOP exchange, to continue to purchase health insurance through the SHOP exchange. An employer participating in the SHOP exchange that experiences an increase in the number of employees so that such employer has in excess of the maximum number of employees as specified in the Mark, may not be excluded from continued participation solely as a result of such increase in employees.
Cost: No significant cost anticipated

SNOWE AMENDMENT # 11 -- Coverage

Short Title: Require Plans in the Exchange to Cover EPSDT.

Description of Amendment: Under the Chairman's Mark, states would provide wrap-around EPSDT coverage. This amendment would require plans in the Exchange to provide such coverage to eligible children.

SNOWE AMENDMENT **#** 12 -- Coverage

Short Title: Change Definition of Newly Eligible

Description of Amendment: This amendment re-defines “newly-eligible” for the purposes of receiving the increased FMAP to include those who were previously eligible for Medicaid but un-enrolled.

Offset: To be provided

KYL AMENDMENT #C1
America's Healthy Future Act of 2009

Short Title: Eliminate the Consumer Operated and Oriented Plan (CO-OP) Program.

Description of Amendment: Strike Subtitle E of Title I (the CO-OPs).

KYL AMENDMENT #C2

America's Healthy Future Act of 2009

Short Title: Eliminate Federal Funding of the Consumer Operated and Oriented Plan (CO-OP) Program.

Description of Amendment: The amendment would strike the authorization of $6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program under Subtitle E of Title I.

KYL AMENDMENT #C3

America's Healthy Future Act of 2009

Short Title: Eliminate the Federal Advisory Board.

Description of Amendment: The amendment would strike the advisory board for the Consumer Operated and Oriented Plan (CO-OP) program chaired by the Secretary of the Department of Health and Human Services under Subtitle E of Title I.

KYL AMENDMENT #C4

America's Healthy Future Act of 2009

Short Title: Prohibit the Federal Government's Takeover of Health Care.

Description of Amendment: Strike Title I.

KYL AMENDMENT #C5

America's Healthy Future Act of 2009

Short Title: Prohibit the Federal Government's Takeover of Health Care.

Description of Amendment: The amendment would Strike Title I, except for the provision prohibiting insurers from denying coverage based on a pre-existing condition.

KYL AMENDMENT #C6

America's Healthy Future Act of 2009

Short Title: Ensuring State Flexibility

Description of Amendment: The amendment would make Title I a state option. The federal government shall be precluded from regulating private health insurance, so as not to pre-empt states' rights and states' experience in overseeing health insurance markets.

KYL AMENDMENT #C7

America's Healthy Future Act of 2009

Short Title: Creating a Web-Based Marketplace

Description of Amendment: The amendment would strike Subtitle B under Title I and replace it with state-based exchanges that are websites run by private entities that display available insurance options, including Health Savings Accounts (HSAs), offered in the non-group and small group markets.

KYL AMENDMENT #C8

America's Healthy Future Act of 2009

Short Title: Increasing Consumer Choice of Insurance Options

Description of Amendment: The amendment would prohibit the federal government from requiring insurers to offer a silver and gold plan in the non-group and small group markets in order to participate in a state exchange.

KYL AMENDMENT #C9

America's Healthy Future Act of 2009

Short Title: Ensuring Consumer Access to Catastrophic Coverage Options

Description of Amendment: The federal government shall not prohibit any individual, regardless of age, from enrolling in the "young invincible policy" or a high deductible health plan with a Health Savings Account.

KYL AMENDMENT #C10

America's Healthy Future Act of 2009

Short Title: Ensuring Consumer Choice of Health Care Benefits

Description of Amendment: The amendment would prohibit the federal government from limiting consumer choice by defining the health care benefits offered through private insurance.

KYL AMENDMENT #C11

America's Healthy Future Act of 2009

Short Title: Ensuring Consumers' Choice of Insurance Options that Best Meet Their Health Care Needs

Description of Amendment: The federal government shall be prohibited from limiting consumer choice by setting actuarial values of health insurance plans.

KYL AMENDMENT #C12

America's Healthy Future Act of 2009

Short Title: Establishing a Level Playing Field for Grandfathered Plans

Description of Amendment: The amendment would make the premium tax credits available to individuals enrolled in grandfathered plans.

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan. It would also eliminate the ability for legal immigrants subject to a five-year waiting period under Medicaid or CHIP to access a tax credit until the waiting period's expiration.

KYL AMENDMENT #C13

America's Healthy Future Act of 2009

Short Title: Make Permanent the Small Business Tax Credit

Description of Amendment: The current credit is only available for two years and only for those that purchase insurance through the exchange. The amendment would permit small businesses to continue to take the tax credit after the initial two-year period and allow them to purchase coverage outside of an exchange.

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C14

America's Healthy Future Act of 2009

Short Title: Clarification that legal immigrants must reside in the U.S. for at least five years in order to be eligible for the tax credit available through the state exchanges.

Description of Amendment: Under current law, legal immigrants are barred from receiving federal Medicaid coverage until they have lived in the U.S. for at least five years. This amendment would clarify that legal immigrants will be eligible for the tax credit provided for in the chairman's mark only after they have lived in the U.S. for five years as well.

KYL AMENDMENT #C15

America's Healthy Future Act of 2009

Short Title: Clarification that real-time information sharing, with appropriate privacy protections, is required among the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service.

Description of Amendment: This amendment clarifies that appropriate real-time sharing of information among DHS, SSA, and IRS is required, at the beginning of the application process for the tax subsidy, to ensure that the multiple use of the same valid Social Security number, and other fraudulent uses, is prevented. The Social Security Administration can verify that an SSN is real, but it does not know whether an individual is using someone else's valid SSN in order to fraudulently obtain the tax subsidy provided for in the bill.

KYL AMENDMENT #C16

America's Healthy Future Act of 2009

Short Title: Allowing the purchase of health insurance across state lines.

Description of Amendment: This amendment would insert the "Health Care Choice Act of 2009." (S. 1459)

SECTION 1. SHORT TITLE.

This Act may be cited as the `Health Care Choice Act of 2009'.

SEC. 2. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This Act is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 3. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing

those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 4. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) In General- Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following:

`PART D--COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

`SEC. 2795. DEFINITIONS.

`In this part:

`(1) PRIMARY STATE- The term `primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

`(2) SECONDARY STATE- The term `secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

`(3) HEALTH INSURANCE ISSUER- The term `health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

`(4) INDIVIDUAL HEALTH INSURANCE COVERAGE- The term `individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

`(5) APPLICABLE STATE AUTHORITY- The term `applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

`(6) HAZARDOUS FINANCIAL CONDITION- The term `hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able--

`(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

`(B) to pay other obligations in the normal course of business.

`(7) COVERED LAWS-

`(A) IN GENERAL- The term `covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to--

`(i) individual health insurance coverage issued by a health insurance issuer;

`(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

`(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

`(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

`(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

`(B) EXCEPTION- Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to

provider contracting, network access or adequacy, health care data collection, or quality assurance.

`(8) STATE- The term `State' means the 50 States and includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

`(9) UNFAIR CLAIMS SETTLEMENT PRACTICES- The term `unfair claims settlement practices' means only the following practices:

`(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

`(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

`(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

`(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

`(E) Refusing to pay claims without conducting a reasonable investigation.

`(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

`(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

`(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or the individual's beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

`(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

`(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

`(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

`(10) FRAUD AND ABUSE- The term `fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

`(A) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker, or its agent, false information as part of, in support of, or concerning a fact material to one or more of the following:

`(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

`(ii) The rating of an insurance policy or reinsurance contract.

`(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

`(iv) Premiums paid on an insurance policy or reinsurance contract.

`(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

`(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

`(vii) The financial condition of an insurer or reinsurer.

`(viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

`(ix) The issuance of written evidence of insurance.

`(x) The reinstatement of an insurance policy.

`(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

`(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance.

`(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

`SEC. 2796. APPLICATION OF LAW.

`(a) In General- The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

`(b) Exemptions From Covered Laws in a Secondary State- Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would--

`(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer--

`(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

`(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

`(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if--

`(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

`(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

`(D) to comply with a lawful order issued--

`(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

`(ii) in a voluntary dissolution proceeding;

`(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

`(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

`(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

`(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

`(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

`(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that secondary State; or

`(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

`(c) Clear and Conspicuous Disclosure- A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

This policy is issued by **XXXXX**, and is governed by the laws and regulations of the State of **XXXXX**, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of **XXXXX**, including coverage of some services or benefits mandated by the law of the State of **XXXXX**. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of **XXXXX**. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.'.

`(d) Prohibition on Certain Reclassifications and Premium Increases-

`(1) IN GENERAL- For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal--

`(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

`(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

`(2) CONSTRUCTION- Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer--

`(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

`(B) from raising premium rates for all policy holders within a class based on claims experience;

`(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives--

`(i) are disclosed to the consumer in the insurance contract;

`(ii) are based on specific wellness activities that are not applicable to all individuals; and

`(iii) are not obtainable by all individuals to whom coverage is offered;

`(D) from reinstating lapsed coverage; or

`(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

`(e) Prior Offering of Policy in Primary State- A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

`(f) Licensing of Agents or Brokers for Health Insurance Issuers- Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

`(g) Documents for Submission to State Insurance Commissioner- Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit--

`(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State--

`(A) a copy of the plan of operation, feasibility study, or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

`(B) written notice of any change in its designation of its primary State; and

`(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

`(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by--

`(A) a member of the American Academy of Actuaries; or

`(B) a qualified loss reserve specialist.

`(h) Power of Courts To Enjoin Conduct- Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin--

`(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

`(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of subsection (b)(1).

`(i) Power of Secondary States To Take Administrative Action- Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in subsection (b)(1).

`(j) State Powers To Enforce State Laws-

`(1) IN GENERAL- Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be

construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

`(2) COURTS OF COMPETENT JURISDICTION- If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

`(k) States' Authority To Sue- Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

`(l) Generally Applicable Laws- Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

`(m) Guaranteed Availability of Coverage to HIPPA Eligible Individuals- To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

`SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

`A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

`SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

`(a) Right to External Appeal- A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless--

`(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

`(2) in any case in which the requirements of paragraph (1) are not met with respect to either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the `Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

`(b) Qualifications of Independent Medical Reviewers- In the case of any independent review mechanism referred to in subsection (a)(2), the following provisions shall apply:

`(1) IN GENERAL- In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that--

`(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

`(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

`(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

`(2) LICENSURE AND EXPERTISE- Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who--

`(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

`(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

`(3) INDEPENDENCE-

`(A) IN GENERAL- Subject to subparagraph (B), each independent medical reviewer in a case shall--

`(i) not be a related party (as defined in paragraph (7));

`(ii) not have a material familial, financial, or professional relationship with such a party; and

`(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

`(B) EXCEPTION- Nothing in subparagraph (A) shall be construed to--

`(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if--

`(I) a non-affiliated individual is not reasonably available;

`(II) the affiliated individual is not involved in the provision of items or services in the case under review;

`(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

`(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

`(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; or

`(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

`(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD-

`(A) IN GENERAL- In a case involving treatment, or the provision of items or services--

`(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

`(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

`(B) PRACTICING DEFINED- For purposes of this paragraph, the term `practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

`(5) PEDIATRIC EXPERTISE- In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

`(6) LIMITATIONS ON REVIEWER COMPENSATION- Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall--

`(A) not exceed a reasonable level; and

`(B) not be contingent on the decision rendered by the reviewer.

`(7) RELATED PARTY DEFINED- For purposes of this section, the term `related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

`(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

`(B) The enrollee (or authorized representative).

`(C) The health care professional that provides the items or services involved in the denial.

`(D) The institution at which the items or services (or treatment) involved in the denial are provided.

`(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

`(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

`(8) DEFINITIONS- For purposes of this subsection:

`(A) ENROLLEE- The term `enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

`(B) HEALTH CARE PROFESSIONAL- The term `health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

`SEC. 2799. ENFORCEMENT.

`(a) In General- Subject to subsection (b), with respect to specific individual health insurance coverage, the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

`(b) Secondary State's Authority- Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

`(c) Court Interpretation- In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

`(d) Notice of Compliance Failure- In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.'.

(b) Effective Date- The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO Ongoing Study and Reports-

(1) STUDY- The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on--

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS- The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

SEC. 5. SEVERABILITY.

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

KYL AMENDMENT #C17

America's Healthy Future Act of 2009

Short Title: Increase Current Limits on HSA Contributions

Description of Amendment: Under current law, contributions to HSAs are limited annually under a formula specified in the statute. The limits are adjusted annually for inflation by the IRS. In 2009 the annual contribution limit for self-only coverage is $3000 and for family coverage is $5,950. Prior to 2007, contributions could not exceed the individual's HDHP deductible.

Although some HDHPs cover 100% of expenses after the deductible is met, many HDHPs charge co-insurance until a higher limit on out-of-pocket expenses (including deductibles, co-payments, and coinsurance) is met. Under current law, these limits cannot exceed $5,800 for HDHP self-only coverage and $11,600 for family coverage in 2009. The limits are adjusted annually for inflation by the IRS.

People with HSAs that have out-of-pocket limits above the annual HSA contribution limits cannot deposit enough money into their HSAs to cover all their potential out-of-pocket expenses. This amendment would increase the annual HSA contribution limits to equal the amount of the individual's HDHP out-of-pocket maximum (i.e., as high as $5,800 for singles and $11,600 for families in 2009).

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C18

America's Healthy Future Act of 2009

Short Title: Improved opportunities to rollover funds from Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs) to fund Health Savings Accounts (HSAs)

Description of Amendment: Current law allows employers that offered Flexible Spending Arrangements (FSAs) or Health Reimbursement Arrangements (HRAs) to roll over unused funds to an HSA as employees transitioned to an HSA for the first time. However, the unused FSA funds may not be rolled over to HSAs unless the employer offers a "grace period" that allows medical expenses to be reimbursed from an FSA through March 15 of the following year (instead of the usual "use or lose" by December 31) and must be made before 2012. In addition, the amount that may be rolled over to the HSA cannot exceed the amount in such an account as of September 21, 2006. This amendment would clarify current law to provide employers greater opportunity to roll-over of funds from employees' FSAs or HRAs to their HSAs in a future year in order to ease the transition from FSAs and HRAs to HSAs.

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C19

America's Healthy Future Act of 2009

Short Title: Catch-up contributions by spouses may be made to one Health Savings Account (HSA)

Description of Amendment: Current law allows HSA-eligible individuals age 55 or older to make additional catch-up contributions each year. However, the contributions must be deposited into separate HSA accounts even if both spouses are eligible to make catch-up contributions. This amendment would allow the spouse who is the HSA account holder to double their catch-up contribution to account for their eligible spouse.

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C20

America's Healthy Future Act of 2009

Short Title: Expanded Definition of "Preventive" Drugs

Description of Amendment: Current law allows "preventive care" services to be paid by HSA-qualified plans without being subject to the policy deductible. Although IRS guidance allowed certain types of prescription drugs to be considered "preventive care," the guidance generally does not permit plans to include drugs that prevent complications resulting from chronic conditions.

This amendment would expand the definition of "preventive care" to include medications that prevent worsening of or complications from chronic conditions. This will provide additional flexibility to health plans that want to provide coverage for these medications and remove a perceived barrier to HSAs for people with chronic conditions.

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C21

America's Healthy Future Act of 2009

Short Title: Greater Flexibility Using HSA Account to Pay Expenses

Description of Amendment: When people enroll in an HSA-qualified plan, some let a few months elapse between the time when their coverage starts (e.g., January) and when the health savings bank account is set up and becomes operational (e.g., March). However, the IRS does not allow for medical expenses incurred in that gap (between January and March) to be reimbursed with HSA funds.

This amendment would allow all "qualified medical expenses" (as defined under the tax code) incurred after HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established by April 15 of the following year.

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C22

America's Healthy Future Act of 2009

Short Title: Expanded definition of "qualified medical expenses"

Description of Amendment: The current definition of "qualified medical expenses" generally does not include fees charged by primary care physicians that offer pre-paid medical services on demand because there is no direct billing for individual services provided by the physician and the arrangement is not considered "insurance." This amendment would allow amounts paid by patients to their primary physician in advance for the right to receive medical services on an as-needed basis to be considered a "qualified medical expense" under the tax code.

The modification would affect all health care programs using the definition, including HSAs, HRAs, FSAs, and the medical expense deduction when taxpayers itemize.

Effective Date: Upon Enactment

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL AMENDMENT #C23

America's Healthy Future Act of 2009

Short Title: Improve Women's Access to Health Care Services and Providers.

Description of Amendment: This amendment would insert the "Healthy Mothers and Healthy Babies Access to Care Act" (S. 244, 110th Congress).

At the appropriate place, insert the following:

TITLE __--

HEALTHY MOTHERS AND HEALTHY BABIES RURAL ACCESS TO CARE

SEC. X01. SHORT TITLE.

This title may be cited as the ``Healthy Mothers and Healthy Babies Rural Access to Care Act''.

SEC. X02. FINDINGS AND PURPOSE.

(a) *Findings*.--

(1) **EFFECT ON WOMEN'S ACCESS TO HEALTH SERVICES**.--Congress finds that--

(A) the current civil justice system is eroding women's access to obstetrical and gynecological services;

(B) the American College of Obstetricians and Gynecologists (ACOG) has identified nearly half of the States as having a medical liability insurance crisis that is threatening access to high-quality obstetrical and gynecological services;

(C) because of the high cost of medical liability insurance and the risk of being sued, one in seven obstetricians and gynecologists have stopped practicing obstetrics and one in five has decreased their number of high-risk obstetrics patients; and

(D) because of the lack of availability of obstetrical services, women--

(i) must travel longer distances and cross State lines to find a doctor;

(ii) have longer waiting periods (in some cases months) for appointments;

(iii) have shorter visits with their physicians once they get appointments;

(iv) have less access to maternal-fetal medicine specialists, physicians with the most experience and training in the care of women with high-risk pregnancies; and

(v) have fewer hospitals with maternity wards where they can deliver their child, potentially endangering the lives and health of the woman and her unborn child.

(2) **EFFECT ON INTERSTATE COMMERCE**.--Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) **EFFECT ON FEDERAL SPENDING**.--Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of--

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) *Purpose*.--It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to--

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ``defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. X03. DEFINITIONS.

In this title:

(1) **ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR**.--The term ``alternative dispute resolution system'' or ``ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) **CLAIMANT**.--The term ``claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) **COLLATERAL SOURCE BENEFITS**.--The term ``collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to--

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) **COMPENSATORY DAMAGES**.--The term ``compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) **CONTINGENT FEE**.--The term ``contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) **ECONOMIC DAMAGES**.--The term ``economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) **HEALTH CARE GOODS OR SERVICES**.--The term ``health care goods or services'' means any obstetrical or gynecological goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any obstetrical or gynecological-related human disease or impairment, or the assessment of the health of human beings.

(8) **HEALTH CARE INSTITUTION**.--The term ``health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) **HEALTH CARE LAWSUIT**.--The term ``health care lawsuit'' means any health care liability claim concerning the provision of obstetrical or gynecological goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) obstetrical or gynecological goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a physician or other health care provider who delivers obstetrical or gynecological services in an rural area or a health care institution (only with respect to obstetrical or gynecological services) located in a rural area regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) **HEALTH CARE LIABILITY ACTION**.--The term ``health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider who delivers obstetrical or gynecological services in a rural area or a health care institution (only with respect to obstetrical or gynecological services) located in a rural area regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) **HEALTH CARE LIABILITY CLAIM**.--The term ``health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider who delivers obstetrical or gynecological services in a rural area or a health care institution (only with respect to obstetrical or gynecological services) located in a rural area, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) obstetrical or gynecological services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) **HEALTH CARE PROVIDER**.--

(A) **IN GENERAL**.--The term ``health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation, and who is providing such services in a rural area.

(B) **TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS**.--For purposes of this title, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) **MALICIOUS INTENT TO INJURE**.--The term ``malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) **NONECONOMIC DAMAGES**.--The term ``noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) **OBSTETRICAL OR GYNECOLOGICAL SERVICES**.--The term ``obstetrical or gynecological services'' means services for pre-natal care or labor and delivery, including the immediate postpartum period (as determined in accordance with the definition of postpartum used for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)).

(16) **PUNITIVE DAMAGES**.--The term ``punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider who delivers obstetrical or gynecological services or a health care institution. Punitive damages are neither economic nor noneconomic damages.

(17) **RECOVERY**.--The term ``recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) **RURAL AREA**.--The term ``rural area'' means any area of the United States that is not--

(A) included within the boundaries of any city, town, borough, or village, whether incorporated or unincorporated, with a population of more than 20,000 inhabitants; or

(B) the urbanized area contiguous and adjacent to such a city or town.

(19) **STATE**.--The term ``State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. X04. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) *In General*.--Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) *General Exception*.--The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of--

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) *Minors*.--An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) *Rule 11 Sanctions*.--Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this title applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter

repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. X05. COMPENSATING PATIENT INJURY.

(a) *Unlimited Amount of Damages for Actual Economic Losses in Health Care Lawsuits*.--In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) *Additional Noneconomic Damages*.--

(1) **HEALTH CARE PROVIDERS**.--In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) **HEALTH CARE INSTITUTIONS**.--

(A) **SINGLE INSTITUTION**.--In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) **MULTIPLE INSTITUTIONS**.--In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) *No Discount of Award for Noneconomic Damages*.--In any health care lawsuit--

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations provided for in subsection (b), the future noneconomic damages shall be reduced first.

(d) *Fair Share Rule*.--In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. X06. MAXIMIZING PATIENT RECOVERY.

(a) *Court Supervision of Share of Damages Actually Paid to Claimants*.--

(1) **IN GENERAL**.--In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) **CONTINGENCY FEES**.--

(A) **IN GENERAL**.--In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) **LIMITATION**.--The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33 1/3 percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) *Applicability*.--

(1) **IN GENERAL**.--The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) **MINORS**.--In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) *Expert Witnesses*.--

(1) **REQUIREMENT**.--No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual--

(A) except as required under paragraph (2), is a health care professional who--

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) **PHYSICIAN REVIEW**.--In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) **SPECIALTIES AND SUBSPECIALTIES**.--With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) **LIMITATION**.--The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. X07. ADDITIONAL HEALTH BENEFITS.

(a) *In General*.--The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) *Preservation of Current Law*.--Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) *Application of Provision*.--This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. X08. PUNITIVE DAMAGES.

(a) *Punitive Damages Permitted*.--

(1) **IN GENERAL**.--Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) **FILING OF LAWSUIT**.--No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) **SEPARATE PROCEEDING**.--At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding--

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) **LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED**.--In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) *Determining Amount of Punitive Damages*.--

(1) **FACTORS CONSIDERED**.--In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) **MAXIMUM AWARD**.--The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) *Liability of Health Care Providers*.--

(1) **IN GENERAL**.--A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) **MEDICAL PRODUCT**.--The term ``medical product'' means a drug or device intended for humans. The terms ``drug'' and ``device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. X09. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) *In General*.--In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) *Applicability*.--This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. X10. EFFECT ON OTHER LAWS.

(a) *General Vaccine Injury*.--

(1) **IN GENERAL**.--To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death--

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) **EXCEPTION**.--If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) *Smallpox Vaccine Injury*.--

(1) **IN GENERAL**.--To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death--

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) **EXCEPTION**.--If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) *Other Federal Law*.--Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. X11. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) *Health Care Lawsuits*.--The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter--

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) *Preemption of Certain State Laws*.--No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive

damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section X05(a).

(c) *Protection of State's Rights and Other Laws*.--

(1) **IN GENERAL**.--Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) **RULE OF CONSTRUCTION**.--Nothing in this title shall be construed to--

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this title;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. X12. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Effective Date: Upon Enactment

KYL AMENDMENT #C24

America's Healthy Future Act of 2009

Short Title: Improve access to Emergency Room Services.

Description of Amendment: This amendment would regulate lawsuits for health care liability claims related to the provision of services provided in the emergency room.

Set a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions.

Require a court to impose sanctions for the filing of frivolous lawsuits.

Limit noneconomic damages in a civil medical liability lawsuit to $250,000 from any provider or health care institution, not to exceed $500,000 from all providers and health care institutions. It would also make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility.

Allow the court to restrict the payment of attorney contingency fees and limit the fees to a decreasing percentage based on the increasing value of the amount awarded.

Prescribe qualifications for expert witnesses.

Require the court to reduce damages received by the amount of collateral source benefits to which a claimant is entitled, unless the payor of such benefits has the right to reimbursement or subrogation under federal or state law.

Authorize the award of punitive damages only where: (1) it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury the claimant was substantially certain to suffer; and (2) compensatory damages are awarded. Limit punitive damages to the greater of two times the amount of economic damages or $250,000.

Prohibit a health care provider from being named as a party in a product liability or class action lawsuit for prescribing or dispensing a Food and Drug Administration (FDA)-approved prescription drug, biological product, or medical device for an approved indication.

Provide for periodic payments of future damage awards.

Protect state flexibility and states' rights.

Effective Date: Upon enactment.

KYL AMENDMENT #C25

America's Healthy Future Act of 2009

Short Title: Medical Liability Reform

Description of Amendment: This amendment would limit noneconomic damages in a civil medical liability lawsuit to $250,000 from any provider or health care institution, not to exceed $500,000 from all providers and health care institutions. It would also make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility.

Additionally, this amendment would require a claimant in a medical liability civil action to determine whether expert testimony is necessary to prove the health care professional's standard of care or liability for the claim, and to file the determination with the claim.

It would require a "preliminary expert opinion affidavit" containing the expert's qualifications, the factual basis for the claim, the health care professional's acts, errors and/or omissions that the expert considers to be a violation of the applicable standard of care, and how the health care professional's acts, errors and/or omissions contributed to the damages sought by the claimant. Courts may dismiss a claim if the preliminary expert opinion affidavit is not filed with the claim.

It would also set the criteria an individual must meet to be considered an expert witness in a medical malpractice civil action. The individual must be licensed in one or more states, in the same specialty or area of practice as the defendant, and must have devoted a majority of his or her professional time during the year preceding the occurrence giving rise to the lawsuit to either active practice or teaching.

The provisions governing health care lawsuits set forth in this amendment shall preempt, subject to subsections (a) and (b), State law to the extent that State law prevents the application of any provisions of law established by or under this Act. The provisions governing health care lawsuits set forth in this Act supersede chapter 171 of

title 28, United States Code, to the extent that such chapter-- provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this Act; or (2) prohibits the introduction of evidence regarding collateral source benefits.

(a) Preemption of Certain State Laws- No provision of this Act shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act, notwithstanding section 5(a).

(b) Protection of State's Rights and Other Laws-

(1) IN GENERAL- Any issue that is not governed by a provision of law established by or under this Act (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION- Nothing in this Act shall be construed to--

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this Act;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

Effective Date: Upon enactment.

KYL AMENDMENT #C26

America's Healthy Future Act of 2009

Short Title: An amendment to ensure that any state receiving funding under Medicaid has requirements for preliminary expert witness testimony and expert qualifications.

Description of Amendment: This amendment would require a claimant in a medical liability civil action to determine whether expert testimony is necessary to prove the health care professional's standard of care or liability for the claim, and to file the determination with the claim.

It would require a "preliminary expert opinion affidavit" containing the expert's qualifications, the factual basis for the claim, the health care professional's acts, errors and/or omissions that the expert considers to be a violation of the applicable standard of care, and how the health care professional's acts, errors and/or omissions contributed to the damages sought by the claimant. Courts may dismiss a claim if the preliminary expert opinion affidavit is not filed with the claim.

It would also set the criteria an individual must meet to be considered an expert witness in a medical malpractice civil action. The individual must be licensed in one or more states, in the same specialty or area of practice as the defendant, and must have devoted a majority of his or her professional time during the year preceding the occurrence giving rise to the lawsuit to either active practice or teaching.

Effective Date: Upon Enactment

Bunning Coverage Amendments

Bunning Amendment #C1 to Subtitle C of Title 1 of America's Healthy Future Act of 2009

Short Title: Equal Access to Affordable Healthcare Amendment

Description of Amendment: This amendment would amend the Chairman's mark to eliminate the age limit for joining the "young invincible" policy.

Offset: Paid for by reducing the federal poverty level threshold for premium credits in the bill by the amount necessary, starting with the premium credit for individuals between 300% and 400% of poverty.

Bunning Amendment #C2 to Subtitle E of Title 1 of America's Healthy Future Act of 2009

Short Title: CO-OP Amendment

Description of Amendment: At the appropriate place in the Chairman's mark, this amendment would insert a requirement that all Members of Congress, the President and the Secretary of the Department of Health and Human Services must purchase health insurance through the Consumer Operated and Oriented Plan (CO-OP), provided that one is available to them.

Offset: If an offset is needed, the amendment is paid for by reducing the federal poverty level threshold for premium credits in the bill by the amount necessary, starting with the premium credit for individuals between 300% and 400% of poverty.

Bunning Amendment #C3 to Subtitle D of Title 1 of America's Healthy Future Act of 2009

Short Title: Excise Tax Exemption

Description of Amendment: This amendment amends the Chairman's mark to require that any taxpayer who requests an exemption on their tax return from the personal responsibility excise tax be granted an exemption.

Offset: Paid for by reducing the federal poverty level threshold for premium credits in the bill by the amount necessary, starting with the premium credit for individuals between 300% and 400% of poverty.

Bunning Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Transparency Amendment

Description of Amendment: This amendment requires that before the Finance Committee can vote on final passage of "America's Healthy Future Act of 2009," the legislative language must be publically available on the Finance Committee's website for at least 72 hours.

Crapo-Roberts Amendment C-1 to Chairman's Mark, America's Healthy Future Act of 2009

Short Title: To amend the employer shared responsibility requirement and protect small businesses.

Description of Amendment:

The amendment would amend the employer shared responsibility requirement outlined in Title I, Subtitle D of the Chairman's Mark. On page 31, the Mark states that "all employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange." This amendment would increase the required firm size from 50 employees to 499 employees.

Offset:

To be provided.

Crapo-Roberts Amendment C-2 to Chairman's Mark, America's Healthy Future Act of 2009

Short Title: To prohibit unfunded federal mandates on states.

Description of Amendment:

The amendment would amend the proposed Medicaid expansion in Title I, Subtitle G of the Chairman's Mark. The amendment would prohibit any expansion of the Medicaid program that would result in any additional costs for the States, now or in the future.

Offset: To be provided.

Ensign Amendment # C1 to America's Healthy Future Act of 2009

Short Title: To maintain current limits on federal benefits.

Description of Amendment: Notwithstanding any other provision of this Act, the Health Care Affordability tax credits ("tax credits") under Title I, Subtitle C of the Chairman's Mark shall be considered a Federal public benefit pursuant to Sections 401 and as Federal means-tested public benefit under Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (referred to herein as PRWORA) (Public Law No. 104-193). This amendment will maintain current law requirements with respect to tax credits so that: (1) aliens who are not qualified aliens will be ineligible for Federal public benefits, including the tax credits; and (2) aliens who are qualified aliens will be ineligible for Federal means-tested public benefits, including the tax credits, for the 5-year waiting period specified under Section 403 of PRWORA.

Ensign Amendment # C2 to America's Healthy Future Act of 2009

Short Title: To ensure that illegal immigrants do not fraudulently receive federal health care tax credits.

Description of Amendment: The amendment would strengthen the eligibility verification provision in Title I, Subtitle C, and the personal responsibility compliance provision in Title I, Subtitle D.

In order to strengthen the eligibility verification provision in Title I, Subtitle C, the amendment would add citizenship status to the list of items to be verified with Social Security Administration data for persons claiming to be citizens.

Consistent with the Chairman's Mark, individuals whose claims of citizenship or lawful status cannot be verified with federal data must be allowed substantial opportunity to provide documentation or correct federal data related to their case that supports their contention. However, during the period of "substantial opportunity," an individual shall not be provided with presumptive eligibility for the federal health care tax credits.

Any individual who is not initially determined to be a citizen must have his/her eligibility redetermined not less than every five years.

In order to ensure compliance with the personal responsibility requirement in Title I, Subtitle D, no tax credit shall be made available to an individual who does not include on the return of tax for the taxable year such individual's valid identification number and in the case of a joint return, the valid identification number of such individual's spouse; and in the case of any qualifying child taken into account, the valid identification number of such qualifying child. A valid identification number means a valid Social Security Number issued to an individual by the Social Security Administration. Such term shall not include a TIN issued by the Internal Revenue Service.

Any false attestation of citizenship shall be subject to penalties of perjury and any individual who falsely claims to be a citizen shall be subject to a fine of not less than $10,000 per occurrence in connection with the application for any Health Care Affordability tax credits.

Ensign Amendment # C3 to America's Healthy Future Act of 2009

Short Title: To protect taxpayers by ensuring that immigrants do not become public charges by requiring an immigrant sponsor's accountable under affidavits of support.

Description of Amendment: Sponsors of legal immigrants shall ensure that the individual(s) who they sponsor for entry into the U.S. shall obtain health insurance coverage. If a sponsored immigrant does not obtain health insurance coverage on his/her own, then the immigrant's sponsor shall be liable for all costs incurred by the American taxpayers should a sponsored alien receive any taxpayer-funded health care. The sponsor shall remain liable for such costs incurred by the taxpayers for the period specified in Section 421 of the Personal Responsibility and Work Opportunity Act (Public Law No. 104-193).

In order to ensure compliance, and consistent with the Personal Responsibility Requirement in the Chairman's Mark, a sponsor shall be required to report on his/her federal income tax return the months for which he/she maintains the required minimum health coverage for him/herself, dependants and all sponsored immigrants. If neither the sponsor nor the sponsored immigrant do not maintain the requisite health insurance for the sponsored immigrant, then the sponsor shall be required to pay the greater of: (1) the excise tax specified in the chairman's mark for an individual who does not maintain insurance (based on the income of the immigrant); or (2) any amount provided to such immigrant in the form of a tax credit pursuant to this bill. Such amounts shall be paid to the government in the manner provided in the chairman's mark for the excise tax under the mark. Furthermore, in the event a sponsor fails to ensure that one of his/her sponsored immigrants maintains adequate health insurance during the period specified in Section 421 of PRWORA, such sponsor will not be allowed to sponsor any immigrants in the future.

Ensign Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Lymphedema Amendment

Description of Amendment: The amendment will require the Secretary of Health and Human Services to conduct a study on the feasibility and advisability of providing for payment under the Medicare program for gradient pumps and compression stockings used in the treatment of lymphedema, chronic venous insufficiency, and other circulatory diseases.

The study conducted under paragraph (1) shall include an examination of the following: the types of pumps and compression stockings available on the market; the clinical appropriateness of furnishing gradient pumps and compression stockings for Medicare beneficiaries who have been diagnosed with lymphedema, chronic venous insufficiency and other circulatory diseases; the financial impact on the Medicare program of providing for the payment described in paragraph (1), including the costs and any savings related to providing for such a payment.

Not later than 1 year after the date of enactment of the underlying Act, the Secretary shall submit to Congress a report on the study conducted, together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

Ensign Amendment #C5 to America's Healthy Future Act of 2009

Short Title: Health Account Balance Protection Act

Explanation: Under current law, HSAs are not exempt from the claims of creditors in federal bankruptcy cases and virtually all state laws are silent on this matter (i.e., do not address the situation). However, Individual Retirement Accounts (IRAs) were made exempt under federal law in the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (P.L. 109-8). Since HSAs can accumulate (and be invested) just like IRAs, these accounts should be treated like IRAs when it comes to bankruptcy.

The amendment would protect HSA dollars from the claims of creditors in federal bankruptcy cases.

Ensign Amendment #C6 to America's Healthy Future Act of 2009

Short Title: Health Savings Account Coverage Protection

Explanation: The amendment requires that regardless of any provision of any other law, including the Chairman's mark, that plans defined under Section 223 of the Internal Revenue Code are deemed to be qualified benefits plans and that the provisions of Section 223 supercede any provisions of this bill.

Ensign Amendment #C7 to America's Healthy Future Act of 2009

Short Title: Building Efforts for Wellness and Encouraging Longer Lives #1 Amendment

Purpose: To codify and enhance existing regulations designed to encourage individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and disease prevention.

Description of Amendment:

Current Law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) currently permits programs of health promotion and disease prevention to encourage healthy behaviors through financial incentives. These incentives include rewards in the form of discounts or rebates of premiums,waivers of all or part of a cost-sharing mechanism under the plan (such as deductibles, co-payments or coinsurance), the absence of a surcharge, or the value of a benefit which would otherwise not be provided under the plan for those who meet a particular health standard, such as stopping the use of tobacco products. Final regulations jointly issued by the Departments of Treasury, Health and Human Services, and Labor generally cap the reward at 20% of employee-only premiums, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, that person must be offered a reasonable alternative standard, and still will be entitled to receive the reward. These wellness regulations implement amendments made by HIPAA to the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) of 1974, and the Public Health Services (PHS) Act.

The HIPAA wellness regulations divide wellness programs into two categories. In the first category are programs in which rewards are based solely on program participation. Examples in the existing regulation include reimbursing enrollees for the cost of gym membership; waiving copayments for parental care; and reimbursing enrollees for the cost of smoking cessation programs, regardless of whether they successfully quit smoking. Programs in this category are automatically permissible.

Programs in the second category are those in which rewards are based on the attainment of certain health standards – for example, achieving a targeted cholesterol level; maintaining a certain body mass index; quitting smoking; or losing a specified amount of weight. Under current regulations, health plans can offer such financial incentives only if five criteria are met – one of these being that the reward cannot exceed 20% of the cost of the employee's coverage (i.e., the employee's premium plus the employer's contribution).

Amendment: The amendment modifies the sections of the Chairman's mark relating to rating rules in the individual market and small group markets by allowing group health plans and health insurance issuers offering coverage in the individual and group markets to vary insurance premiums based on an individual or an employee's participation in wellness programs.

The language defines programs of health promotion of disease prevention to meet certain requirements and to assure that none of the conditions are based on health status factors.

The amendment describes programs in which rewards are based solely on program participation and programs in which rewards are based on the attainment of certain health standards.

The amendment would cap the reward at 50% of employee-only premiums under the plan, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, then that person must be offered a reasonable alternative standard or a waiver, and still will be entitled to receive the reward. If necessary, the wellness program may require verification of these circumstances, including a statement from an individual's physician.

Programs which reward based on the attainment of certain health standards would need to meet the following criteria:

- Be reasonably designed to promote health or prevent disease.
- Provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year.
- Ensure that the reward must be available to all "similarly situated" individuals. If someone's medical condition keeps them from achieving a reward under the program, or if it is medically inadvisable for them to try to achieve the reward, then a reasonable alternative standard for obtaining the reward must be made available.
- Plan materials describing the terms of the wellness program must disclose the availability of the reasonable alternative standard for similarly situated individuals, or the possibility that the standard will be waived.

The amendment would apply these wellness provisions to programs of health promotion and disease prevention offered in the individual market in a state in a manner that is similar to the manner in which such provisions apply to a group health plan or a health insurance issuer offering group health insurance coverage.

Furthermore, the amendment would apply these wellness programs of health promotion and disease prevention to plans offered in the Co-Op and the Federal Employees Health Benefits Program.

Ensign Amendment #C8 to America's Healthy Future Act of 2009

Short Title: Building Efforts for Wellness and Encouraging Longer Lives Amendment #2

Purpose: To codify and enhance existing regulations designed to encourage individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and disease prevention

Description of Amendment:

Current Law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) currently permits programs of health promotion and disease prevention to encourage healthy behaviors through financial incentives. These incentives include rewards in the form of discounts or rebates of premiums,waivers of all or part of a cost-sharing mechanism under the plan (such as deductibles, co-payments or coinsurance), the absence of a surcharge, or the value of a benefit which would otherwise not be provided under the plan for those who meet a particular health standard, such as stopping the use of tobacco products. Final regulations jointly issued by the Departments of Treasury, Health and Human Services, and Labor generally cap the reward at 20% of employee-only premiums, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, that person must be offered a reasonable alternative standard, and still will be entitled to receive the reward. These wellness regulations implement amendments made by HIPAA to the Internal Revenue Code (IRC), the Employee Retirement Income Security Act (ERISA) of 1974, and the Public Health Services (PHS) Act.

The HIPAA wellness regulations divide wellness programs into two categories. In the first category are programs in which rewards are based solely on program participation. Examples in the existing regulation include reimbursing enrollees for the cost of gym membership; waiving copayments for parental care; and reimbursing enrollees for the cost of smoking cessation programs, regardless of whether they successfully quit smoking. Programs in this category are automatically permissible.

Programs in the second category are those in which rewards are based on the attainment of certain health standards – for example, achieving a targeted cholesterol level; maintaining a certain body mass index; quitting smoking; or losing a specified amount of weight. Under current regulations, health plans can offer such financial incentives only if five criteria are met – one of these being that the reward cannot exceed 20% of the cost of the employee's coverage (i.e., the employee's premium plus the employer's contribution).

Amendment: The amendment modifies the sections of the Chairman's mark relating to rating rules in the individual market and small group markets by allowing group health plans and health insurance issuers offering coverage in the individual and group markets to vary insurance premiums based on an individual or an employee's participation in wellness programs.

The language defines programs of health promotion of disease prevention to meet certain requirements and to assure that none of the conditions are based on health status factors.

The amendment describes programs in which rewards are based solely on program participation and programs in which rewards are based on the attainment of certain health standards.

The amendment would cap the reward at 30% of the employee-only premiums under the plan, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it it is medically inadvisable to do so and would allow the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to take the percentage up to 50% for adherence to or participation in a reasonably designed program of health promotion and disease prevention. Specifically, if it is "unreasonably difficult due to a medical standard" or "medically unadvisable" to attempt to meet the otherwise applicable standard, then that person must be offered a reasonable alternative standard or a waiver, and still will be entitled to receive the reward. If necessary, the wellness program may require verification of these circumstances, including a statement from an individual's physician.

Programs which reward based on the attainment of certain health standards would need to meet the following criteria:

- Be reasonably designed to promote health or prevent disease.
- Provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year.
- Ensure that the reward must be available to all "similarly situated" individuals. If someone's medical condition keeps them from achieving a reward under the program, or if it is medically inadvisable for them to try to achieve the reward, then a reasonable alternative standard for obtaining the reward must be made available.
- Plan materials describing the terms of the wellness program must disclose the availability of the reasonable alternative standard for similarly situated individuals, or the possibility that the standard will be waived.

The amendment would apply these wellness provisions to programs of health promotion and disease prevention offered in the individual market in a state in a manner that is similar to the manner in which such provisions apply to a group health plan or a health insurance issuer offering group health insurance coverage.

Ensign Amendment #C9 to America's Healthy Future Act of 2009

Short Title: To ensure that non-smokers are not forced to subsidize smokers.

Description of Amendment:

Chairman's Mark: Under the Chairman's Mark, rating would vary based on the following conditions: tobacco use, age, and family composition. More specifically, premiums could vary by a certain ratio for each characteristic, as follows:

- Tobacco use not to exceed 1.5:1
- Age not to exceed 5:1
- Family composition
    - single 1:1
    - adult with child 1.8:1
    - family 3:1
    - two adults 2:1

Premiums could also vary among, but not within, rating areas to reflect geographic differences. States would define geographic rating areas. Together taking all permissible risk factors, premiums within a family category could not vary by more than a 7.5:1 composite ratio.

Ensign Amendment: The amendment would modify the rating rules in Title I, Subtitle A of the Chairman's Mark so that rating would vary based on the following conditions: tobacco use, age, family composition, and geography. More specifically, premiums could vary by a certain ratio for each characteristic, as follows:

- Age not to exceed 5:1
- Family composition
    - single 1:1
    - adult with child 1.8:1
    - family 3:1
    - two adults 2:1

Premiums could also vary among, but not within, rating areas to reflect geographic differences. States would define geographic rating areas. Taking age, family composition and geography into account, premiums within a family category could not vary by more than a 7.5:1 composite ratio.

After applying the risk adjustment factors for age, family composition, and geography, a carrier may vary the rate for tobacco usage, not to exceed 1:5:1. This would allow for a total rate composition of 9:1, after tobacco is taken into account.

Ensign Amendment #C10 to America's Healthy Future Act of 2009

Short Title: Transparency in Czars

Description of Amendment:

Any czar handling health care issues shall be subject to the Senate confirmation process.

Ensign Amendment # C11 to America's Healthy Future Act of 2009

Short Title: Skin in the Game Amendment

Description of Amendment: Notwithstanding any other provision in this Act, any individual covered by Medicaid or CHIP shall be subject to the same cost-sharing requirements as an individual at the same income levels that receive assistance through the Health Care Affordability Tax Credits.

Ensign Amendment #C12 to America's Healthy Future Act of 2009

Short Title: Protect Health Care for Veterans and Military Service Officers

Description of Amendment: Nothing in this Act shall prohibit or penalize veterans or their eligible family members from receiving timely access to quality health care from a VA healthcare provider or in a Department of Veterans Affairs health care delivery facility.

Nothing in this Act shall prohibit or penalize eligible military health care beneficiaries from receiving timely access to quality health care in a Department of Defense medical treatment facility or a contracted health care provider (TRICARE or TRICARE for Life).

Ensign Amendment #C13 to America's Healthy Future Act of 2009

Short Title: An amendment to require a CBO certification that "costs will go down by as much as $2,500 per year," before the Chairman's bill takes effect.

Description of Amendment: President Obama promised that, "Under the [Obama-Biden] plan, if you like your current health insurance, nothing changes, except your costs will go down by as much as $2,500 per year." The amendment requires that CBO undertake an analysis of the impact of health costs on Americans and determine whether such costs will "go down by as much as $2,500 per year," as the President indicated. Based upon this analysis, CBO would certify, if true, that healthcare costs had gone down by "as much as $2,500 per year." If CBO can affirmatively certify that costs had gone down in this manner, then the provisions of the bill would take effect. If CBO could not certify that costs had gone down in this manner, then the bill would not take effect.

This amendment has not been scored yet; offset to be derived from a proportionate decrease in certain spending provisions in the Chairman's bill except for Medicare spending.

Ensign Amendment # C14 to America's Healthy Future Act of 2009

Short Title: Protecting States from an Unfunded Mandate

Description of Amendment: If the change in a state's spending on Medicaid would increase by more than one percentage point from the previous year as a result of the Medicaid expansion provisions in Title I, Subtitle G of the Chairman's Mark, then the state shall be able to opt-out of the Medicaid expansion provisions in Title I, Subtitle G.

This amendment has not been scored yet; offset to be derived from a proportionate decrease in certain spending provisions in the Chairman's bill, excluding Medicare spending.

Ensign Amendment # C15 to America's Healthy Future Act of 2009

Short Title: Protecting States from Forced Medicaid Expansion

Description of Amendment:

Nothing in this bill shall prohibit a state from establishing its own Medicaid income eligibility requirements for all non-elderly individuals – parents, children and childless adults – this amendment strikes the increase in the federal poverty level included in the bill and leaves current law in place.

This amendment has not been scored yet; offset to be derived from a proportionate decrease in certain spending provisions in the Chairman's bill, excluding Medicare spending.

ENZI AMENDMENT #C1

Enzi Amendment #C1 to America's Healthy Future Act of 2009

Short Title: Lowering the cost of health care by increasing benefit flexibility.

Description of Amendment: The amendment lowers the actuarial value of the bronze plan to 60 percent and maintains the out-of-pocket limit specified in the Chairman's mark.

ENZI AMENDMENT #C2

Enzi Amendment #C2 to America's Healthy Future Act of 2009

Short Title: Lowering the cost of health care by increasing benefit flexibility.

Description of Amendment: The amendment ensures that Americans are not forced to purchase richer plans than those purchased by Members of Congress by allowing enrollment in a high deductible health plan to satisfy the minimum creditable coverage requirement.

Enzi Amendment #C3

Enzi Amendment #C3 to the America's Healthy Future Act of 2009

Short Title: Ensure American workers are protected from lower wages and job loss.

Description of Amendment: Prior to implementing the employer assessments or fees described in Title 1, Subtitle D, the Secretary of Labor must certify that the implementation of such fees and assessments would not result in a reduction of workers' wages or an increase in the unemployment rate.

ENZI AMENDMENT #C4

Enzi Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Ensuring Americans are protected from dramatic cost increases.

Description of Amendment: The amendment requires that prior to a State implementing the rating rules in the individual market or the rating rules in the small group market specified in the Chairman's mark, the State Insurance Commissioner must certify the health insurance premiums in the State will not increase for a majority of residents.

ENZI AMENDMENT #C5

Enzi Amendment #C5 to America's Healthy Future Act of 2009

Short Title: Lowering the cost of health insurance by increasing premium variability.

Description of Amendment: The amendment modifies the sections of the Chairman's mark relating to rating rules in the individual and small group markets by allowing group health plans and health insurance issuers offering coverage in the individual and group markets to vary insurance premiums based on an individual's participation in wellness programs.

ENZI AMENDMENT #C6

Enzi Amendment #C6 to America's Healthy Future Act of 2009-

Short Title: To provide additional choices to individuals who would otherwise be enrolled in Medicaid thru expansions in this bill.

Description of Amendment: This amendment would allow individuals who would otherwise be enrolled in Medicaid thru the expansion in this bill the right to choose to be covered by Medicaid or a qualified private health plan offered through their State exchange.

Offset: Reduce exchange subsidies as much as necessary to make this amendment budget neutral starting with subsidies awarded to individuals earning 400% of poverty.

ENZI AMENDMENT #C7

Enzi Amendment #C7 to America's Healthy Future Act of 2009-

Short Title: Congressional Enrollment in Medicaid.

Description of Amendment: Not withstanding any other provision of law, on the date of enactment of this Act, all members of Congress shall enroll in the Medicaid program under title XIX of the Social Security Act.

The term "Member of Congress" means any member of the House of Representatives or the Senate.

ENZI AMENDMENT #C8

Enzi Amendment #C8 to America's Healthy Future Act of 2009-

Short Title: To ensure that Medicaid expansions will not take effect until State Medicaid programs can guarantee that enough physicians in the State will actually accept and treat Medicaid patients.

Description of Amendment: Any federally-mandated expansion of a State's Medicaid program shall not apply until to a State until the State's Medicaid program certifies that at least 70% of primary care physicians and pediatricians in the State are willing to accept and treat Medicaid patients.

ENZI AMENDMENT #C9

Enzi Amendment #C9 to America's Healthy Future Act of 2009-

Short Title: To exempt any State that the State's revenues have declined for 2 consecutive fiscal year quarters from any mandatory Medicaid expansions.

Description of Amendment: Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes on the State a federally-mandated expansion of Medicaid shall not apply to the State if the State's revenues have declined for the 2 most recent consecutive fiscal year quarters as of the date of enactment of this Act.

ENZI AMENDMENT #C10

Enzi Amendment #C10 to America's Healthy Future Act of 2009-

Short Title: Prohibit a state from expanding its Medicaid program until it implements program integrity and quality improvement measures.

Description of Amendment: This amendment prohibits a State from expanding its Medicaid program until it implements program integrity and quality improvement measures specified in the bill and is able to certify that it has reduced its payment error rate to the lower of 3.6 percent or the most recent annual Medicare payment error rate.

ENZI AMENDMENT #C11

Enzi Amendment #C11 to America's Healthy Future Act of 2009-

Short Title: Terminates Medicaid expansions that results in increased costs for a State

Description of Amendment: Notwithstanding any other provision of this Act, with respect to a State, any provision under this Act or an amendment made by this Act, a State may terminate a federally-mandated expansion of its Medicaid program authorized under this bill if the State can demonstrate that such expansion has increased its total Medicaid costs by more than 3 percent.

ENZI AMENDMENT #C12

Enzi Amendment #C12 to America's Healthy Future Act of 2009

Short Title: To ensure that no mandates on abortions are prohibited.

Description of Amendment:

The amendment prohibits the any federal government entity from requiring that a health plan cover or provide access to abortions except in the case where the mother's life is in danger or the pregnancy is the result of rape or incest.

The amendment strikes the language in the bill regarding the requirement to offer plans with abortions, the requirement to segregate funds, the rules regarding the tax credits and abortions, and the non discrimination language on abortions.

ENZI AMENDMENT #C13

Enzi Amendment #C13 to America's Healthy Future Act of 2009

Short Title: To ensure that abortions are not paid for with federal funds and for the purchase of supplemental abortion coverage without federal funds.

Description of Amendment:

The amendment prohibits federal funds to be used to pay for any abortion or cover any part of the cost of any health plan that includes coverage of abortion, except in the case where the mother's life is in danger or the pregnancy is the result of rape or incest. The amendment allows individuals to purchase supplemental abortion coverage with non-federal funds.

It strikes the language in the bill regarding the requirement to offer plans with abortions, the requirement to segregate funds, the rules regarding the tax credits and abortions, and the non discrimination language on abortions.

ENZI AMENDMENT #C14

Enzi Amendment #C14 to America's Healthy Future Act of 2009

Short Title: To ensure state abortion laws and regulations are not preempted by provisions in the underlying bill.

Description of Amendment:

The amendment prohibits any provision in the bill from overturning or preempting constitutionally permissible laws or regulations of a State, that place limitations or procedural requirements on abortions, including any state law requiring parental notification or consent for the performance of an abortion on a minor.

It strikes the language in the bill regarding the requirement to offer plans with abortions, the requirement to segregate funds, the rules regarding the tax credits and abortions, and the non discrimination language on abortions.

ENZI AMENDMENT #C15

Enzi Amendment #C15 to America's Healthy Future Act of 2009

Short Title: To ensure that conscience protections are applied.

Description of Amendment:

The amendment prohibits the federal government, any state or local government, health care provider or health plan that receives federal financial assistance from discriminating against an individual or institutional health care entity on the basis that the individual or entity does not perform or participate in specific surgical or medical procedures or prescribe certain pharmaceuticals in violation of the moral, ethical, or religious beliefs of the individual or entity.

It strikes the language in the bill regarding the requirement to offer plans with abortions, the requirement to segregate funds, the rules regarding the tax credits and abortions, and the non discrimination language on abortions.

Cornyn Amendment #C1 to America's Healthy Future Act of 2009

Short Title: Ensuring that Nothing Requires Individuals or Employers to Change the Coverage They Have.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark. The amendment would deem any individual enrolled in any health plan governed by the Employee Retirement Income Security Act to have met the personal responsibility requirement.

Offset: If needed, will be provided at markup.

Cornyn Amendment #C2 to America's Healthy Future Act of 2009

Short Title: Promoting Personal Responsibility.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark. The amendment would deem any individual who has posted a $10,000 bond for future health care expenses to have met the personal responsibility requirement.

Offset: If needed, will be provided at markup.

Cornyn Amendment #C3 to America's Healthy Future Act of 2009

Short Title: Ensuring that Nothing Requires Individuals or Employers to Change the Coverage They Have.

Description of Amendment: Strike the provisions in Title I, Subtitle D of the Chairman's Mark that would effectively require employers to change the coverage they offer their employees.

Offset: No offset necessary.

Cornyn Amendment #C4 to America's Healthy Future Act of 2009

Short Title: Promoting Affordable Choices in Coverage.

Description of Amendment: The amendment would amend Title I, Subtitle C of the Chairman's Mark to make the "young invincible" policy, a catastrophic only policy in which the catastrophic coverage level would be set at the HSA limit, available to those 64 years or younger.

Offset: No offset needed.

Cornyn Amendment #C5 to America's Healthy Future Act of 2009

Short Title: Promoting Affordable Choices in Coverage.

Description of Amendment: The amendment would amend Title I, Subtitle C of the Chairman's Mark to make the "young invincible" policy, a catastrophic only policy in which the catastrophic coverage level would be set at the HSA limit, represent minimum creditable coverage.

Offset: Request sent to CBO.

Cornyn Amendment #C6 to America's Healthy Future Act of 2009

Short Title: Promoting Affordable Choices in Coverage.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark. Prior to implementation of the employer requirements known as the "free rider" provision, the Secretary of Labor must certify that the new requirements will not result in lower wages or higher unemployment.

Offset: To be provided at markup.

Cornyn Amendment #C7 to America's Healthy Future Act of 2009

Short Title: Ensuring the Accuracy of Punitive Taxes.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark on Required Payments for Employees Receiving Premium Credits. The amendment would require the Secretary of Health and Human Services to annually submit to Congress for consideration the flat dollar amount required of employers under Subtitle D. In order to take effect, Congress must enact and the President must sign the penalty into law. If Congress fails to enact the penalty by September 30th of each calendar year, the penalty shall not take effect January 1st of the following year.

Offset: To be provided at markup, if needed.

Cornyn Amendment #C8 to America's Healthy Future Act of 2009

Short Title: Limiting the Growth of Washington Bureaucracy.

Description of Amendment: The amendment would amend Title I of the Chairman's Mark. For every Washington bureaucrat added because of this Title, the amendment would require the Secretary of Health and Human Services to ensure a corresponding decrease in one bureaucrat.

Offset: No offset necessary.

Cornyn Amendment #C9 to America's Healthy Future Act of 2009

Short Title: Preserving the Right of Individuals to Access Quality Plans

Description of Amendment: The amendment would give states the authority to approve individual and small group health insurance plans that offer only one type of insurance product, if the state determines this would not result in significant adverse selection.

Offset: No offset necessary.

Cornyn Amendment #C10 to America's Healthy Future Act of 2009

Short Title: Preserving the Right of Individuals to Access Innovative Plans

Description of Amendment: The amendment would give states the authority to allow individual and small group health insurance plans that do not meet the actuarial standards described in Subtitle C, if the state determines this would result in more affordable coverage options for their residents.

Offset: No offset necessary.

Cornyn Amendment #C11 to America's Healthy Future Act of 2009

Short Title: Rewarding Healthy Behaviors

Description of Amendment: The amendment would permit health insurance rating based on healthy behaviors, as determined by the state.

Offset: If necessary, will be provided at the markup.

Cornyn Amendment #C12 to America's Healthy Future Act of 2009

Short Title: Promoting Individual Choice

Description of Amendment: Allow eligible individuals to access the Health Care Affordability Tax Credits for the purchase of health insurance outside of the state exchanges.

Offset: Reduction in government spending.

Cornyn Amendment #C13 to America's Healthy Future Act of 2009

Short Title: Reducing Health Insurance Premiums

Description of Amendment: This amendment amends Title I, Subtitle A of the Chairman's Mark. States could allow unlimited rating based on tobacco use if a state determines that will lower premiums for non-smokers.

Offset: If necessary, will be provided at markup.

Cornyn Amendment #C14 to America's Healthy Future Act of 2009

Short Title: Reducing political influence on the health care cooperatives.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). The amendment strikes the political appointment process for the Advisory Board and replaces it with the non-political appointment process used for the Medicare Payment Advisory Committee.

Offset: No offset necessary.

Cornyn Amendment #C15 to America's Healthy Future Act of 2009

Short Title: Reducing the political influence with regard to health care cooperatives.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). No federal funds may be used by the CO-OPs to lobby Congress, and if the CO-OPs lobby Congress then federal funding shall be eliminated for such CO-OP.

Offset: No offset necessary.

Cornyn Amendment #C16 to America's Healthy Future Act of 2009

Short Title: Improving health care cooperatives.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). No federal funds may be used by the CO-OPs for marketing.

Offset: No offset necessary.

Cornyn Amendment #C17 to America's Healthy Future Act of 2009

Short Title: Ensuring the solvency of health care cooperatives.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). The CO-OPs must meet private sector solvency standards.

Offset: No offset necessary.

Cornyn Amendment #C18 to America's Healthy Future Act of 2009

Short Title: Ensuring fair competition.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). Before the CO-OPs can operate or receive federal funding, the state must have implemented all the insurance reforms required by America's Healthy Future Act.

Offset: No offset necessary.

Cornyn Amendment #C19 to America's Healthy Future Act of 2009

Short Title: Targeting federal dollars to create affordable choices.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). If the Government Accountability Office finds that adequate competition exists in a state, no CO-OP funding shall be made available in that state.

Offset: No offset necessary.

Cornyn Amendment #C20 to America's Healthy Future Act of 2009

Short Title: Ensuring fair competition.

Description of Amendment: This amendment amends Title I, Subtitle E of the Chairman's Mark regarding health care cooperatives (CO-OPs). The CO-OPs must comply with the same state laws as private health insurers.

Offset: No offset necessary.

Cornyn Amendment #C21 to America's Healthy Future Act of 2009

Short Title: Providing choice of health benefits for low-income Americans.

Description of Amendment: The Chairman's Mark expands the Medicaid program for all non-elderly, non-pregnant individuals (childless adults) to 133 percent of FPL. Non-elderly, non-pregnant adults below 100 percent of FPL would have no choice of affordable coverage other than Medicaid. This amendment would allow all new non-elderly, non-pregnant Medicaid individuals to access their choice of private health coverage through the state exchange established under Title I.

Offset: Reduce spending on wealthier individuals under the Mark.

Cornyn Amendment #C22 to America's Healthy Future Act of 2009

Short Title: Encouraging personal responsibility for all Americans.

Description of Amendment: The Chairman's Mark exempts Medicaid beneficiaries from the personal responsibility requirement. This amendment would require certain non-elderly, non-pregnant Medicaid beneficiaries to sign a state-designed personal responsibility or "member" agreement. The personal responsibility agreement would include broad responsibilities and rights, such as the following:

- "I will do my best to stay healthy."
- "I will show up on time when I have my appointments."
- "I will use the hospital emergency room only for emergencies."
- "I have a right to decide things about my health care and the health care of my children."
- "I will be treated fairly and with respect."

Offset: No offset needed.

Cornyn Amendment #C23 to America's Healthy Future Act of 2009

Short Title: Promoting equality between low-income Americans and their elected officials.

Description of Amendment: Requires any Member of Congress who votes for America's Healthy Future Act to enroll in the Medicaid program.

Offset: Reduction in spending.

Cornyn Amendment #C24 to America's Healthy Future Act of 2009

Short Title: Promoting equality between low-income Americans and their elected officials.

Description of Amendment: Requires Member of the Congress of the United States to enroll in the Medicaid program of their respective states.

Offset: Reduction in spending.

Cornyn Amendment #C25 to America's Healthy Future Act of 2009

Short Title: Ensuring that states are able to invest adequate resources in education.

Description of Amendment: The Medicaid program expansions in the bill would be optional for states that spend more on Medicaid than they do on education.

Offset: No offset necessary.

Cornyn Amendment #C26 to America's Healthy Future Act of 2009

Short Title: Ensuring that states are able to invest adequate resources in law enforcement.

Description of Amendment: The Medicaid program expansions in the bill would be optional for states that spend more on Medicaid than they do on law enforcement.

Offset: No offset necessary.

Cornyn Amendment #C27 to America's Healthy Future Act of 2009

Short Title: Ensuring states are able to invest adequate resources to education and law enforcement.

Description of Amendment: The Medicaid program expansions in the bill would be optional for states that spend more on Medicaid than they do on education and law enforcement combined.

Offset: No offset necessary.

Cornyn Amendment #C28 to America's Healthy Future Act of 2009

Short Title: Promoting access to employer-based coverage for Medicaid beneficiaries.

Description of Amendment: The Chairman's Mark requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost-effective to do so, consistent with current law requirements. Many states and employers have found the determining and implementing the "wrap-around" benefit packages so administratively difficult that it threatens access to employer-sponsored insurance for Medicaid beneficiaries. In order to promote access to employer-sponsored insurance, this amendment would remove the requirement for states to include a "wrap-around" benefit package in offering premium assistance for employer-sponsored insurance.

Offset: If needed, will be provided at markup.

Cornyn Amendment #C29 to America's Healthy Future Act of 2009

Short Title: Giving states flexibility to expand their Medicaid programs in a fiscally responsible manner.

Description of Amendment: The amendment would make the Medicaid program expansions in the Chairman's Mark a state option.

Offset: Request for spending impact sent to CBO.

Cornyn Amendment #C30 to America's Healthy Future Act of 2009

Short Title: Reducing waste, fraud, and abuse in the Medicaid program.

Description of Amendment: Prior to implementing the mandatory Medicaid program expansions in the Chairman's Mark, the Secretary of Health and Human Services must certify that the Medicaid program's average Payment Error Rate Measurement is less than 3.5 percent.

Offset: No offset needed.

Cornyn Amendment #C31 to America's Healthy Future Act of 2009

Short Title: Protecting competition and fighting monopoly in health care.

Description of Amendment: The anti-trust laws of the United States shall fully apply to any health care entity created, authorized, or funded under this Act, to the same extent that they would apply to a privately funded entity.

Cornyn Amendment #C32 to America's Healthy Future Act of 2009

Short Title: Preserving American Jobs.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark. Prior to implementation, the Secretary of Labor must certify that the free-rider provision will not reduce incentives for employers to hire low-wage workers.

Offset: To be provided at markup.

Cornyn Amendment #C33 to America's Healthy Future Act of 2009

Short Title: Prohibiting inappropriate business interests in the cooperatives.

Description of Amendment: The amendment would amend Title I, Subtitle E of the Chairman's Mark to prohibit any involvement of ACORN or its subsidiaries in the organization, operation, governance, or sponsorship of cooperatives.

Offset: Not necessary

Cornyn Amendment #C34 to America's Healthy Future Act of 2009

Short Title: Prohibiting inappropriate interests in health cooperatives.

Description of Amendment: The amendment would amend Title I, Subtitle B of the Chairman's Mark. The amendment would prohibit ACORN or its subsidiaries from any involvement in enrollment activities for the state exchanges.

Offset: Estimated to save taxpayer dollars.

Cornyn Amendment #C35 to America's Healthy Future Act of 2009

Short Title: To allow American families to choose the health insurance that best fits their needs.

Description of Amendment: The amendment would amend Title I, Subtitle D of the Chairman's Mark. American individuals and families would be able to choose the health plan, licensed in their home state, that best fits their needs. Such plan will be deemed to have met the requirements for personal responsibility under Title I, Subtitle D.