

110TH CONGRESS
2^D SESSION

H. R. 7129

To provide for innovation in health care through a demonstration program to expand coverage under the State Child Health Insurance Program through an employer buy-in, through access to health benefits through regional State arrangements, and through State initiatives that expand coverage and access, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 2008

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

A BILL

To provide for innovation in health care through a demonstration program to expand coverage under the State Child Health Insurance Program through an employer buy-in, through access to health benefits through regional State arrangements, and through State initiatives that expand coverage and access, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
 3 “Several Approaches to Reduce the Uninsured Act of
 4 2008”.

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

Sec. 1. Short title; table of contents.

TITLE I—PROMOTION UNDER ERISA OF STATE-BASED
 EXPANSION OF HEALTH CARE COVERAGE

Sec. 101. Exemption from ERISA preemption for State comprehensive health
 care programs.

Sec. 102. State coverage buy-in arrangements and small employer coverage
 buy-in arrangements.

Sec. 103. Exemption from preemption to permit pay or play under State law.

Sec. 104. Exemption from preemption to permit mandates for data collection
 under State law relating to group health plans.

TITLE II—HEALTH PARTNERSHIP THROUGH CREATIVE
 FEDERALISM

Sec. 201. Short title.

Sec. 202. State health reform projects.

Sec. 203. Effective date.

TITLE III—DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN

Sec. 301. Demonstration project for employer buy-in.

TITLE IV—ACCESS TO HEALTH BENEFITS THROUGH REGIONAL
 STATE ARRANGEMENTS

Sec. 401. Promoting access through regional State arrangements under a dem-
 onstration project.

Sec. 402. Transparency and accountability for health benefit plans.

TITLE V—AMENDMENTS RELATING TO PREEXISTING CONDITION
 EXCLUSION

Sec. 501. Short title.

Sec. 502. Amendments relating to preexisting condition exclusions under group
 health plans.

Sec. 503. Amendments relating to preexisting condition exclusions in health in-
 surance coverage in the individual market.

1 **TITLE I—PROMOTION UNDER**
2 **ERISA OF STATE-BASED EX-**
3 **PANSION OF HEALTH CARE**
4 **COVERAGE**

5 **SEC. 101. EXEMPTION FROM ERISA PREEMPTION FOR**
6 **STATE COMPREHENSIVE HEALTH CARE PRO-**
7 **GRAMS.**

8 (a) EXEMPTION FROM PREEMPTION.—Section
9 514(b) of the Employee Retirement Income Security Act
10 of 1974 (29 U.S.C. 1144(b)) is amended—

11 (1) by redesignating paragraph (9) as para-
12 graph (10); and

13 (2) by inserting after paragraph (8) the fol-
14 lowing new paragraph:

15 “(9)(A) Except as provided in subparagraph (B),
16 subsection (a) shall not apply to any program established
17 by or under the laws of any State which is listed pursuant
18 to section 721 as a State comprehensive health care pro-
19 gram (as defined in section 722(a)).

20 “(B) Nothing in subparagraph (A) shall be construed
21 to exempt from subsection (a) any State tax law relating
22 to employee benefit plans.

23 “(C) Notwithstanding subparagraph (A), parts 1 and
24 4 of this subtitle, and the preceding sections of this part
25 to the extent they govern matters which are governed by

1 the provisions of such parts 1 and 4, shall supersede any
 2 program described in subparagraph (A), but the Secretary
 3 may enter into cooperative arrangements under this para-
 4 graph and section 506 with officials of the State involved
 5 to assist them in effectuating the policies of the provisions
 6 of such program which are superseded by such parts 1
 7 and 4 and the preceding sections of this part.”.

8 (b) STATE COMPREHENSIVE HEALTH CARE PRO-
 9 GRAMS.—

10 (1) IN GENERAL.—Part 7 of subtitle B of title
 11 I of such Act (29 U.S.C. 1181 et seq.) is amended—

12 (A) by redesignating subpart C ad subpart
 13 D; and

14 (B) by inserting after subpart B the fol-
 15 lowing new subpart:

16 **“Subpart C—State Comprehensive Health Care**
 17 **Programs**

18 **“SEC. 721. DESIGNATION OF STATE COMPREHENSIVE**
 19 **HEALTH CARE PROGRAMS EXEMPT FROM**
 20 **FEDERAL PREEMPTION.**

21 “The Secretary shall, for purposes of the application
 22 section 514(b)(9), establish and maintain a comprehensive
 23 list of which programs (if any) established by or under
 24 the laws of each State constitute, as determined by the
 25 Secretary, State comprehensive health care programs. The

1 Secretary shall undertake an ongoing review of such list
2 so as to ensure such list remains comprehensive and exclu-
3 sive of any programs which may have ceased to be State
4 comprehensive health care programs. Such list shall be pe-
5 riodically published in the Federal Register and main-
6 tained so as to be readily accessible to the general public.

7 **“SEC. 722. REQUIREMENTS.**

8 “(a) IN GENERAL.—For purposes of this subpart and
9 section 514(b)(9), the term ‘State comprehensive health
10 care program’ means a program established by or under
11 the laws of any State under which—

12 “(1) residents of such State are required to ob-
13 tain and maintain health insurance coverage meeting
14 the Federal threshold of adequate medical care,

15 “(2) each employer employing individuals in
16 such State—

17 “(A) that is not a small employer within
18 the meaning of subsection (c) for a calendar
19 year,

20 “(B) that does not otherwise provide group
21 health plan coverage for its employees which
22 provides benefits meeting the criteria for the
23 Federal threshold of adequate medical care (as
24 described in subsection (d)) for such calendar
25 year, and

1 “(C) in whose case the Secretary has not
2 waived the requirements of this subsection for
3 such calendar year pursuant to subsection (e)
4 on the basis of substantial business hardship,
5 is required to establish and maintain a group health
6 plan for such employees for such calendar year pro-
7 viding benefits which meet the Federal threshold of
8 adequate medical care.

9 “(b) SINGLE PROGRAM PER STATE.—A program
10 may be considered a State comprehensive health care pro-
11 gram in connection with any State only if it is the only
12 such program in effect by or under the laws of such State.

13 “(c) FEDERAL THRESHOLD OF ADEQUATE MEDICAL
14 CARE.—For purposes of this section, the term ‘Federal
15 threshold of adequate medical care’ means the package of
16 benefits constituting medical care which the Comprehen-
17 sive Health Care Commission currently maintains as the
18 Federal threshold of adequate medical care as prescribed
19 pursuant to section 723(f)(1).

20 “(d) SMALL EMPLOYERS.—

21 “(1) IN GENERAL.—For purposes of subsection
22 (a)(2), the term ‘small employer’ means, with re-
23 spect to a calendar year, an employer who employed
24 an average of at least 2 but not more than 100 em-
25 ployees on business days during the preceding cal-

1 endar year and who employs at least 2 employees on
2 the first day of the current calendar year. For pur-
3 poses of the preceding sentence, all persons treated
4 as a single employer under subsection (b), (c), (m),
5 or (o) of section 414 of the Internal Revenue Code
6 of 1986 shall be treated as 1 employer.

7 “(2) EMPLOYERS NOT IN EXISTENCE IN PRE-
8 CEDING YEAR.—In the case of an employer which
9 was not in existence throughout the preceding cal-
10 endar year, the determination of whether such em-
11 ployer is a small employer shall be based on the av-
12 erage number of employees that it is reasonably ex-
13 pected such employer will employ on business days
14 in the current calendar year.

15 “(3) PREDECESSORS.—Any reference in this
16 subsection to an employer shall include a reference
17 to any predecessor of such employer.

18 “(e) EXCEPTION ALLOWED FOR EMPLOYERS OTHER-
19 WISE PROVIDING GROUP HEALTH PLAN COVERAGE.—
20 For purposes of subsection (a)(2), an employer shall be
21 treated, for any current calendar year, as otherwise pro-
22 viding coverage of an employee under a group health plan
23 for its employees which meets the criteria for the Federal
24 threshold of adequate medical care if, with respect to such
25 calendar year, such employee—

1 “(1) was eligible under such a group health
2 plan maintained by the employer for the preceding
3 calendar year, or

4 “(2) may be reasonably expected to be eligible
5 during the current calendar year under a group
6 health plan referred to in paragraph (1).

7 “(f) WAIVER IN CASES OF SUBSTANTIAL BUSINESS
8 HARDSHIP.—

9 “(1) IN GENERAL.—If an employer is unable to
10 satisfy the requirements of subsection (a) for any
11 calendar year without substantial business hardship
12 and application of such requirements for such cal-
13 endar year would be adverse to the interests of plan
14 participants in the aggregate, the Secretary may
15 waive the requirements of subsection (a) for such
16 calendar year. The Secretary shall not waive such
17 requirements with respect to a plan for more than
18 3 of any 15 consecutive calendar years.

19 “(2) DETERMINATION OF SUBSTANTIAL BUSI-
20 NESS HARDSHIP.—For purposes of this section, the
21 factors taken into account in determining substantial
22 business hardship shall include (but shall not be lim-
23 ited to) whether or not—

24 “(A) the employer is operating at an eco-
25 nomic loss,

1 “(B) there is substantial unemployment or
2 under-employment in the trade or business and
3 in the industry concerned,

4 “(C) the sales and profits of the industry
5 concerned are depressed or declining, and

6 “(D) it is reasonable to expect that the
7 plan will be established or maintained only if
8 the waiver is granted.

9 **“SEC. 723. COMPREHENSIVE HEALTH CARE COMMISSION.**

10 “(a) ESTABLISHMENT.—The Secretary, in consulta-
11 tion with the Secretary of Health and Human Services,
12 shall establish a commission to be known as the Com-
13 prehensive Health Care Commission (referred to in this
14 section as the ‘Commission’).

15 “(b) MEMBERSHIP.—

16 “(1) NUMBER AND APPOINTMENT.—The Com-
17 mission shall be composed of 15 members appointed
18 by the Secretary, in consultation with the Secretary
19 of Health and Human Services.

20 “(2) QUALIFICATIONS.—

21 “(A) IN GENERAL.—The membership of
22 the Commission shall include—

23 “(i) consumers of health services that
24 represent those individuals who have not
25 had insurance within 2 years of appoint-

1 ment, that have had chronic illnesses, in-
2 cluding mental illness, are disabled, and
3 those who receive insurance coverage
4 through medicare and medicaid; and

5 “(ii) individuals with expertise in fi-
6 nancing and paying for benefits and access
7 to care, business and labor perspectives,
8 and providers of health care. The member-
9 ship shall reflect a broad geographic rep-
10 resentation and a balance between urban
11 and rural representatives.

12 “(B) PROHIBITED APPOINTMENTS.—Mem-
13 bers of the Commission shall not include Mem-
14 bers of Congress or other elected government
15 officials (Federal, State, or local). Individuals
16 appointed to the Commission shall not be paid
17 employees or representatives of associations or
18 advocacy organizations involved in the health
19 care system.

20 “(c) PERIODS OF APPOINTMENT.—Members of the
21 Commission shall serve for terms of 6 years, except that,
22 of the members first appointed—

23 “(1) 5 shall serve for a term of 2 years,

24 “(2) 5 shall serve for a term of 4 years, and

25 “(3) 5 shall serve for a term of 6 years,

1 as designated by the Secretary at the time of appointment.
2 Any vacancies shall not affect the power and duties of the
3 Commission but shall be filled in the same manner as the
4 original appointment.

5 “(d) DESIGNATION OF THE CHAIRPERSON.—The
6 Secretary shall designate the chairperson of the Commis-
7 sion.

8 “(e) SUBCOMMITTEES.—The Commission may estab-
9 lish subcommittees if doing so increases the efficiency of
10 the Commission in completing its tasks.

11 “(f) DUTIES.—

12 “(1) IN GENERAL.—The Commission shall pre-
13 scribe, and from time to time revise as the Commis-
14 sion deems appropriate, a package of benefits consti-
15 tuting medical care which it determines to be, for
16 purposes of this part, the Federal threshold of ade-
17 quate medical care.

18 “(2) HEARINGS.—The Commission may hold
19 hearings which are determined by the Commission to
20 be necessary by the Commission in carrying out its
21 duties.

22 “(3) COMMUNITY MEETINGS.—

23 “(A) IN GENERAL.—Not later than 1 year
24 after the date on which all the members of the
25 Commission have been appointed under sub-

1 section (b)(1) and appropriations are first made
2 available to carry out this section, the Commis-
3 sion shall annually provide for health care com-
4 munity meetings throughout the United States
5 (in this paragraph referred to as ‘community
6 meetings’). Such community meetings may be
7 geographically or regionally based.

8 “(B) FREQUENCY OF MEETINGS.—The
9 Commission shall ensure that community meet-
10 ings are held with such frequency as to ensure
11 that the Commission receives information that
12 reflects, on an ongoing basis—

13 “(i) the geographic differences
14 throughout the United States;

15 “(ii) diverse populations; and

16 “(iii) a balance among urban and
17 rural populations.

18 “(C) MEETING REQUIREMENTS.—

19 “(i) FACILITATOR.—A State health
20 officer may be the facilitator at the com-
21 munity meetings.

22 “(ii) ATTENDANCE.—At least 1 mem-
23 ber of the Commission shall attend and
24 serve as chair of each community meeting.

1 Other members may participate through
2 interactive technology.

3 “(iii) TOPICS.—The community meet-
4 ings shall, at a minimum, address the fol-
5 lowing questions:

6 “(I) What health care benefits
7 and services should be provided?

8 “(II) How does the American
9 public want health care delivered?

10 “(III) How should health care
11 coverage be financed?

12 “(IV) What trade-offs are the
13 American public willing to make in ei-
14 ther benefits or financing to ensure
15 access to affordable, high quality
16 health care coverage and services?

17 “(iv) INTERACTIVE TECHNOLOGY.—
18 The Commission may encourage public
19 participation in community meetings
20 through interactive technology and other
21 means as determined appropriate by the
22 Commission.

23 “(g) ADMINISTRATION.—

24 “(1) EXECUTIVE DIRECTOR.—There shall be an
25 Executive Director of the Commission who shall be

1 appointed by the chairperson of the Commission in
2 consultation with the members of the Commission.

3 “(2) COMPENSATION.—While serving on the
4 business of the Commission (including travel time),
5 a member of the Commission shall be entitled to
6 compensation at the per diem equivalent of the rate
7 provided for level IV of the Executive Schedule
8 under section 5315 of title 5, United States Code,
9 and while so serving away from home and the mem-
10 ber’s regular place of business, a member may be al-
11 lowed travel expenses, as authorized by the chair-
12 person of the Commission. For purposes of pay and
13 employment benefits, rights, and privileges, all per-
14 sonnel of the Commission shall be treated as if they
15 were employees of the Senate.

16 “(3) INFORMATION FROM FEDERAL AGEN-
17 CIES.—The Commission may secure directly from
18 any Federal department or agency such information
19 as the Commission considers necessary to carry out
20 this section. Upon request of the Commission, the
21 head of such department or agency shall furnish
22 such information.

23 “(4) POSTAL SERVICES.—The Commission may
24 use the United States mails in the same manner and

1 under the same conditions as other departments and
2 agencies of the Federal Government.

3 “(h) DETAIL.—Not more than 10 Federal Govern-
4 ment employees employed by the Department of Labor
5 and 10 Federal Government employees employed by the
6 Department of Health and Human Services may be de-
7 tailed to the Commission under this section without fur-
8 ther reimbursement. Any detail of an employee shall be
9 without interruption or loss of civil service status or privi-
10 lege.

11 “(i) TEMPORARY AND INTERMITTENT SERVICES.—
12 The chairperson of the Commission may procure tem-
13 porary and intermittent services under section 3109(b) of
14 title 5, United States Code, at rates for individuals which
15 do not exceed the daily equivalent of the annual rate of
16 basic pay prescribed for level V of the Executive Schedule
17 under section 5316 of such title.

18 “(j) ANNUAL REPORT.—Not later than 1 year after
19 the date of enactment of this Act, and annually thereafter,
20 the Commission shall report to Congress and make public
21 a detailed description of the expenditures of the Commis-
22 sion used to carry out its duties under this section.

23 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

1 \$3,000,000 for each fiscal year beginning on or after Octo-
 2 ber 1, 2008.”.

3 (2) CONFORMING AMENDMENTS.—The table of
 4 contents in section 1 of such Act is amended by in-
 5 serting after the item relating to section 713 the fol-
 6 lowing new items:

“SUBPART C—STATE COMPREHENSIVE HEALTH CARE PROGRAMS

“Sec. 721. Designation of State comprehensive health care programs exempt
 from Federal preemption.

“Sec. 722. Requirements.

“Sec. 723. Comprehensive Health Care Commission.”.

7 **SEC. 102. STATE COVERAGE BUY-IN ARRANGEMENTS AND**
 8 **SMALL EMPLOYER COVERAGE BUY-IN AR-**
 9 **RANGEMENTS.**

10 (a) AUTHORIZATION FOR INCLUSION OF INDIVID-
 11 UALS AS PARTICIPANTS IN GROUP HEALTH PLANS
 12 UNDER STATE COVERAGE BUY-IN ARRANGEMENTS.—
 13 Section 404 of the Employee Retirement Income Security
 14 Act of 1974 (29 U.S.C. 1104) is amended by adding at
 15 the end the following new subsection:

16 “(e)(1) Any requirement of the preceding provisions
 17 of this section or any other provision of this title shall
 18 not be treated as violated by reason of the entry of the
 19 plan administrator into a State coverage buy-in arrange-
 20 ment or the treatment as a participant under the plan,
 21 pursuant to such an arrangement, of an individual who
 22 is not an employee, former employee, or member or former

1 member of an employee organization described in section
2 3(7)(A) in connection with the plan.

3 “(2) For purposes of paragraph (1), the term ‘State
4 coverage buy-in arrangement’ means an arrangement en-
5 tered into between the plan administrator of a group
6 health plan and a State pursuant to which—

7 “(A) individuals who are residents of such
8 State, are identified under the arrangement, and are
9 not otherwise participants (within the meaning of
10 section 3(7)(A)) in the plan are treated as partici-
11 pants in the plan,

12 “(B) premiums are payable to the plan, by such
13 individuals, by the State on behalf of such individ-
14 uals, or by both, in total amounts equivalent to the
15 total cost of coverage of the individuals and their
16 beneficiaries under the plan, and

17 “(C) the Secretary determines, under a proce-
18 dure providing for determinations prior to the entry
19 into the arrangement, and annually thereafter dur-
20 ing the term of the arrangement, that the arrange-
21 ment is—

22 “(i) administratively feasible,

23 “(ii) in the interests of the plan and of its
24 participants and beneficiaries, and

1 “(iii) protective of the rights of partici-
2 pants and beneficiaries of the plan.

3 “(3) A fiduciary of a group health plan shall have
4 the same fiduciary duties with respect to participants and
5 their beneficiaries who are covered under a group health
6 plan solely by reason of a State coverage buy-in arrange-
7 ment as are applicable with respect to individuals who are
8 otherwise participants or beneficiaries under the plan.”.

9 (b) AUTHORIZATION FOR INCLUSION OF EMPLOYEES
10 OF SMALL EMPLOYERS AS PARTICIPANTS IN GROUP
11 HEALTH PLANS OF LARGE EMPLOYERS UNDER SMALL
12 EMPLOYER COVERAGE BUY-IN ARRANGEMENTS.—Sec-
13 tion 404 of such Act (as amended by subsection (a)) is
14 amended further by adding at the end the following new
15 subsection:

16 “(f)(1) Any requirement of the preceding provisions
17 of this section or any other provision of this title shall
18 not be treated as violated by reason of the entry of a small
19 employer into a small employer coverage buy-in arrange-
20 ment with the plan administrator of a large employer
21 group health plan or the treatment as a participant under
22 the plan, pursuant to such an arrangement, of an indi-
23 vidual who is an employee of the small employer and who
24 is not an employee or former employee of the plan sponsor
25 of the plan or a member or former member of an employee

1 organization referred to in section 3(7)(A) in connection
2 with the plan.

3 “(2) For purposes of paragraph (1), the term ‘small
4 employer coverage buy-in arrangement’ means an arrange-
5 ment entered into between a small employer referred to
6 in paragraph (1) and a plan administrator of a large em-
7 ployer group health plan referred to in paragraph (1) pur-
8 suant to which—

9 “(A) individuals who are employees of the small
10 employer, are identified under such arrangement,
11 and are not otherwise participants (within the mean-
12 ing of section 3(7)(A)) in the plan are treated as
13 participants in the plan,

14 “(B) premiums are payable to the plan, by such
15 individuals, by the small employer, or by both, in
16 total amounts equivalent to the total cost of cov-
17 erage of such individuals and their beneficiaries
18 under the plan, and

19 “(C) the Secretary determines, under a proce-
20 dure providing for determinations prior to the entry
21 into the arrangement, and annually thereafter dur-
22 ing the term of the arrangement, that the arrange-
23 ment is—

24 “(i) administratively feasible,

1 “(ii) in the interests of the plan and of its
2 participants and beneficiaries, and

3 “(iii) protective of the rights of partici-
4 pants and beneficiaries of the plan.

5 “(3) A fiduciary of a group health plan shall have
6 the same fiduciary duties with respect to participants and
7 their beneficiaries who are covered under a group health
8 plan solely by reason of a small employer coverage buy-
9 in arrangement as are applicable with respect to individ-
10 uals who are otherwise participants or beneficiaries under
11 the plan.

12 “(4) For purposes of this subsection—

13 “(A)(i) The term ‘small employer’ means, in
14 connection with the calendar year in which the ar-
15 rangement referred to in paragraph (1) is entered
16 into, an employer who, on business days during the
17 period commencing with the preceding calendar year
18 and ending on the date on which the arrangement
19 referred to in paragraph (1) is entered into, em-
20 ployed an average of at least 2 but not more than
21 50 employees.

22 “(ii) For purposes of this subparagraph—

23 “(I) rules similar to the rules under sub-
24 sections (b), (c), (m), and (o) of section 414 of
25 the Internal Revenue Code of 1986 shall apply

1 for purposes of treating persons as a single em-
2 ployer;

3 “(II) in the case of an employer which was
4 not in existence throughout the period described
5 in subparagraph (A), the determination of
6 whether the employer is a small employer shall
7 be based on the average number of employees
8 that it is reasonably expected the employer will
9 employ on business days in the calendar year
10 during which the arrangement referred to in
11 paragraph (1) is entered into; and

12 “(III) any reference in this subparagraph
13 to an employer shall include a reference to any
14 predecessor of the employer.

15 “(B) The term ‘large employer group health
16 plan’ means a group health plan with respect to
17 which the plan sponsor is not a small employer in
18 connection with the calendar year in which the ar-
19 rangement referred to in paragraph (1) is entered
20 into.”.

21 (c) CONFORMING AMENDMENTS.—

22 (1) INCLUSION IN DEFINITION OF PARTICI-
23 PANT.—Section 3(7) of such Act (29 U.S.C.
24 1002(7)) is amended—

25 (A) by inserting “(A)” after “(7)”; and

1 (B) by adding at the end the following new
2 subparagraph:

3 “(B) In connection with a group health plan (as de-
4 fined in section 733(a)), the term ‘participant’ includes
5 any individual not described in subparagraph (A) who is
6 treated as a participant in connection with a State cov-
7 erage buy-in arrangement entered into pursuant to section
8 404(e) or a small employer coverage buy-in arrangement
9 entered into pursuant to section 404(f).”.

10 (2) EXCLUSION FROM DEFINITION OF MUL-
11 TIPLE EMPLOYER WELFARE ARRANGEMENT.—Sec-
12 tion 3(40)(A) of such Act (29 U.S.C. 1002(40((A))
13 is amended—

14 (A) in clause (ii), by striking “or”;

15 (B) in clause (iii), by striking “associa-
16 tion.” and inserting “association, or”; and

17 (C) by adding at the end the following new
18 clause:

19 “(iv) pursuant to subsection (e) or (f) of
20 section 404.”.

21 (d) CREDIT FOR PREMIUMS PAID UNDER STATE
22 COVERAGE BUY-IN ARRANGEMENTS.—

23 (1) IN GENERAL.—Subpart D of part IV of
24 subchapter A of chapter 1 of the Internal Revenue
25 Code of 1986 (relating to business related credits) is

1 amended by adding at the end the following new sec-
2 tion:

3 **“SEC. 45Q. PREMIUMS PAID UNDER QUALIFIED COVERAGE**
4 **BUY-IN ARRANGEMENTS.**

5 “(a) GENERAL RULE.—For purposes of section 38,
6 the qualified coverage buy-in arrangement credit deter-
7 mined under this section for any taxable year is the aggre-
8 gate amount paid in the taxable year as premiums for
9 qualified participants under a qualified coverage buy-in ar-
10 rangement.

11 “(b) DEFINITIONS.—For purposes of this section—

12 “(1) QUALIFIED COVERAGE BUY-IN ARRANGE-
13 MENT.—The term ‘qualified coverage buy-in ar-
14 rangement’ means—

15 “(A) a State coverage buy-in arrangement,
16 and

17 “(B) a small employer coverage buy-in ar-
18 rangement.

19 “(2) STATE COVERAGE BUY-IN ARRANGEMENT;
20 SMALL EMPLOYER COVERAGE BUY-IN ARRANGE-
21 MENT.—The terms ‘State coverage buy-in arrange-
22 ment’ and ‘small employer coverage buy-in arrange-
23 ment’ have the respective meanings given such terms
24 by subsections (e)(2) and (f)(2) of section 404 of the
25 Employee Retirement Income Security Act of 1974.

1 “(3) QUALIFIED PARTICIPANT.—The term
2 ‘qualified participant’ means a participant (as de-
3 fined in section 3(7)(B) of the Employee Retirement
4 Income Security Act of 1974).

5 “(4) PREMIUM.—The term ‘premium’ means
6 the applicable premium (as defined in section
7 4980B(f)(4)).”.

8 (2) CREDIT ALLOWED AS PART OF GENERAL
9 BUSINESS CREDIT.—Section 38(b) of such Code (de-
10 fining current year business credit) is amended by
11 striking “plus” at the end of paragraph (32), by
12 striking the period at the end of paragraph (33) and
13 inserting “, plus”, and by adding at the end the fol-
14 lowing new paragraph:

15 “(34) State coverage buy-in arrangement credit
16 determined under section 45Q(a).”.

17 (3) CLERICAL AMENDMENT.—The table of sec-
18 tions for subpart D of part IV of subchapter A of
19 chapter 1 of such Code is amended by adding at the
20 end the following new item:

“Sec. 45Q. Premiums paid under State coverage buy-in arrangements.”.

21 (e) EFFECTIVE DATES.—The amendments made by
22 subsections (a), (b), and (c) shall apply with respect to
23 arrangements entered into after December 31, 2008. The
24 amendments made by subsection (d) shall apply to costs

1 paid or incurred in taxable years beginning after Decem-
2 ber 31, 2008.

3 **SEC. 103. EXEMPTION FROM PREEMPTION TO PERMIT PAY**
4 **OR PLAY UNDER STATE LAW.**

5 Section 514(b) of the Employee Retirement Income
6 Security Act of 1974 (as amended by section 201) is
7 amended further—

8 (1) by redesignating paragraph (10) as para-
9 graph (11); and

10 (2) by inserting after paragraph (9) the fol-
11 lowing new paragraph:

12 “(10) Subsection (a) shall not apply to any provision
13 of State law to the extent it provides an assessment
14 against an employer, or a credit against an otherwise ap-
15 plicable assessment against an employer, based on wheth-
16 er, or the extent to which, such employer makes contribu-
17 tions to a group health plan established or maintained by
18 such employer, if such provision does not condition the ap-
19 plicability of the assessment or credit on the satisfaction
20 of any requirement applicable to such plan.”.

1 **SEC. 104. EXEMPTION FROM PREEMPTION TO PERMIT MAN-**
2 **DATES FOR DATA COLLECTION UNDER STATE**
3 **LAW RELATING TO GROUP HEALTH PLANS.**

4 Section 514(b) of the Employee Retirement Income
5 Security Act of 1974 (as amended by the preceding provi-
6 sions of this title) is amended further—

7 (1) by redesignating paragraph (11) as para-
8 graph (12); and

9 (2) by inserting after paragraph (10) the fol-
10 lowing new paragraph:

11 “(10)(A) Subsection (a) shall not apply to any provi-
12 sion of State law to the extent such provision—

13 “(i) provides for the collection from the plan
14 sponsor or plan administrator of a group health
15 plan, by the agency or instrumentality of the State
16 responsible for the administration or enforcement of
17 any State law regulating insurance or medical care
18 (as defined in section 733(a)(2)), of information re-
19 lating to the cost and availability of such medical
20 care through group health insurance coverage or ac-
21 cess of individuals to such coverage, or

22 “(ii) provides for the enforcement of any State
23 law described in clause (i).

24 “(B) For purposes of subparagraph (A), any provi-
25 sion of State law providing for the extent of the informa-
26 tion described in subparagraph (A)(i) to be collected or

1 the timing allowed for compliance with requests for such
2 information shall be treated as a provision of State law
3 referred to in subparagraph (A)(i).”.

4 **TITLE II—HEALTH PARTNER-**
5 **SHIP THROUGH CREATIVE**
6 **FEDERALISM**

7 **SEC. 201. SHORT TITLE.**

8 This title may be cited as the “Health Partnership
9 Through Creative Federalism Act”.

10 **SEC. 202. STATE HEALTH REFORM PROJECTS.**

11 (a) **PURPOSES; ESTABLISHMENT OF STATE HEALTH**
12 **CARE EXPANSION AND IMPROVEMENT PROGRAM.—**

13 (1) **PURPOSES.—**The purposes of the programs
14 approved under this section shall include—

15 (A) achieving the goals of increased health
16 coverage and access; and

17 (B) testing alternative reforms, such as
18 building on the public or private health systems,
19 or creating new systems, to achieve the objec-
20 tives of this title.

21 (2) **INTENT OF CONGRESS.—**It is the intent of
22 Congress that—

23 (A) the programs approved under this title
24 each comprise significant coverage expansions;

1 (B) taken as a whole, such programs
2 should be diverse and balanced in their ap-
3 proaches to covering the uninsured; and

4 (C) each such program should be rigor-
5 ously and objectively evaluated, so that the
6 State programs developed pursuant to this title
7 may guide the development of future State and
8 national policy.

9 (b) APPLICATIONS BY STATES AND LOCAL GOVERN-
10 MENTS.—

11 (1) ENTITIES THAT MAY APPLY.—

12 (A) IN GENERAL.—A State may apply for
13 a State health care expansion and improvement
14 program for the entire State (or for regions of
15 the State) under paragraph (2).

16 (B) REGIONAL AND SUB-STATE GROUPS.—
17 A regional entity consisting of more than one
18 State or one or more local governments within
19 a State may apply for a multi-State or a sub-
20 State, respectively, health care expansion and
21 improvement program for the region or area in-
22 volved.

23 (C) STATE DEFINED.—In this title, the
24 term “State” means the 50 States, the District
25 of Columbia, and the Commonwealth of Puerto

1 Rico. Such term shall include a regional entity
2 described in subparagraph (B).

3 (2) SUBMISSION OF APPLICATION.—In accord-
4 ance with this section, each State or regional entity
5 desiring to implement a State health care expansion
6 and improvement program may submit an applica-
7 tion to the State Health Coverage Innovation Com-
8 mission under subsection (e) for approval.

9 (3) LOCAL GOVERNMENT APPLICATIONS.—
10 Where a State fails to submit an application under
11 this section, a unit of local government of such
12 State, or a consortium of such units of local govern-
13 ments, may submit an application directly to the
14 Commission for programs or projects under this sub-
15 section. Such an application shall be subject to the
16 requirements of this section.

17 (e) STATE HEALTH COVERAGE INNOVATION COM-
18 MISSION.—

19 (1) IN GENERAL.—Not later than 90 days after
20 the date of the enactment of this Act, the Secretary
21 of Health and Human Services (in this section re-
22 ferred to as the “Secretary”) shall establish a State
23 Health Coverage Innovation Commission (referred to
24 in this section as the “Commission”).

1 (2) MEMBERSHIP.—The Commission shall be
2 composed of the following members:

3 (A) The Secretary.

4 (B) Four State governors to be appointed
5 by the National Governors Association on a bi-
6 partisan basis.

7 (C) Two members of a State legislature to
8 be appointed, on a joint and bipartisan basis,
9 by the National Conference of State Legislators
10 and the American Legislative Exchange Coun-
11 cil.

12 (D) Two county officials to be appointed
13 by the National Association of Counties on a bi-
14 partisan basis.

15 (E) Two mayors to be appointed, on a
16 joint and bipartisan basis, by the National
17 League of Cities and by the United States Con-
18 ference of Mayors.

19 (F) Two individuals to be appointed by the
20 Speaker of the House of Representatives.

21 (G) Two individuals to be appointed by the
22 minority leader of the House of Representa-
23 tives.

24 (H) Two individuals to be appointed by the
25 majority leader of the Senate.

1 (I) Two individuals to be appointed by the
2 minority leader of the Senate.

3 (3) DUTIES.—The Commission—

4 (A) shall request States to submit pro-
5 posals, which may include a variety of reform
6 options such as tax credit approaches, expan-
7 sions of public programs such as Medicaid and
8 the State Children’s Health Insurance Pro-
9 gram, the creation of purchasing pooling ar-
10 rangements similar to the Federal Employees
11 Health Benefits Program, individual market
12 purchasing options, single risk pool or single
13 payer systems, health savings accounts, a com-
14 bination of the options described in this sub-
15 paragraph, or other alternatives determined ap-
16 propriate by the Commission, including options
17 suggested by States or the public, and nothing
18 in this subparagraph shall be construed to pre-
19 vent the Commission from approving a reform
20 proposal not included in this subparagraph;

21 (B) shall conduct a thorough review of the
22 grant application from a State and carry on a
23 dialogue with all State applicants concerning
24 possible modifications and adjustments;

1 (C) shall submit the recommendations and
2 legislative proposal described in subsection
3 (d)(4)(C);

4 (D) shall be responsible for receiving infor-
5 mation to determine the status and progress
6 achieved under the program or projects granted
7 under this section;

8 (E) shall report to the public concerning
9 progress made by States with respect to the
10 performance measures and goals established
11 under this title, the periodic progress of the
12 State relative to its State performance meas-
13 ures and goals, and the State program applica-
14 tion procedures, by region and State jurisdic-
15 tion;

16 (F) shall promote information exchange
17 between States and the Federal Government;

18 (G) shall be responsible for making rec-
19 ommendations to the Secretary and the Con-
20 gress, using equivalency or minimum standards,
21 for minimizing the negative effect of State pro-
22 gram on national employer groups, provider or-
23 ganizations, and insurers because of differing
24 State requirements under the programs; and

1 (H) may require States to submit addi-
2 tional information or reports concerning the
3 status and progress achieved under health care
4 expansion and improvement programs granted
5 under this section, as needed.

6 (4) PERIOD OF APPOINTMENT; REPRESENTA-
7 TION REQUIREMENTS; VACANCIES.—Members shall
8 be appointed for a term of 5 years. In appointing
9 such members under paragraph (2), the designated
10 appointing individuals shall ensure the representa-
11 tion of urban and rural areas and an appropriate ge-
12 ographic distribution of such members. Any vacancy
13 in the Commission shall not affect its powers, but
14 shall be filled in the same manner as the original ap-
15 pointment.

16 (5) CHAIRPERSON, MEETINGS.—

17 (A) CHAIRPERSON.—The Commission shall
18 select a Chairperson from among its members.

19 (B) QUORUM.—Two-thirds of the members
20 of the Commission shall constitute a quorum,
21 but a lesser number of members may hold hear-
22 ings.

23 (C) MEETINGS.—Not later than 30 days
24 after the date on which all members of the
25 Commission have been appointed, the Commis-

1 sion shall hold its first meeting. The Commis-
2 sion shall meet at the call of the Chairperson.

3 (6) POWERS OF THE COMMISSION.—

4 (A) NEGOTIATIONS WITH STATES.—The
5 Commission may conduct detailed discussions
6 and negotiations with States submitting appli-
7 cations under this section, either individually or
8 in groups, to facilitate a final set of rec-
9 ommendations for purposes of subsection
10 (d)(4)(C).

11 (B) HEARINGS.—The Commission may
12 hold such hearings, sit and act at such times
13 and places, take such testimony, and receive
14 such evidence as the Commission considers ad-
15 visable to carry out the purposes of this sub-
16 section.

17 (C) MEETINGS.—In addition to other
18 meetings the Commission may hold, the Com-
19 mission shall hold an annual meeting with the
20 participating States under this section for the
21 purpose of having States report progress to-
22 ward the purposes in subsection (a) and for an
23 exchange of information.

24 (D) INFORMATION.—The Commission may
25 secure directly from any Federal department or

1 agency such information as the Commission
2 considers necessary to carry out the provisions
3 of this subsection. Upon request of the Chair-
4 person of the Commission, the head of such de-
5 partment or agency shall furnish such informa-
6 tion to the Commission if the head of the de-
7 partment or agency involved determines it ap-
8 propriate.

9 (E) POSTAL SERVICES.—The Commission
10 may use the United States mails in the same
11 manner and under the same conditions as other
12 departments and agencies of the Federal Gov-
13 ernment.

14 (7) PERSONNEL MATTERS.—

15 (A) COMPENSATION.—Each member of the
16 Commission who is not an officer or employee
17 of the Federal Government or of a State or
18 local government shall be compensated at a rate
19 equal to the daily equivalent of the annual rate
20 of basic pay prescribed for level IV of the Exec-
21 utive Schedule under section 5315 of title 5,
22 United States Code, for each day (including
23 travel time) during which such member is en-
24 gaged in the performance of the duties of the
25 Commission. All members of the Commission

1 who are officers or employees of the United
2 States shall serve without compensation in addi-
3 tion to that received for their services as offi-
4 cers or employees of the United States.

5 (B) TRAVEL EXPENSES.—The members of
6 the Commission shall be allowed travel ex-
7 penses, including per diem in lieu of subsist-
8 ence, at rates authorized for employees of agen-
9 cies under subchapter I of chapter 57 of title 5,
10 United States Code, while away from their
11 homes or regular places of business in the per-
12 formance of services for the Commission.

13 (C) STAFF.—The Chairperson of the Com-
14 mission may, without regard to the civil service
15 laws and regulations, appoint and terminate an
16 executive director and such other additional
17 personnel as may be necessary to enable the
18 Commission to perform its duties. The employ-
19 ment of an executive director shall be subject to
20 confirmation by the Commission.

21 (D) DETAIL OF GOVERNMENT EMPLOY-
22 EES.—Any Federal Government employee may
23 be detailed to the Commission without reim-
24 bursement, and such detail shall be without

1 interruption or loss of civil service status or
2 privilege.

3 (E) TEMPORARY AND INTERMITTENT
4 SERVICES.—The Chairperson of the Commis-
5 sion may procure temporary and intermittent
6 services under section 3109(b) of title 5, United
7 States Code, at rates for individuals which do
8 not exceed the daily equivalent of the annual
9 rate of basic pay prescribed for level V of the
10 Executive Schedule under section 5316 of such
11 title.

12 (8) FUNDING.—For the purpose of carrying out
13 this subsection, there are authorized to be appro-
14 priated \$3,000,000 for fiscal year 2009 and each fis-
15 cal year thereafter.

16 (d) REQUIREMENTS FOR PROGRAMS.—

17 (1) STATE PLAN.—A State that seeks to oper-
18 ate a program under this section shall prepare and
19 submit to the Commission, as part of the application
20 under subsection (b)(2), a State plan that shall have
21 as its goal increased health care coverage, and in
22 service of that goal such additional goals as improve-
23 ments in health care quality, efficiency, cost-effec-
24 tiveness, and the appropriate use of information

1 technology. To achieve such goal, the State plan
2 shall comply with the following:

3 (A) COVERAGE.—

4 (i) IN GENERAL.—With respect to
5 coverage, the State plan shall—

6 (I) provide and describe the man-
7 ner in which the State will ensure that
8 an increased number of individuals re-
9 siding within the State will have ex-
10 panded access to health care coverage
11 with a specific 5-year target for reduc-
12 tion in the number or proportion of
13 uninsured individuals through either
14 private or public program expansion,
15 or both, in accordance with or in addi-
16 tion to the options established by the
17 Commission;

18 (II) describe the number and per-
19 centage of current uninsured individ-
20 uals who will achieve coverage under a
21 State health program;

22 (III) describe the coverage that
23 will be provided to beneficiaries under
24 a State health program;

1 (IV) identify Federal, State, or
2 local and private programs that cur-
3 rently provide health care services in
4 the State and describe how such pro-
5 grams could be coordinated with a
6 State health program, to the extent
7 practicable; and

8 (V) provide for improvements in
9 the availability of appropriate health
10 care coverage that will increase access
11 to care in urban, suburban, rural, and
12 frontier areas of the State with medi-
13 cally underserved populations or
14 where there may be an inadequate
15 supply of health care providers.

16 (ii) COVERAGE OPTIONS.—The cov-
17 erage under the State plan may be—

18 (I) health insurance coverage
19 that meets the aggregate actuarial
20 value requirement of section
21 2103(a)(2)(B) of the Social Security
22 Act (42 U.S.C. 1397cc(a)(2)(B));

23 (II) a combination of health in-
24 surance coverage and a consumer-di-
25 rected health care spending account, if

1 the actuarial value of such coverage
2 plus the amount of annual deposits
3 into such account from sources other
4 than the beneficiary is not less than
5 the actuarial value amount described
6 in subclause (I); or

7 (III) health care access not less
8 on average than that provided
9 through coverage described in sub-
10 clause (I).

11 (iii) CONSTRUCTION.—Nothing in this
12 clause shall be construed to limit in any
13 way the authority of the Secretary of
14 Health and Human Services to issue waiv-
15 ers under section 1115 of the Social Secu-
16 rity Act.

17 (B) QUALITY.—With respect to quality,
18 the State plan may describe efforts to improve
19 health care quality in the State, including an
20 explanation of how such efforts would change
21 (if at all) under the State plan.

22 (C) COSTS.—With respect to costs, the
23 State plan shall—

1 (i) describe such steps as the State
2 may undertake to improve the efficiency of
3 health care;

4 (ii) describe the public and private
5 sector financing to be provided for the
6 State health program;

7 (iii) estimate the amount of Federal,
8 State, and local expenditures, as well as,
9 the costs to business and individuals under
10 the State health program; and

11 (iv) describe how the State plan will
12 ensure the financial solvency of the State
13 health program.

14 (D) HEALTH INFORMATION TECH-
15 NOLOGY.—With respect to health information
16 technology, the State plan may describe efforts
17 to improve the appropriate use of health infor-
18 mation technology, including an explanation of
19 how such efforts would change (if at all) under
20 the State plan.

21 (E) EXCEPTIONS TO FEDERAL POLICIES.—

22 (i) IN GENERAL.—Subject to clause
23 (ii), the State plan shall describe the ex-
24 ceptions to otherwise applicable Federal
25 statutes, regulations, and policies that

1 would apply within the geographic area
2 and time period governed by the plan.

3 (ii) RECOGNITION OF ERISA REQUIRE-
4 MENTS.—Except to the extent authorized
5 under subsection (j)(4), the State plan
6 may not include exceptions to the provi-
7 sions of the Employee Retirement Income
8 Security Act of 1974 but may take into ac-
9 count the amendments made by title I of
10 this Act.

11 (2) TECHNICAL ASSISTANCE.—The Secretary
12 shall, if requested, provide technical assistance to
13 States to assist such States in developing applica-
14 tions and plans under this section, including tech-
15 nical assistance by private sector entities if deter-
16 mined appropriate by the Commission.

17 (3) INITIAL REVIEW.—With respect to a State
18 application under subsection (b)(2), the Secretary
19 and the Commission shall complete an initial review
20 of such State application not later than 60 days
21 after the receipt of such application, analyze the
22 scope of the proposal, and determine whether addi-
23 tional information is needed from the State. The
24 Commission shall advise the State within such pe-
25 riod of the need to submit additional information.

1 (4) FINAL DETERMINATION.—

2 (A) IN GENERAL.—In a timely manner
3 consistent with subparagraph (C), the Commis-
4 sion shall determine whether to submit a State
5 proposal to Congress for approval.

6 (B) VOTING.—

7 (i) IN GENERAL.—The determination
8 to submit a State proposal to Congress
9 under subparagraph (A) shall be approved
10 by $\frac{2}{3}$ of the members of the Commission
11 who are present and eligible to vote and a
12 majority of the entire Commission.

13 (ii) ELIGIBILITY.—A member of the
14 Commission shall not participate in a de-
15 termination under subparagraph (A) if—

16 (I) in the case of a member who
17 is a Governor, such determination re-
18 lates to the State of which the mem-
19 ber is the Governor; or

20 (II) in the case of member not
21 described in subclause (I), such deter-
22 mination relates to the geographic
23 area of a State of which such member
24 serves as a State or local official or as
25 a Member of Congress.

1 (C) SUBMISSION.—Not later than 90 days
2 before October 1 of each fiscal year, the Com-
3 mission may submit to Congress a list, in the
4 form of a legislative proposal, of the State ap-
5 plications that the Commission recommends for
6 approval under this section.

7 (5) PROGRAM OR PROJECT PERIOD.—A State
8 program or project may be approved for a period of
9 5 years and may be extended for a subsequent pe-
10 riod of time upon approval by the Commission,
11 based upon achievement of targets.

12 (e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

13 (1) INTRODUCTION AND EXPEDITED CONSIDER-
14 ATION IN THE HOUSE OF REPRESENTATIVES.—

15 (A) INTRODUCTION IN HOUSE OF REP-
16 RESENTATIVES.—The legislative proposal sub-
17 mitted pursuant to subsection (d)(4)(C) shall be
18 in the form of a joint resolution (in this sub-
19 section referred to as the “resolution”). Such
20 resolution shall be introduced in the House of
21 Representatives by the Speaker immediately
22 upon receipt of the language and shall be re-
23 ferred non-sequentially to the appropriate com-
24 mittee (or committees) of House of Representa-
25 tives. If the resolution is not introduced in ac-

1 cordance with the preceding sentence, the reso-
2 lution may be introduced by any member of the
3 House of Representatives.

4 (B) COMMITTEE CONSIDERATION.—Not
5 later than 15 calendar days after the introduc-
6 tion of the resolution described in subparagraph
7 (A), each committee of the House of Represent-
8 atives to which the resolution was referred shall
9 report the resolution. The report may include,
10 at the committee's discretion, a recommenda-
11 tion for action by the House. If a committee
12 has not reported such resolution (or an iden-
13 tical resolution) at the end of 15 calendar days
14 after its introduction or at the end of the first
15 day after there has been reported to the House
16 a resolution, whichever is earlier, such com-
17 mittee shall be deemed to be discharged from
18 further consideration of such resolution and
19 such resolution shall be placed on the appro-
20 priate calendar of the House of Representatives.

21 (C) EXPEDITED PROCEDURE IN HOUSE.—
22 Not later than 5 legislative days after the date
23 on which all committees have been discharged
24 from consideration of a resolution, the Speaker
25 of the House of Representatives, or the Speak-

1 er's designee, shall move to proceed to the con-
2 sideration of the resolution. It shall also be in
3 order for any member of the House of Rep-
4 resentatives to move to proceed to the consider-
5 ation of the resolution at any time after the
6 conclusion of such 5-day period. All points of
7 order against the resolution (and against con-
8 sideration of the resolution) are waived. A mo-
9 tion to proceed to the consideration of the reso-
10 lution is highly privileged in the House of Rep-
11 resentatives and is not debatable. The motion is
12 not subject to amendment, to a motion to post-
13 pone consideration of the resolution, or to a mo-
14 tion to proceed to the consideration of other
15 business. A motion to reconsider the vote by
16 which the motion to proceed is agreed to or not
17 agreed to shall not be in order. If the motion
18 to proceed is agreed to, the House of Rep-
19 resentatives shall immediately proceed to con-
20 sideration of the resolution without intervening
21 motion, order, or other business, and the reso-
22 lution shall remain the unfinished business of
23 the House of Representatives until disposed of.
24 A motion to recommit the resolution shall not
25 be in order. Upon its passage in the House, the

1 clerk of the House shall provide for its imme-
2 diate transmittal to the Senate.

3 (2) EXPEDITED CONSIDERATION IN THE SEN-
4 ATE.—

5 (A) REFERRAL TO COMMITTEE.—If the
6 resolution is agreed to by the House of Rep-
7 resentatives, upon its receipt in the Senate the
8 majority leader of the Senate, or the leader's
9 designee, the resolution shall be referred to the
10 appropriate committee of Senate.

11 (B) COMMITTEE CONSIDERATION.—Not
12 later than 15 calendar days after the referral of
13 the resolution under subparagraph (A), the
14 committee of the Senate to which the resolution
15 was referred shall report the resolution. The re-
16 port may include, at the committee's discretion,
17 a recommendation for action by the Senate. If
18 a committee has not reported such resolution
19 (or an identical resolution) at the end of 15 cal-
20 endar days after its referral or at the end of the
21 first day after there has been reported to the
22 Senate a resolution, whichever is earlier, such
23 committee shall be deemed to be discharged
24 from further consideration of such resolution

1 and such resolution shall be placed on the ap-
2 propriate calendar of the Senate.

3 (C) EXPEDITED FLOOR CONSIDERATION.—

4 Not later than 5 legislative days after the date
5 on which all committees have been discharged
6 from consideration of a resolution, the majority
7 leader of the Senate, or the majority leader's
8 designee, shall move to proceed to the consider-
9 ation of the resolution. It shall also be in order
10 for any member of the Senate to move to pro-
11 ceed to the consideration of the resolution at
12 any time after the conclusion of such 5-day pe-
13 riod. All points of order against the resolution
14 (and against consideration of the resolution)
15 are waived. A motion to proceed to the consid-
16 eration of the resolution in the Senate is privi-
17 leged and is not debatable. The motion is not
18 subject to amendment, to a motion to postpone
19 consideration of the resolution, or to a motion
20 to proceed to the consideration of other busi-
21 ness. A motion to reconsider the vote by which
22 the motion to proceed is agreed to or not
23 agreed to shall not be in order. If the motion
24 to proceed is agreed to, the Senate shall imme-
25 diately proceed to consideration of the resolu-

1 tion without intervening motion, order, or other
2 business, and the resolution shall remain the
3 unfinished business of the Senate until disposed
4 of.

5 (3) RULES OF THE SENATE AND HOUSE OF
6 REPRESENTATIVES.—This subsection is enacted by
7 Congress—

8 (A) as an exercise of the rulemaking power
9 of the Senate and House of Representatives, re-
10 spectively, and is deemed to be part of the rules
11 of each House, respectively, but applicable only
12 with respect to the procedure to be followed in
13 that House in the case of a resolution under
14 this subsection, and it supersedes other rules
15 only to the extent that it is inconsistent with
16 such rules; and

17 (B) with full recognition of the constitu-
18 tional right of either House to change the rules
19 (so far as they relate to the procedure of that
20 House) at any time, in the same manner, and
21 to the same extent as in the case of any other
22 rule of that House.

23 (4) FEDERAL BUDGET NEUTRALITY.—Except
24 insofar as it allots appropriations made pursuant to
25 subsection (k), the legislative proposal submitted

1 pursuant to subsection (d)(4)(C) may not increase
2 the cumulative, net Federal budget deficit during the
3 multi-year operation of all the State applications
4 contained therein, taking into account such applica-
5 tions' impact on Federal mandatory and discre-
6 tionary spending, Federal revenue, and Federal tax
7 expenditures.

8 (f) FUNDING.—

9 (1) IN GENERAL.—The Secretary shall provide
10 a grant to a State that has an application approved
11 under subsection (e) to enable such State to carry
12 out an innovative State health program in the State,
13 to the extent that such a grant is included in the
14 recommendation of the Commission.

15 (2) AMOUNT OF GRANT.—The amount of a
16 grant provided to a State under paragraph (1) shall
17 be determined based upon the recommendations of
18 the Commission, subject to the amount appropriated
19 under subsection (k).

20 (3) PERFORMANCE-BASED FUNDING ALLOCA-
21 TION.—In awarding grants under paragraph (1), the
22 Commission shall direct the Secretary to—

23 (A) fund a balanced diversity of ap-
24 proaches as provided for by the Commission in
25 subsection (c)(1)(B); and

1 (B) link allocations to the State to the
2 meeting of the goals and performance measures
3 relating to health care coverage and health care
4 costs established under this title through the
5 State project application process.

6 (4) REPORT.—One year before the end of the
7 5-year period beginning on the date on which the
8 first State begins to implement a plan approved
9 under subsection (e), the Commission shall prepare
10 and submit to the appropriate committees of Con-
11 gress, a report on the progress made by States in
12 meeting the goals of expanded coverage and cost
13 containment through performance measures estab-
14 lished during the 5-year period of the State plan.
15 Such report may contain the recommendation of the
16 Commission concerning any future action that Con-
17 gress should take concerning health care reform, in-
18 cluding whether or not to extend the program estab-
19 lished under this subsection.

20 (g) MONITORING AND EVALUATION.—

21 (1) ANNUAL REPORTS AND PARTICIPATION BY
22 STATES.—Each State that has received a program
23 approval shall—

24 (A) submit to the Commission an annual
25 report based on the period representing the re-

1 spective State’s fiscal year, detailing compliance
2 with the requirements established by the Com-
3 mission and the Secretary in the approval and
4 in this section; and

5 (B) participate in the annual meeting
6 under subsection (c)(4)(C).

7 (2) EVALUATIONS BY COMMISSION.—The Com-
8 mission shall prepare and submit to Congress annual
9 reports that shall contain—

10 (A) a description of the effects of the re-
11 forms undertaken in States receiving approvals
12 under this section;

13 (B) a description of the recommendations
14 of the Commission and actions taken based on
15 these recommendations;

16 (C) an independent evaluation of the effec-
17 tiveness of such reforms in—

18 (i) expanding health care coverage for
19 State residents; and

20 (ii) reducing or containing health care
21 costs in the States,

22 as well as other relevant or significant findings;

23 (D) recommendations regarding the advis-
24 ability of increasing Federal financial assistance
25 for State ongoing or future health program ini-

1 tiatives, including the amount and source of
2 such assistance; and

3 (E) as required by the Commission or the
4 Secretary under this section, a periodic, inde-
5 pendent evaluation of the program.

6 (h) NONCOMPLIANCE.—

7 (1) CORRECTIVE ACTION PLANS.—If a State is
8 not in compliance with a requirement of this section,
9 the Commission, on recommendation of the Sec-
10 retary, shall develop a corrective action plan for such
11 State.

12 (2) TERMINATION.—The Commission, on rec-
13 ommendation of the Secretary, may revoke any pro-
14 gram granted under this section. Such decisions
15 shall be subject to a petition for reconsideration and
16 appeal pursuant to regulations established by the
17 Secretary.

18 (i) RELATIONSHIP TO FEDERAL PROGRAMS.—

19 (1) IN GENERAL.—Nothing in this title, or in
20 section 1115 of the Social Security Act (42 U.S.C.
21 1315) shall be construed as authorizing the Sec-
22 retary, the Commission, a State, or any other person
23 or entity to alter or affect in any way—

1 (A) the provisions of title XIX of such Act
2 (42 U.S.C. 1396 et seq.) or the regulations im-
3 plementing such title or,

4 (B) except as authorized in subsection
5 (j)(4), the provisions of the Employee Retire-
6 ment Income Security Act of 1974 (as amended
7 by this Act) or the regulations implementing
8 such Act.

9 (2) MAINTENANCE OF EFFORT.—No payment
10 may be made under subsection (f)(1) if the State
11 adopts criteria for benefits or criteria for standards
12 and methodologies for purposes of determining an
13 individual’s eligibility for medical assistance under
14 the State plan under title XIX that are more restric-
15 tive than those required under Federal law and ap-
16 plied as of the date of enactment of this Act.

17 (j) MISCELLANEOUS PROVISIONS.—

18 (1) APPLICATION OF CERTAIN REQUIRE-
19 MENTS.—

20 (A) RESTRICTION ON APPLICATION OF
21 PREEXISTING CONDITION EXCLUSIONS.—

22 (i) IN GENERAL.—Subject to subpara-
23 graph (B), a State shall not permit the im-
24 position of any preexisting condition exclu-

1 sion for covered benefits under a program
2 or project under this section.

3 (ii) GROUP HEALTH PLANS AND
4 GROUP HEALTH INSURANCE COVERAGE.—

5 If the State program or project provides
6 for benefits through payment for, or a con-
7 tract with, a group health plan or group
8 health insurance coverage, the program or
9 project may permit the imposition of a pre-
10 existing condition exclusion but only inso-
11 far and to the extent that such exclusion is
12 permitted under the applicable provisions
13 of part 7 of subtitle B of title I of the Em-
14 ployee Retirement Income Security Act of
15 1974 and title XXVII of the Public Health
16 Service Act.

17 (B) COMPLIANCE WITH OTHER REQUIRE-
18 MENTS.—Coverage offered under the program
19 or project shall comply with the requirements of
20 subpart 2 of part A of title XXVII of the Public
21 Health Service Act insofar as such require-
22 ments apply with respect to a health insurance
23 issuer that offers group health insurance cov-
24 erage.

1 (2) PREVENTION OF DUPLICATIVE PAY-
2 MENTS.—

3 (A) OTHER HEALTH PLANS.—No payment
4 shall be made to a State under subsection (f)(1)
5 for expenditures for health assistance provided
6 for an individual to the extent that a private in-
7 surer (as defined by the Secretary by regulation
8 and including a group health plan (as defined
9 in section 607(1) of the Employee Retirement
10 Income Security Act of 1974), a service benefit
11 plan, and a health maintenance organization)
12 would have been obligated to provide such as-
13 sistance but for a provision of its insurance con-
14 tract which has the effect of limiting or exclud-
15 ing such obligation because the individual is eli-
16 gible for or is provided health assistance under
17 the plan.

18 (B) OTHER FEDERAL GOVERNMENTAL
19 PROGRAMS.—Except as provided in any other
20 provision of law, no payment shall be made to
21 a State under subsection (f)(1) for expenditures
22 for health assistance provided for an individual
23 to the extent that payment has been made or
24 can reasonably be expected to be made prompt-
25 ly (as determined in accordance with regula-

1 tions) under any other federally operated or fi-
2 nanced health care insurance program. For
3 purposes of this paragraph, rules similar to the
4 rules for overpayments under section
5 1903(d)(2) of the Social Security Act shall
6 apply.

7 (3) APPLICATION OF CERTAIN GENERAL PROVI-
8 SIONS.—The following provisions of the Social Secu-
9 rity Act shall apply to States under subsection (f)(1)
10 in the same manner as they apply to a State under
11 such title XIX:

12 (A) TITLE XIX PROVISIONS.—

13 (i) Section 1902(a)(4)(C) (relating to
14 conflict of interest standards).

15 (ii) Paragraphs (2), (16), and (17) of
16 section 1903(i) (relating to limitations on
17 payment).

18 (iii) Section 1903(w) (relating to limi-
19 tations on provider taxes and donations).

20 (iv) Section 1920A (relating to pre-
21 sumptive eligibility for children).

22 (B) TITLE XI PROVISIONS.—

23 (i) Section 1116 (relating to adminis-
24 trative and judicial review), but only inso-
25 far as consistent with this title.

1 (ii) Section 1124 (relating to disclo-
2 sure of ownership and related informa-
3 tion).

4 (iii) Section 1126 (relating to disclo-
5 sure of information about certain convicted
6 individuals).

7 (iv) Section 1128A (relating to civil
8 monetary penalties).

9 (v) Section 1128B(d) (relating to
10 criminal penalties for certain additional
11 charges).

12 (vi) Section 1132 (relating to periods
13 within which claims must be filed).

14 (4) RELATION TO HIPAA.—Health benefits cov-
15 erage provided under a State program or project
16 under this section shall be treated as creditable cov-
17 erage for purposes of part 7 of subtitle B of title I
18 of the Employee Retirement Income Security Act of
19 1974, title XXVII of the Public Health Service Act,
20 and subtitle K of the Internal Revenue Code of
21 1986.

22 (k) AUTHORIZATION OF APPROPRIATIONS.—There is
23 authorized to be appropriated to carry out this section
24 (other than subsection (c)), such sums as may be nec-
25 essary for each of fiscal years 2009 through 2013.

1 Amounts appropriated for a fiscal year under this sub-
2 section and not expended may be used in subsequent fiscal
3 years to carry out this section.

4 **SEC. 203. EFFECTIVE DATE.**

5 The provisions of this title shall take effect as of the
6 date of the enactment of this Act.

7 **TITLE III—DEMONSTRATION**
8 **PROJECT FOR EMPLOYER**
9 **BUY-IN**

10 **SEC. 301. DEMONSTRATION PROJECT FOR EMPLOYER BUY-**
11 **IN.**

12 Title XXI of the Social Security Act is amended by
13 adding at the end the following new section:

14 **“SEC. 2111. DEMONSTRATION PROJECT FOR EMPLOYER**
15 **BUY-IN.**

16 “(a) **AUTHORITY.—**

17 “(1) **IN GENERAL.—**The Secretary shall estab-
18 lish a demonstration project under which up to 10
19 States (each referred to in this section as a ‘partici-
20 pating State’) that meet the conditions of paragraph
21 (2) may provide, under its State child health plan
22 (notwithstanding section 2102(b)(3)(C)) for a period
23 of 5 years, for child health assistance in relation to
24 family coverage described in subsection (d) for chil-
25 dren who would be targeted low-income children but

1 for coverage as beneficiaries under a group health
2 plan as the children of participants by virtue of a
3 qualifying employer’s contribution under subsection
4 (b)(2).

5 “(2) CONDITIONS.—The conditions described in
6 this paragraph for a State are as follows:

7 “(A) NO WAITING LISTS.—The State does
8 not impose any waiting list, enrollment cap, or
9 similar limitation on enrollment of targeted low-
10 income children under the State child health
11 plan.

12 “(B) ELIGIBILITY OF ALL CHILDREN
13 UNDER 200 PERCENT OF POVERTY LINE.—The
14 State is applying an income eligibility level
15 under section 2110(b)(1)(B)(ii)(I) that is at
16 least 200 percent of the poverty line.

17 “(3) QUALIFYING EMPLOYER DEFINED.—In
18 this section, the term ‘qualifying employer’ means an
19 employer that has a majority of its workforce com-
20 posed of full-time workers with family incomes rea-
21 sonably estimated by the employer (based on wage
22 information available to the employer) at or below
23 200 percent of the poverty line. In applying the pre-
24 vious sentence, two part-time workers shall be treat-
25 ed as a single full-time worker.

1 “(b) FUNDING.—A demonstration project under this
2 section in a participating State shall be funded, with re-
3 spect to assistance provided to children described in sub-
4 section (a)(1), consistent with the following:

5 “(1) LIMITED FAMILY CONTRIBUTION.—The
6 family involved shall be responsible for providing
7 payment towards the premium for such assistance of
8 such amount as the State may specify, except that
9 the limitations on cost-sharing (including premiums)
10 under paragraphs (2) and (3) of section 2103(e)
11 shall apply to all cost-sharing of such family under
12 this section.

13 “(2) MINIMUM EMPLOYER CONTRIBUTION.—
14 The qualifying employer involved shall be responsible
15 for providing payment to the State child health plan
16 in the State of at least 50 percent of the portion of
17 the cost (as determined by the State) of the family
18 coverage in which the employer is enrolling the fam-
19 ily that exceeds the amount of the family contribu-
20 tion under paragraph (1) applied towards such cov-
21 erage.

22 “(3) LIMITATION ON FEDERAL FINANCIAL PAR-
23 TICIPATION.—In no case shall the Federal financial
24 participation under section 2105 with respect to a
25 demonstration project under this section be made for

1 any portion of the costs of family coverage described
2 in subsection (d) (including the costs of administra-
3 tion of such coverage) that are not attributable to
4 children described in subsection (a)(1).

5 “(c) UNIFORM ELIGIBILITY RULES.—In providing
6 assistance under a demonstration project under this sec-
7 tion—

8 “(1) a State shall establish uniform rules of eli-
9 gibility for families to participate; and

10 “(2) a State shall not permit a qualifying em-
11 ployer to select, within those families that meet such
12 eligibility rules, which families may participate.

13 “(d) TERMS AND CONDITIONS.—The family coverage
14 offered to families of qualifying employers under a dem-
15 onstration project under this section in a State shall be
16 the same as the coverage and benefits provided under the
17 State child health plan in the State for targeted low-in-
18 come children with the highest family income level per-
19 mitted.”.

1 **TITLE IV—ACCESS TO HEALTH**
2 **BENEFITS THROUGH RE-**
3 **GIONAL STATE ARRANGE-**
4 **MENTS**

5 **SEC. 401. PROMOTING ACCESS THROUGH REGIONAL STATE**
6 **ARRANGEMENTS UNDER A DEMONSTRATION**
7 **PROJECT.**

8 (a) IN GENERAL.—

9 (1) REGIONAL STATE ARRANGEMENTS.—Under
10 this title the Secretary of Health and Human Serv-
11 ices, in collaboration with the Secretary of Labor,
12 shall facilitate the establishment of regional State
13 arrangements (each in this title referred to as a “re-
14 gional State arrangement”) under which two or
15 more States ban together in order to increase their
16 purchasing pooling power and offer affordable health
17 insurance to citizens of those States consistent with
18 paragraph (2). Such arrangements shall include the
19 following components:

20 (A) The appointment of a Benefits Admin-
21 istrator under subsection (b)

22 (B) The offering of standard health benefit
23 plans under subsection (c).

1 (C) The charging of premiums using a
2 modified community-rated premiums under sub-
3 section (d).

4 (D) A requirement for individual health in-
5 surance coverage under subsection (e).

6 (E) Subsidies for financially disadvantages
7 persons under subsection (f).

8 (F) Employer rule in funding health ben-
9 efit plans under subsection (g).

10 (2) APPLICATION ON A DEMONSTRATION
11 BASIS.—This title shall be implemented on a dem-
12 onstration basis so that—

13 (A) the regional State arrangements cover
14 no more than 20 States; and

15 (B) implementation occurs only over a 10-
16 year period.

17 (3) COLLABORATIVE FEDERAL IMPLEMENTA-
18 TION.—

19 (A) IN GENERAL.—In carrying out this
20 title—

21 (i) the Secretary of Labor shall be pri-
22 marily responsible for implementation with
23 respect to employees and dependents; and

24 (ii) the Secretary of Health and
25 Human Services shall be primarily respon-

1 sible for implementation for all other indi-
2 viduals.

3 (B) REFERENCE TO SECRETARY.—Except
4 as otherwise provided, in this title, the term
5 “Secretary” means the Secretary of Health and
6 Human Services working in collaboration with
7 the Secretary of Labor.

8 (4) REPORT.—The Secretary shall jointly sub-
9 mit to Congress a biannual report on the implemen-
10 tation of this title and shall include in such report
11 recommendations regarding the expansion and ex-
12 tension of the program under this title.

13 (b) BENEFIT ADMINISTRATOR.—

14 (1) IN GENERAL.—Each regional State ar-
15 rangement shall be administered by a Benefit Ad-
16 ministrator who shall be responsible for the adminis-
17 tration of this title under the arrangement.

18 (2) DISCLOSURE OF PERFORMANCE OF BEN-
19 EFIT ADMINISTRATORS.—The Secretary shall make
20 available to the public information on the relative
21 administrative performance of each Benefit Adminis-
22 trator.

23 (c) STANDARD HEALTH BENEFIT PLANS.—

24 (1) OFFERING OF STANDARD HEALTH BENEFIT
25 PLANS.—Under each regional State arrangement

1 State, the Benefit Administrator shall, through a
2 bidding process determined and administered by the
3 Secretary, offer, directly or indirectly, three to five
4 standard health benefit plans to all individuals, re-
5 gardless of employment, who reside in a State cov-
6 ered by the arrangement.

7 (2) STANDARD HEALTH BENEFIT PLANS.—In
8 this title, the term “standard health benefit plan”
9 means a health benefits plan that meets standards
10 relating to benefits recognized by the Secretary. The
11 Secretary shall request the National Association of
12 Insurance Commissioners or another appropriate en-
13 tity to develop such standards for such plans in a
14 manner consistent with the model for standards de-
15 velopment used under section 1881 of the Social Se-
16 curity Act (42 U.S.C. 1395rr) for medicare supple-
17 mental policies. Such standards shall be designed to
18 permit the offering of low-cost benefit options.

19 (d) APPLICATION OF MODIFIED COMMUNITY-RATED
20 PREMIUMS.—

21 (1) IN GENERAL.—The premiums for the stand-
22 ard health benefit plans offered under a regional
23 State arrangement within a defined service area (as
24 identified under paragraph (2)) shall be established
25 consistent with the following:

1 (A) All such plans in the area shall uni-
2 formly bear the cost of disease and injury.

3 (B) Except as otherwise provided in this
4 paragraph, the premiums shall be uniform with-
5 in such area for family coverage and for indi-
6 vidual coverage for each plan in such area.

7 (C) In the case of a plan purchased by an
8 individual and not in connection with a group
9 health plan, the regional State arrangement
10 may permit the variation of premiums based
11 upon the age band in which an individual or
12 family falls in a manner that reasonable reflects
13 the health cost differences of individuals among
14 such age bands.

15 (D) There shall be a mechanism whereby
16 there would be standardized risk adjustments to
17 premiums of each plan in the area based on the
18 actual claims under the respective plans during
19 the previous plan year.

20 (E) Adjustments related to self-imposed
21 lifestyle risks, such as smoking, alcohol con-
22 sumption, and avoidance of personal risk, may
23 be made.

24 (F) Premiums may be varied among stand-
25 ard health benefit plans based on efficiencies

1 generated by better administrator practices, in-
2 cluding efficiencies derived from superior dis-
3 ease management, utilization management, case
4 management, lifestyle management, “pay-for-
5 performance” systems, and other innovative ini-
6 tiatives designed to lower costs, increase qual-
7 ity, and improve accountability.

8 (2) IDENTIFICATION OF DEFINED SERVICE
9 AREAS.—For purposes of paragraph (1), the Sec-
10 retary shall divide the area covered by each regional
11 State arrangement into separate defined service
12 areas based on major medical markets.

13 (e) INDIVIDUAL COVERAGE MANDATE.—

14 (1) IN GENERAL.—Subject to paragraph (3),
15 each regional State arrangement shall provide that
16 each uninsured individual (as defined in paragraph
17 (4)) shall—

18 (A) automatically be enrolled in a standard
19 health benefit plan under this title; and

20 (B) be liable, through payroll deduction or
21 otherwise, for the payment of premiums for
22 such enrollment, taking into account the
23 amount of any financial subsidy offered under
24 subsection (f).

1 (2) CERTIFICATION.—Each Benefit Adminis-
2 trator for a regional State arrangement shall develop
3 a satisfactory method for certifying compliance with
4 the provisions of individuals residing in the area cov-
5 ered by the arrangement with the requirement of
6 paragraph (1).

7 (3) EXCEPTIONS.—The Secretary may establish
8 exceptions to the requirement of paragraph (1) in
9 appropriate cases, such as in the case of individuals
10 who are financially unable to afford to pay the pre-
11 miums required to enroll in a standard health ben-
12 efit plan.

13 (4) UNINSURED INDIVIDUAL DEFINED.—In this
14 subsection, the term “uninsured individual” means,
15 with respect to a regional State arrangement, an in-
16 dividual who—

17 (A) resides in a State included in a re-
18 gional State arrangement;

19 (B) is not enrolled for benefits under—

20 (i) the Medicare or Medicaid program
21 or another government-sponsored health
22 program (as identified by the Secretary of
23 Health and Human Services); or

1 (ii) a group health plan (as defined in
2 section 607(1) of the Employee Retirement
3 Income Security Act of 1974); and

4 (C) does not have coverage that is other-
5 wise found to be qualifying by the Secretary.

6 (f) SUBSIDIES FOR FINANCIALLY DISADVANTAGED
7 PERSONS.—The Secretary shall establish a system of sub-
8 sidies to assist in the payment of premiums and cost-shar-
9 ing for individuals who are required under subsection (e)
10 (but for paragraph (3)) to be covered under a standard
11 health benefit plan but who are financially unable to af-
12 ford to pay such premiums..

13 (g) EMPLOYER ROLE IN FUNDING HEALTH BENEFIT
14 PLANS.—

15 (1) IN GENERAL.—Nothing in this title shall
16 prevent an employer from providing health benefits
17 coverage to employees and their dependents through
18 existing arrangements or through a standard health
19 benefit plan offered through a regional State ar-
20 rangement under this title.

21 (2) REQUIRED REGISTRATION WITH BENEFITS
22 ADMINISTRATOR.—Each employer with employees
23 residing in an area covered by a regional State ar-
24 rangement shall register with the Benefits Adminis-
25 trator for such arrangement.

1 **SEC. 402. TRANSPARENCY AND ACCOUNTABILITY FOR**
2 **HEALTH BENEFIT PLANS.**

3 (a) **PLAN COMPARISONS.**—The Secretary shall estab-
4 lish a method for making available, in comparative form,
5 to health consumers, providers, employers, and health
6 plans, how health benefit plans offered under this title
7 compare to each other within a regional State arrange-
8 ment.

9 (b) **PROVIDER TRANSPARENCY AND ACCOUNT-**
10 **ABILITY.**—

11 (1) **QUALITY STANDARDS.**—Not later than 1
12 year after the date of the enactment of this Act, the
13 Secretary shall develop definitions and standards for
14 quality care in collaboration with providers, public
15 and private-sector representatives, payers, and con-
16 sumers.

17 (2) **COVERAGE.**—The quality standards devel-
18 oped under paragraph (1) shall cover both process
19 and outcome measures and shall be applied to health
20 care entities, including individual physicians, groups
21 of physicians, hospitals, integrated systems, and, to
22 the extent specified by the Secretary, an entire en-
23 terprise. Such standards shall be based on evidence-
24 based medicine and shall be continuously updated
25 and expanded.

1 (3) MEASUREMENT.—Once such standards are
2 developed, performance of health care entities shall
3 be measured against these standards.

4 (c) HEALTH PLAN TRANSPARENCY AND ACCOUNT-
5 ABILITY.—

6 (1) ACCOUNTABILITY.—The Secretary shall de-
7 velop standards to hold administrators of health ben-
8 efit plans accountable for their claims administrative
9 practices, including overhead costs, delayed claims
10 payments, errors, lost claims, and aggressive denial
11 of claims.

12 (2) DEVELOPMENT OF STANDARDS.—The Sec-
13 retary shall develop such standards through a col-
14 laborative process between the public-sector and pri-
15 vate-sector stakeholders to measure and make avail-
16 able to the public information on the performance of
17 health benefit plan administrators during the period
18 measured. Such information for each health benefit
19 plan administrator shall include, for each health
20 plan administered for each measurement period, the
21 following:

22 (A) Expense loadings added to the basic
23 premium amount to cover expenses of the plan,
24 including commissions, premium taxes, mar-

1 keting support costs, and other similar ex-
2 penses.

3 (B) The total number and cost of denied
4 claims.

5 (C) The total cost of denied claims that is
6 transferred to providers.

7 (D) The average out-of-pocket expense in-
8 curred by participants.

9 (E) Consumer assessments regarding plan
10 administration.

11 (F) The relative efficiency and quality of
12 claims administration and other administrative
13 processes.

14 (d) OVERSIGHT.—The Secretary shall have oversight
15 responsibility to ensure that health benefit plans are ad-
16 ministered properly.

17 **TITLE V—AMENDMENTS RELAT-**
18 **ING TO PREEXISTING CONDI-**
19 **TION EXCLUSION**

20 **SEC. 501. SHORT TITLE.**

21 This Act may be cited as the “Preexisting Condition
22 Exclusion Patient Protection Act of 2008”.

1 **SEC. 502. AMENDMENTS RELATING TO PREEXISTING CON-**
2 **DITION EXCLUSIONS UNDER GROUP HEALTH**
3 **PLANS.**

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

6 (1) REDUCTION IN LOOK-BACK PERIOD.—Sec-
7 tion 701(a)(1) of the Employee Retirement Income
8 Security Act of 1974 (29 U.S.C. 1181(a)(1)) is
9 amended by striking “6-month period” and inserting
10 “30-day period”.

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

17 (b) AMENDMENTS TO THE PUBLIC HEALTH SERVICE
18 ACT.—

19 (1) REDUCTION IN LOOK-BACK PERIOD.—Sec-
20 tion 2701(a)(1) of the Public Health Service Act (42
21 U.S.C. 300gg(a)(1)) is amended by striking “6-
22 month period” and inserting “30-day period”.

23 (2) REDUCTION IN PERMITTED PREEXISTING
24 CONDITION LIMITATION PERIOD.—Section
25 2701(a)(2) of such Act (42 U.S.C. 300gg(a)(2)) is
26 amended by striking “12 months” and inserting “3

1 months”, and by striking “18 months” and inserting
2 “9 months”.

3 (c) AMENDMENTS TO THE INTERNAL REVENUE
4 CODE OF 1986.—

5 (1) REDUCTION IN LOOK-BACK PERIOD.—Para-
6 graph (1) of section 9801(a) of the Internal Revenue
7 Code of 1986 (relating to limitation on preexisting
8 condition exclusion period and crediting for periods
9 of previous coverage) is amended by striking “6-
10 month period” and inserting “30-day period”.

11 (2) REDUCTION IN PERMITTED PREEXISTING
12 CONDITION LIMITATION PERIOD.—Paragraph (2) of
13 section 9801(a) of such Code is amended by striking
14 “12 months” and inserting “3 months”, and by
15 striking “18 months” and inserting “9 months”.

16 (d) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 shall apply with respect to group health plans for
20 plan years beginning after the end of the 12th cal-
21 endar month following the date of the enactment of
22 this Act.

23 (2) SPECIAL RULE FOR COLLECTIVE BAR-
24 GAINING AGREEMENTS.—In the case of a group
25 health plan maintained pursuant to one or more col-

1 lective bargaining agreements between employee rep-
2 resentatives and one or more employers ratified be-
3 fore the date of the enactment of this Act, the
4 amendments made by this section shall not apply to
5 plan years beginning before the earlier of—

6 (A) the date on which the last of the col-
7 lective bargaining agreements relating to the
8 plan terminates (determined without regard to
9 any extension thereof agreed to after the date
10 of the enactment of this Act), or

11 (B) 3 years after the date of the enact-
12 ment of this Act.

13 For purposes of subparagraph (A), any plan amend-
14 ment made pursuant to a collective bargaining
15 agreement relating to the plan which amends the
16 plan solely to conform to any requirement added by
17 the amendments made by this section shall not be
18 treated as a termination of such collective bar-
19 gaining agreement.

20 **SEC. 503. AMENDMENTS RELATING TO PREEXISTING CON-**
21 **DITION EXCLUSIONS IN HEALTH INSURANCE**
22 **COVERAGE IN THE INDIVIDUAL MARKET.**

23 (a) **APPLICABILITY OF GROUP HEALTH INSURANCE**
24 **LIMITATIONS ON IMPOSITION OF PREEXISTING CONDI-**
25 **TION EXCLUSIONS.—**

1 (1) IN GENERAL.—Section 2741 of the Public
2 Health Service Act (42 U.S.C. 300gg–41) is amend-
3 ed—

4 (A) by redesignating the second subsection
5 (e) (relating to market requirements) and sub-
6 section (f) as subsections (f) and (g), respec-
7 tively; and

8 (B) by adding at the end the following new
9 subsection:

10 “(h) APPLICATION OF GROUP HEALTH INSURANCE
11 LIMITATIONS ON IMPOSITION OF PREEXISTING CONDI-
12 TION EXCLUSIONS.—

13 “(1) IN GENERAL.—Subject to paragraph (2), a
14 health insurance issuer that provides individual
15 health insurance coverage may not impose a pre-
16 existing condition exclusion (as defined in subsection
17 (b)(1)(A) of section 2701) with respect to such cov-
18 erage except to the extent that such exclusion could
19 be imposed consistent with such section if such cov-
20 erage were group health insurance coverage.

21 “(2) LIMITATION.—In the case of an individual
22 who—

23 “(A) is enrolled in individual health insur-
24 ance coverage;

1 “(B) during the period of such enrollment
2 has a condition for which no medical advice, di-
3 agnosis, care, or treatment had been rec-
4 ommended or received as of the enrollment
5 date; and

6 “(C) seeks to enroll under other individual
7 health insurance coverage which provides bene-
8 fits different from those provided under the cov-
9 erage referred to in subparagraph (A) with re-
10 spect to such condition,

11 the issuer of the individual health insurance cov-
12 erage described in subparagraph (C) may impose a
13 preexisting condition exclusion with respect to such
14 condition and any benefits in addition to those pro-
15 vided under the coverage referred to in subpara-
16 graph (A), but such exclusion may not extend for a
17 period of more than 3 months.”.

18 (2) ELIMINATION OF COBRA REQUIREMENT.—

19 Subsection (b) of such section is amended—

20 (A) by adding “and” at the end of para-
21 graph (2);

22 (B) by striking the semicolon at the end of
23 paragraph (3) and inserting a period; and

24 (C) by striking paragraphs (4) and (5).

1 (3) CONFORMING AMENDMENT.—Section
2 2744(a)(1) of such Act (42 U.S.C. 300gg–44(a)(1))
3 is amended by inserting “(other than subsection
4 (h))” after “section 2741”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 this section shall apply with respect to health insurance
7 coverage offered, sold, issued, renewed, in effect, or oper-
8 ated in the individual market after the end of the 12th
9 calendar month following the date of the enactment of this
10 Act.

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