

**AMENDMENT TO THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 3200**

OFFERED BY

(AINS-EC_001)

【Affordability credits for certain employed individuals】 In section 242(a), add at the end the following:

1 (3) EQUAL TREATMENT OF CERTAIN EMPLOYED
2 INDIVIDUALS.—

3 (A) IN GENERAL.—For purposes of apply-
4 ing this section with respect to an individual
5 who is an employee of an employer that has an
6 annual payroll (for the preceding calendar year)
7 which does not exceed \$750,000 and that
8 makes the contribution which would be required
9 under section 313(a) if the table specified in
10 subparagraph (B) were substituted for the table
11 specified in section 313(b)(1) (and if, in apply-
12 ing section 313(b)(2), \$750,000 were sub-
13 stituted for \$400,000), such individual shall be
14 treated in the same manner as an employee of
15 an employer that makes the contribution de-
16 scribed in section 313(a) (without regard to this
17 paragraph).

1 (B) TABLE.—The table specified in this
 2 subparagraph is the following:

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed \$500,000	0 percent
Exceeds \$500,000, but does not exceed \$585,000	2 percent
Exceeds \$585,000, but does not exceed \$670,000	4 percent
Exceeds \$670,000, but does not exceed \$750,000	6 percent

【Negotiated payment rates under public option:】 In
 section 223—

(1) amend the heading to read “**NEGOTIATED
 PAYMENT RATES FOR ITEMS AND SERVICES.**”;

and

(2) amend subsection (a) to read as follows:

3 (a) NEGOTIATION OF PAYMENT RATES.—

4 (1) IN GENERAL.—The Secretary shall nego-
 5 tiate payment rates for the public health insurance
 6 option for services and health care providers con-
 7 sistent with this section and section 224.

8 (2) MANNER OF NEGOTIATION.—The Secretary
 9 shall negotiate such rates in a manner that results
 10 in payment rates that are not lower, in the aggre-
 11 gate, than rates under title XVIII of the Social Se-
 12 curity Act, and not higher, in the aggregate, than
 13 the average rates paid by other QHBP offering enti-
 14 ties for services and health care providers.

1 (3) INNOVATIVE PAYMENT METHODS.—Nothing
 2 in this subsection shall be construed as preventing
 3 the use of innovative payment methods such as those
 4 described in section 224 in connection with the nego-
 5 tiation of payment rates under this subsection.

In section 223(b), strike paragraphs (1) and (2) and designate paragraph (3) as subsection (b).

In section 223, strike subsections (c), (d), and (e) and redesignate subsection (f) as subsection (c).

In section 224(d), in the matter before paragraph (1), strike “and under Medicare”.

【Change in subsidy schedule:】 In section 242(b)(2)(B), strike “11 percent” and insert “12 percent”.

Amend section 243(d)(1) to read as follows:

6 (1) IN GENERAL.—For purposes of this sub-
 7 title, subject to paragraph (3), the table specified in
 8 this subsection is as follows:

In the case of family income (expressed as a percent of FPL) within the following income tier:	The initial premium percent- age is—	The final pre- mium percent- age is—	The actuarial value percent- age is—
133% through 150%	1.5%	3.0%	97%
150% through 200%	3.0%	5.5%	93%
200% through 250%	5.5%	8%	85%
250% through 300%	8%	10%	78%
300% through 350%	10%	11%	72%
350% through 400%	11%	12%	70%

Add at the end of section 243(d) the following:

1 (3) INDEXING.—For years after Y1, the Com-
2 missioner shall adjust the initial and final premium
3 percentages to maintain the ratio of governmental to
4 enrollee shares of premiums over time, for each in-
5 come tier identified in the table in paragraph (1).

【Medicaid matching:】 Amend paragraph (2) of sec-
tion 1701(a) to read as follows:

6 (2) INCREASED FMAP FOR NON-TRADITIONAL
7 MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of
8 such Act (42 U.S.C. 1396d) is amended—

9 (A) in the first sentence of subsection (b),
10 by striking “and” before “(4)” and by inserting
11 before the period at the end the following: “,
12 and (5) 100 percent (or 90 percent for periods
13 beginning with 2015) with respect to amounts
14 described in subsection (y)”;

15 (B) by adding at the end the following new
16 subsection:

17 “(y) ADDITIONAL EXPENDITURES SUBJECT TO IN-
18 CREASED FMAP.—For purposes of section 1905(b)(5),
19 the amounts described in this subsection are the following:

1 “(1) Amounts expended for medical assistance
2 for individuals described in subclause (VIII) of sec-
3 tion 1902(a)(10)(A)(i).”.

 In the heading of section 1701(b)(2), strike “100%”
and insert “INCREASED”.

 In the heading of section 1701(c), strike “100%”
and insert “INCREASED”.

 In the heading of section 1721(b), strike “100%”
and insert “INCREASED”.

 In subtitle E of title VII of division B, add at the
end the following new section:

4 **SEC. 1745. REVIEWS OF MEDICAID.**

5 (a) GAO STUDY ON FMAP.—

6 (1) STUDY.—The Comptroller General of the
7 United States shall conduct a study regarding fed-
8 eral payments made to the State Medicaid programs
9 under title XIX of the Social Security Act for the
10 purposes of making recommendations to Congress.

11 (2) REPORT.—Not later than February 15,
12 2011, the Comptroller General shall submit to the
13 appropriate committees of Congress a report on the
14 study conducted under paragraph (1) and the effect
15 on the federal government, States, providers, and
16 beneficiaries of—

1 (A) removing the 50 percent floor, or 83
2 percent ceiling, or both, in the Federal medical
3 assistance percentage under section 1905(b)(1)
4 of the Social Security Act; and

5 (B) revising the current formula for such
6 Federal medical assistance percentage to better
7 reflect State fiscal capacity and State effort to
8 pay for health and long-term care services and
9 to better adjust for adjustments for national or
10 reciprocal economic downturns.

11 (b) GAO STUDY ON MEDICAID ADMINISTRATIVE
12 COSTS.—

13 (1) STUDY.—The Comptroller General of the
14 United States shall conduct a study of the adminis-
15 tration of the Medicaid program by the Department
16 of Health and Human Services, State Medicaid
17 agencies, and local government agencies. The report
18 shall address the following issues:

19 (A) The extent to which federal funds for
20 each administrative function, such as survey
21 and certification and claims processing, are
22 being used effectively and efficiently

23 (B) The administrative functions on which
24 federal Medicaid funds expended and the

1 amounts of such expenditures (whether spent
2 directly or by contract).

3 (2) REPORT.—Not later than February 15,
4 2011, the Comptroller General shall submit to the
5 appropriate committees of Congress a report on the
6 study conducted under paragraph (1).

【Level Playing Field for Public Option:】 In section 112, insert “and shall apply to the public health insurance option” after “or otherwise,”.

In section 113(a), in the matter before paragraph (1), insert “and for coverage under public health insurance option” after “for an insured qualified health benefits plan”.

In section 114(a), insert “(including the public health insurance option)” after “A qualified health benefits plan”.

In section 115(a), insert “(including the public health insurance option)” after “A qualified health benefits plan”.

In section 133(a)(1), insert “(including the public health insurance option)” after “A qualified health benefits plan”.

In section 133(b), insert “(including the public health insurance option)” after “A qualified health benefits plan”.

In section 133(c), insert “(including the public health insurance option)” after “a qualified health benefits plan”.

In section 222(a)(2), insert before the period the following: “(which shall be not less than 90 days of estimated claims)”.

In section 222(a)(2), add at the end the following: “Before setting such appropriate amount for years starting with Y3, the Secretary shall solicit a recommendation on such amount from the American Academy of Actuaries.”.

At the end of subtitle B of title II of division A, add the following

1 **SEC. 227. APPLICATION OF HIPAA INSURANCE REQUIRE-**
2 **MENTS.**

3 The requirements of sections 2701 through 2792 of
4 the Public Health Service Act shall apply to the public
5 health insurance option in the same manner as they apply
6 to health insurance coverage offered by a health insurance
7 issuer in the individual market.

1 **SEC. 228. APPLICATION OF HEALTH INFORMATION PRI-**
2 **VACY, SECURITY, AND ELECTRONIC TRANS-**
3 **ACTION REQUIREMENTS.**

4 Part C of title XI of the Social Security Act, relating
5 to standards for protections against the wrongful dislo-
6 sure of individually identifiable health information, health
7 information security, and the electronic exchange of health
8 care information, shall apply to the public health insur-
9 ance option in the same manner as such part applies to
10 other health plans (as defined in section 1171(5) of such
11 Act).

【Agents and Brokers:】 Add at the end of section
205 the following:

12 (g) **ROLE FOR ENROLLMENT AGENTS AND BRO-**
13 **KERS.**—Nothing in this division shall be construed to af-
14 fect the role of enrollment agents and brokers under State
15 law, including with regard to the enrollment of individuals
16 and employers in qualified health benefits plans including
17 the public health insurance option.

【Presumptive State operation of certain Ex-
changes:】 In section 208(b), designate the current text
as a paragraph (1), with the heading “**IN GENERAL.—**”
and appropriate redesignations of subordinate provisions
and add at the end the following new paragraph:

1 (2) PRESUMPTION FOR CERTAIN STATE-OPER-
2 ATED EXCHANGES.—

3 (A) IN GENERAL.—In the case of a State
4 operating an Exchange prior to January 1,
5 2010 that seeks to operate the State-based
6 Health Insurance Exchange under this section,
7 the Commissioner shall presume that such Ex-
8 change meets the standards under this section
9 unless the Commissioner determines, after com-
10 pletion of the process established under sub-
11 paragraph (B), that the Exchange does not
12 comply with such standards.

13 (B) PROCESS.—The Commissioner shall
14 establish a process to work with a State de-
15 scribed in subparagraph (A) to provide assist-
16 ance necessary to assure that the State's Ex-
17 change comes into compliance with the stand-
18 ards for approval under this section.

【Physician opt-out from public option:】 Amend sec-
 tion 223(b) to read as follows:

19 (b) ESTABLISHMENT OF A PROVIDER NETWORK.—
20 (1) IN GENERAL.—Health care providers par-
21 ticipating (including physicians and hospitals) in
22 Medicare are participating providers in the public
23 health insurance option unless they opt out in a

1 process established by the Secretary consistent with
2 this subsection.

3 (2) REQUIREMENTS FOR OPT-OUT PROCESS.—

4 Under the process established under paragraph
5 (1)—

6 (A) providers described in such subpara-
7 graph shall be provided at least a 1-year period
8 prior to the first day of Y1 to opt out of par-
9 ticipating in the public health insurance option;

10 (B) no provider shall be subject to a pen-
11 alty for not participating in the public health
12 insurance option;

13 (C) the Secretary shall include information
14 on how providers participating in Medicare who
15 chose to opt out of participating in the public
16 health insurance option may opt back in; and

17 (D) there shall be an annual enrollment
18 period in which providers may decide whether
19 to participate in the public health insurance op-
20 tion.

21 (3) RULEMAKING.—Not later than 18 months
22 before the first day of Y1, the Secretary shall pro-
23 mulgate rules (pursuant to notice and comment) for
24 the process described in paragraph (1).

Amend section 225(c) to read as follows:

1 **SEC. 252. START-UP AND SOLVENCY GRANTS AND LOANS.**

2 (a) IN GENERAL.—Not later than 36 months after
3 the date of the enactment of this Act, the Commissioner,
4 acting through the CO–OP program, may make—

5 (1) loans (of such period and with such terms
6 as the Secretary may specify) to cooperatives to as-
7 sist such cooperatives with start-up costs; and

8 (2) grants to cooperatives to assist such co-
9 operatives in meeting State solvency requirements in
10 the States in which such cooperative offers or issues
11 insurance coverage.

12 (b) CONDITIONS.—A grant or loan may not be
13 awarded under this section with respect to a cooperative
14 unless the following conditions are met:

15 (1) The cooperative is structured as a not-for-
16 profit, member organization under the law of each
17 State in which such cooperative offers, intends to
18 offer, or issues insurance coverage, with the mem-
19 bership of the cooperative being made up entirely of
20 beneficiaries of the insurance coverage offered by
21 such cooperative.

22 (2) The cooperative did not offer insurance on
23 or before July 16, 2009, and the cooperatives is not
24 an affiliate or successor to an insurance company of-
25 fering insurance on or before such date.

1 (3) The governing documents of the coopera-
2 tives incorporate ethical and conflict of interest
3 standards designed to protect against insurance in-
4 dustry involvement and interference in the govern-
5 ance of the cooperative.

6 (4) The cooperative is not sponsored by a State
7 government.

8 (5) Substantially all of the activities of the co-
9 operative consist of the issuance of qualified health
10 benefit plans through the Health Insurance Ex-
11 change or a State-based health insurance exchange.

12 (6) The cooperative is licenced to offer insur-
13 ance in each State in which it offers insurance.

14 (7) The governance of the cooperative must be
15 subject to a majority vote of its members.

16 (8) As provided in guidance issued by the Sec-
17 retary of Health and Human Services, the coopera-
18 tive operates with a strong consumer focus, includ-
19 ing timeliness, responsiveness, and accountability to
20 members.

21 (9) Any profits made by the cooperative are
22 used to lower premiums, improve benefits, or to oth-
23 erwise improve the quality of health care delivered to
24 members.

1 (c) PRIORITY.—The Commissioner, in making grants
2 and loans under this section, shall give priority to coopera-
3 tives that—

4 (1) operate on a Statewide basis;

5 (2) use an integrated delivery system; or

6 (3) have a significant level of financial support
7 from non-governmental sources.

8 (d) RULES OF CONSTRUCTION.—Nothing in this sub-
9 title shall be construed to prevent a cooperative established
10 in one State from integrating with a cooperative estab-
11 lished in another State the administration, issuance of cov-
12 erage, or other activities related to acting as a QHBP of-
13 fering entity. Nothing in this subtitle shall be construed
14 as preventing State governments from taking actions to
15 permit such integration.

16 (e) REPAYMENT FOR VIOLATIONS OF TERMS OF
17 PROGRAM.—If a cooperative violates the terms of the CO-
18 OP program and fails to correct the violation within a rea-
19 sonable period of time, as determined by the Commis-
20 sioner, the cooperative shall repay the total amount of any
21 loan or grant received by such cooperative under this sec-
22 tion, plus interest (at a rate determined by the Secretary).

23 (f) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated \$5,000,000,000 for the

1 period of fiscal years 2010 through 2014 to provide for
2 grants and loans under this section.

3 **SEC. 253. DEFINITIONS.**

4 For purposes of this subtitle:

5 (1) STATE.—The term “State” means each of
6 the 50 States and the District of Columbia.

7 (2) MEMBER.—The term “member”, with re-
8 spect to a cooperative, means an individual who,
9 after the cooperative offers health insurance cov-
10 erage, is enrolled in such coverage.

In section 100(a)(3)(B), insert “and cooperatives under subtitle D of title II” after “alongside private plans”.

In section 100(c)(11), insert “and cooperatives under subtitle D of title II” after “the public health insurance option”.

In section 100(c)(19)(B), insert “, including a cooperative under subtitle D of title II” after “offering the coverage”.

In section 100(c)(20), insert “and cooperatives under subtitle D of title II” after “public health insurance option”.

In section 201, insert before the period the following “and cooperatives under subtitle D of title II”.

【Clinic participation in medical home project:】 In the proposed section 1866E of the Social Security Act, added by section 1302 of the bill—

(1) in subsection (c)(4), insert “private, non-profit health clinics,” after “federally qualified community health centers,”; and

(2) in subsection (d)(4)(A), insert “private, nonprofit health clinics,” after “federally qualified community health centers,”.

【Center for Payment Innovation:】 In section 1222(a), insert “and the Center for Medicare and Medicaid Payment Innovation established under section 1115A of the Social Security Act (as added by section 1311) and consistent with the applicable provisions of such section” after “Centers for Medicare & Medicaid Services”.

In section 1236(a), insert “, acting through the Center for Medicare and Medicaid Payment Innovation established under section 1115A of the Social Security Act (as added by section 1311) and consistent with the applicable provisions of such section,” after “Secretary of Health and Human Services”.

Add at end of title IX of division B the following:

1 **SEC. 1906. ESTABLISHMENT OF CENTER FOR MEDICARE**
2 **AND MEDICAID PAYMENT INNOVATION WITH-**
3 **IN CMS.**

4 (a) IN GENERAL.—Title XI of the Social Security Act
5 is amended by inserting after section 1115 the following
6 new section:

7 “CENTER FOR MEDICARE AND MEDICAID PAYMENT
8 INNOVATION

9 “SEC. 1115A. (a) CENTER FOR MEDICARE AND
10 MEDICAID PAYMENT INNOVATION ESTABLISHED.—

11 “(1) IN GENERAL.—There is created within the
12 Centers for Medicare & Medicaid Services a Center
13 for Medicare and Medicaid Payment Innovation (in
14 this section referred to as the ‘CMPI’) to carry out
15 the duties described in paragraph (4).

16 “(2) DIRECTOR.—The CMPI shall be headed by
17 a Director who shall report directly to the Adminis-
18 trator of the Centers for Medicare & Medicaid Serv-
19 ices.

20 “(3) DEADLINE.—The Secretary shall ensure
21 that the CMPI is carrying out the duties described
22 in paragraph (4) by not later than January 1, 2011.

23 “(4) DUTIES.—The duties described in this
24 paragraph are the following:

25 “(A) To carry out the duties described in
26 this section.

1 “(B) Such other duties as the Secretary
2 may specify.

3 “(5) CONSULTATION.—In carrying out the du-
4 ties under paragraph (4), the CMPI shall consult
5 representatives of relevant Federal agencies and out-
6 side clinical and analytical experts with expertise in
7 medicine and health care management. The CMPI
8 shall use open door forums or other mechanisms to
9 seek input from interested parties.

10 “(b) TESTING OF MODELS (PHASE I).—

11 “(1) IN GENERAL.—The CMPI shall test pay-
12 ment models in accordance with selection criteria
13 under paragraph (2) to determine the effect of ap-
14 plying such models under title XVIII, title XIX, or
15 both titles on program expenditures under such ti-
16 tles and the quality of care received by individuals
17 receiving benefits under such titles.

18 “(2) SELECTION OF MODELS TO BE TESTED.—

19 “(A) IN GENERAL.—The Secretary shall
20 give preference to testing models for which, as
21 determined by the professional staff at the Cen-
22 ters for Medicare & Medicaid Services and
23 using such input from outside the Centers as
24 the Secretary determines appropriate, there is
25 evidence that the model addresses a defined

1 population for which there are deficits in care
2 leading to poor clinical outcomes or potentially
3 avoidable expenditures. The Secretary shall
4 focus on models expected to reduce program
5 costs under title XVIII, title XIX, or both titles
6 while preserving or enhancing the quality of
7 care received by individuals receiving benefits
8 under such titles.

9 “(B) APPLICATION TO OTHER DEM-
10 ONSTRATIONS.—The Secretary shall operate the
11 demonstration programs under sections 1222
12 and 1236 of the America’s Affordable Health
13 Choices Act of 2009 through the CMPI in ac-
14 cordance with the rules applicable under this
15 section, including those relating to evaluations,
16 terminations, and expansions.

17 “(3) BUDGET NEUTRALITY.—

18 “(A) INITIAL PERIOD.—The Secretary
19 shall not require as a condition for testing a
20 model under paragraph (1) that the design of
21 the model ensure that the model is budget neu-
22 tral initially with respect to expenditures under
23 titles XVIII and XIX.

24 “(B) TERMINATION.—The Secretary shall
25 terminate or modify the design and implemen-

1 tation of a model unless the Secretary deter-
2 mines (and the Chief Actuary of the Centers for
3 Medicare & Medicaid Services, with respect to
4 spending under such titles, certifies), after test-
5 ing has begun, that the model is expected to—

6 “(i) improve the quality of patient
7 care (as determined by the Administrator
8 of the Centers for Medicare & Medicaid
9 Services) without increasing spending
10 under such titles;

11 “(ii) reduce spending under such titles
12 without reducing the quality of patient
13 care; or

14 “(iii) do both.

15 Such termination may occur at any time after
16 such testing has begun and before completion of
17 the testing.

18 “(4) EVALUATION.—The Secretary shall con-
19 duct an evaluation of each model tested under this
20 subsection. Such evaluation shall include an analysis
21 of—

22 “(A) the quality of patient care furnished
23 under the model, including through the use of
24 patient-level outcomes measures; and

1 “(B) the changes in spending under titles
2 XVIII and XIX by reason of the model.

3 The Secretary shall make the results of each evalua-
4 tion under this paragraph available to the public in
5 a timely fashion.

6 “(c) EXPANSION OF MODELS (PHASE II).—The Sec-
7 retary may expand the duration and the scope of a model
8 that is being tested under subsection (b) (including imple-
9 mentation on a nationwide basis), to the extent deter-
10 mined appropriate by the Secretary, if—

11 “(1) the Secretary determines that such expan-
12 sion is expected—

13 “(A) to improve the quality of patient care
14 without increasing spending under titles XVIII
15 and XIX;

16 “(B) to reduce spending under such titles
17 without reducing the quality of patient care; or

18 “(C) to do both; and

19 “(2) the Chief Actuary of the Centers for Medi-
20 care & Medicaid Services certifies that such expan-
21 sion would reduce (or not result in any increase in)
22 net program spending under such titles.

23 “(d) IMPLEMENTATION.—

24 “(1) WAIVER AUTHORITY.—The Secretary may
25 waive such requirements of title XVIII and of sec-

1 tions 1902(a)(1), 1902(a)(13), and
2 1903(m)(2)(A)(iii) as may be necessary solely for
3 purposes of carrying out this section with respect to
4 testing models described in subsection (b).

5 “(2) LIMITATIONS ON REVIEW.—There shall be
6 no administrative or judicial review under section
7 1869, section 1878, or otherwise of—

8 “(A) the selection of models for testing or
9 expansion under this section;

10 “(B) the elements, parameters, scope, and
11 duration of such models for testing or dissemi-
12 nation;

13 “(C) the termination or modification of the
14 design and implementation of a model under
15 subsection (b)(3)(B); and

16 “(D) determinations about expansion of
17 the duration and scope of a model under sub-
18 section (c) including the determination that a
19 model is not expected to meet criteria described
20 in paragraphs (1) or (2) of such subsection.

21 “(3) ADMINISTRATION.—Chapter 35 of title 44,
22 United States Code shall not apply to this section
23 and testing and evaluation of models or expansion of
24 such models under this section.

1 “(4) FUNDING FOR TESTING ITEMS AND SERV-
2 ICES AND ADMINISTRATIVE COSTS.—There shall be
3 available from the Federal Supplementary Medical
4 Insurance Trust Fund for payments for designing,
5 conducting, and evaluating payment models, as well
6 as for additional benefits for items and services
7 under models tested under subsection (b) not other-
8 wise covered under this title and the evaluation of
9 such models, \$350,000,000 for fiscal year 2010 and,
10 for a subsequent fiscal year, the amount determined
11 under this sentence for the preceding fiscal year in-
12 creased by the annual percentage rate of increase in
13 total expenditures under this title for the previous
14 fiscal year. There are also appropriated, from any
15 amounts in the Treasury not otherwise appropriated,
16 \$25,000,000 for each fiscal year (beginning with fis-
17 cal year 2010) for administrative costs of admin-
18 istering this section with respect to the Medicaid
19 program under title XIX of the Social Security Act.
20 “(e) REPORT TO CONGRESS.—Beginning in 2012,
21 and not less than once every other year thereafter, the
22 Secretary shall submit to Congress a report on activities
23 under this section. Each such report shall describe the
24 payment models tested under subsection (b), any models
25 chosen for expansion under subsection (c), and the results

1 from evaluations under subsection (b)(4). In addition,
2 each such report shall provide such recommendations as
3 the Secretary believes are appropriate for legislative action
4 to facilitate the development and expansion of successful
5 payment models.”.

6 (b) MEDICAID CONFORMING AMENDMENT.—Section
7 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
8 as amended by sections 1631(b), 1703, 1753, 1757, and
9 1759, is amended—

10 (1) in paragraph (77), by striking “and” at the
11 end;

12 (2) in paragraph (78), by striking the period at
13 the end and inserting “; and”; and

14 (3) by inserting after paragraph (78) the fol-
15 lowing new paragraph:

16 “(79) provide for implementation of the pay-
17 ment models specified by the Secretary under section
18 1115A(c) for implementation on a nationwide basis
19 unless the State demonstrates to the satisfaction of
20 the Secretary that implementation would not be ad-
21 ministratively feasible or appropriate to the health
22 care delivery system of the State.”.

【end-of-life planning】 Add at the end of subtitle D
of title I of division A the following:

1 **SEC. 138. INFORMATION ON END-OF-LIFE PLANNING.**

2 (a) IN GENERAL.—The QHBP offering entity —

3 (1) shall provide for the dissemination of infor-
4 mation related to end-of-life planning to individuals
5 seeking enrollment in Exchange-participating health
6 benefits plans offered through the Exchange;

7 (2) shall present such individuals with—

8 (A) the option to establish advanced direc-
9 tives and physician's orders for life sustaining
10 treatment according to the laws of the State in
11 which the individual resides; and

12 (B) information related to other planning
13 tools; and

14 (3) shall not promote suicide, assisted suicide,
15 or the active hastening of death.

16 The information presented under paragraph (2) shall not
17 presume the withdrawal of treatment and shall include
18 end-of-life planning information that includes options to
19 maintain all or most medical interventions.

20 (b) CONSTRUCTION.— Nothing in this section shall
21 be construed—

22 (1) to require an individual to complete an ad-
23 vanced directive or a physician's order for life sus-
24 taining treatment or other end-of-life planning docu-
25 ment;

1 (2) to require an individual to consent to re-
2 strictions on the amount, duration, or scope of med-
3 ical benefits otherwise covered under a qualified
4 health benefits plan; or

5 (3) to encourage the hastening of death or the
6 promotion of assisted suicide.

7 (c) **ADVANCED DIRECTIVE DEFINED.**—In this sec-
8 tion, the term “advanced directive” includes a living will,
9 a comfort care order, or a durable power of attorney for
10 health care

11 (d) **PROHIBITION ON THE PROMOTION OF ASSISTED**
12 **SUICIDE.**—

13 (1) **IN GENERAL.**—Subject to paragraph (3),
14 information provided to meet the requirements of
15 subsection (a)(2) shall not include advanced direc-
16 tives or other planning tools that list or describe as
17 an option suicide, assisted suicide or the intentional
18 hastening of death regardless of legality.

19 (2) **CONSTRUCTION.**—Nothing in paragraph (1)
20 shall be construed to apply to or affect any option
21 to—

22 (A) the withhold or withdraw of medical
23 treatment or medical care;

24 (B) withhold or withdraw of nutrition or
25 hydration; and

1 (C) provide palliative or hospice care or
2 use an item, good, benefit, or service furnished
3 for the purpose of alleviating pain or discom-
4 fort, even if such use may increase the risk of
5 death, so long as such item, good, benefit, or
6 service is not also furnished for the purpose of
7 causing, or the purpose of assisting in causing,
8 death, for any reason.

9 (3) EXEMPTION.—The requirements of sub-
10 section (a) shall not apply to any State that as of
11 August 1, 2009, requires the inclusion of informa-
12 tion prohibited in such paragraph in advanced direc-
13 tives or other planning tools.

【Public option enrollment voluntary; sense of Com-
mittee on Congressional option:】 At the end of subtitle
B of title II of division A, add the following:

14 **SEC. 229. ENROLLMENT IN PUBLIC HEALTH INSURANCE**
15 **OPTION IS VOLUNTARY.**

16 Nothing in this division shall be construed as requir-
17 ing anyone to enroll in the public health insurance option.
18 Enrollment in such option is voluntary.

1 **SEC. 230. SENSE OF COMMITTEE REGARDING ENROLLMENT**
2 **OF MEMBERS OF CONGRESS.**

3 It is the sense of the Committee on Energy and Com-
4 merce of the House of Representatives that Members of
5 Congress should have the option to enroll in the public
6 health insurance option.

