

110<sup>TH</sup> CONGRESS  
2<sup>D</sup> 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.

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## 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

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## 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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