# AMENDMENT TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3200 OFFERED BY

**(AINS-EC__001)**

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

(3) EQUAL TREATMENT OF CERTAIN EMPLOYED INDIVIDUALS.—

(A) IN GENERAL.—For purposes of applying this section with respect to an individual who is an employee of an employer that has an annual payroll (for the preceding calendar year) which does not exceed $750,000 and that makes the contribution which would be required under section 313(a) if the table specified in subparagraph (B) were substituted for the table specified in section 313(b)(1) (and if, in applying section 313(b)(2), $750,000 were substituted for $400,000), such individual shall be treated in the same manner as an employee of an employer that makes the contribution described in section 313(a) (without regard to this paragraph).

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

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

[Negotiated payment rates under public option:] In section 223—

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

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

(a) NEGOTIATION OF PAYMENT RATES.—

(1) IN GENERAL.—The Secretary shall negotiate payment rates for the public health insurance option for services and health care providers consistent with this section and section 224.

(2) MANNER OF NEGOTIATION.—The Secretary shall negotiate such rates in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHBP offering entities for services and health care providers.

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

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

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

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

[Change in subsidy schedule:] In section 242(b)(2)(B), strike ''11 percent'' and insert ''12 percent''.

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

(1) IN GENERAL.—For purposes of this subtitle, subject to paragraph (3), the table specified in this subsection is as follows:

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

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

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

[Medicaid matching:] Amend paragraph (2) of section 1701(a) to read as follows:

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

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

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

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

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

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

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

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

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

(a) GAO STUDY ON FMAP.—.

(1) STUDY.—The Comptroller General of the United States shall conduct a study regarding federal payments made to the State Medicaid programs under title XIX of the Social Security Act for the purposes of making recommendations to Congress.

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

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

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

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

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the administration of the Medicaid program by the Department of Health and Human Services, State Medicaid agencies, and local government agencies. The report shall address the following issues:

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

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

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

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

[Level Playing Field for Public Option:] In section 112, insert ''and shall apply to the public health insurance option'' after ''or otherwise,''.

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

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

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

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

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

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

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

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

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

**SEC. 227. APPLICATION OF HIPAA INSURANCE REQUIREMENTS.**

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

**SEC. 228. APPLICATION OF HEALTH INFORMATION PRIVACY, SECURITY, AND ELECTRONIC TRANSACTION REQUIREMENTS.**

Part C of title XI of the Social Security Act, relating to standards for protections against the wrongful disclosure of individually identifiable health information, health information security, and the electronic exchange of health care information, shall apply to the public health insurance option in the same manner as such part applies to other health plans (as defined in section 1171(5) of such Act).

**[**Agents and Brokers:**]** Add at the end of section 205 the following:

(g) ROLE FOR ENROLLMENT AGENTS AND BROKERS.—Nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefits plans including the public health insurance option.

**[**Presumptive State operation of certain Exchanges:**]** In section 208(b), designate the current text as a paragraph (1), with the heading ''IN GENERAL.—'' and appropriate redesignations of subordinate provisions and add at the end the following new paragraph:

(2) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—

(A) IN GENERAL.—In the case of a State operating an Exchange prior to January 1, 2010 that seeks to operate the State-based Health Insurance Exchange under this section, the Commissioner shall presume that such Exchange meets the standards under this section unless the Commissioner determines, after completion of the process established under subparagraph (B), that the Exchange does not comply with such standards.

(B) PROCESS.—The Commissioner shall establish a process to work with a State described in subparagraph (A) to provide assistance necessary to assure that the State's Exchange comes into compliance with the standards for approval under this section.

[Physician opt-out from public option:] Amend section 223(b) to read as follows:

(b) ESTABLISHMENT OF A PROVIDER NETWORK.—

(1) IN GENERAL.—Health care providers participating (including physicians and hospitals) in Medicare are participating providers in the public health insurance option unless they opt out in a

process established by the Secretary consistent with this subsection.

(2) REQUIREMENTS FOR OPT-OUT PROCESS.—Under the process established under paragraph (1)—

(A) providers described in such subparagraph shall be provided at least a 1-year period prior to the first day of Y1 to opt out of participating in the public health insurance option;

(B) no provider shall be subject to a penalty for not participating in the public health insurance option;

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

(D) there shall be an annual enrollment period in which providers may decide whether to participate in the public health insurance option.

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

Amend section 225(c) to read as follows:

(c) PAYMENT TERMS FOR PROVIDERS.—The Secretary shall establish terms and conditions for the participation (on an annual or other basis specified by the Secretary) of physicians and other health care providers under the public health insurance option, for which payment may be made for services furnished during the year.

**[**Cooperatives:**]** In title II of division A, add at the end the following new subtitle:

# Subtitle D—Health Insurance Cooperatives

**SEC. 251. ESTABLISHMENT.**

Not later than 6 months after the date of the enactment of this Act, the Commissioner, in consultation with the Secretary of the Treasury, shall establish a Consumer Operated and Oriented Plan program (in this subtitle referred to as the ''CO–OP program'') under which the Commissioner may make grants and loans for the establishment and initial operation of not-for-profit, member–run health insurance cooperatives (in this subtitle individually referred to as a ''cooperative'') that provide insurance through the Health Insurance Exchange or a State-based Health Insurance Exchange under section 208. Nothing in this subtitle shall be construed as requiring a State to establish such a cooperative.

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

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

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

(2) grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

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

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

(2) The cooperative did not offer insurance on or before July 16, 2009, and the cooperatives is not an affiliate or successor to an insurance company offering insurance on or before such date.

(3) The governing documents of the cooperatives incorporate ethical and conflict of interest standards designed to protect against insurance industry involvement and interference in the governance of the cooperative.

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

(5) Substantially all of the activities of the cooperative consist of the issuance of qualified health benefit plans through the Health Insurance Exchange or a State-based health insurance exchange.

(6) The cooperative is licenced to offer insurance in each State in which it offers insurance.

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

(8) As provided in guidance issued by the Secretary of Health and Human Services, the cooperative operates with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(9) Any profits made by the cooperative are used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to members.

(c) PRIORITY.—The Commissioner, in making grants and loans under this section, shall give priority to cooperatives that—

(1) operate on a Statewide basis;

(2) use an integrated delivery system; or

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

(d) RULES OF CONSTRUCTION.—Nothing in this subtitle shall be construed to prevent a cooperative established in one State from integrating with a cooperative established in another State the administration, issuance of coverage, or other activities related to acting as a QHBP offering entity. Nothing in this subtitle shall be construed as preventing State governments from taking actions to permit such integration.

(e) REPAYMENT FOR VIOLATIONS OF TERMS OF PROGRAM.—If a cooperative violates the terms of the CO–OP program and fails to correct the violation within a reasonable period of time, as determined by the Commissioner, the cooperative shall repay the total amount of any loan or grant received by such cooperative under this section, plus interest (at a rate determined by the Secretary).

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

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

**SEC. 253. DEFINITIONS.**

For purposes of this subtitle:

(1) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

(2) MEMBER.—The term ''member'', with respect to a cooperative, means an individual who, after the cooperative offers health insurance coverage, is enrolled in such coverage.

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

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

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

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

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

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

(1) in subsection (c)(4), insert ''private, nonprofit health clinics,'' after ''federally qualified community health centers,''; and

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

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

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

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

**SEC. 1906. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID PAYMENT INNOVATION WITHIN CMS.**

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

''CENTER FOR MEDICARE AND MEDICAID PAYMENT INNOVATION

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

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

''(2) DIRECTOR.—The CMPI shall be headed by a Director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

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

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

''(A) To carry out the duties described in this section.

''(B) Such other duties as the Secretary may specify.

''(5) CONSULTATION.—In carrying out the duties under paragraph (4), the CMPI shall consult representatives of relevant Federal agencies and outside clinical and analytical experts with expertise in medicine and health care management. The CMPI shall use open door forums or other mechanisms to seek input from interested parties.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMPI shall test payment models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under title XVIII, title XIX, or both titles on program expenditures under such titles and the quality of care received by individuals receiving benefits under such titles.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall give preference to testing models for which, as determined by the professional staff at the Centers for Medicare & Medicaid Services and using such input from outside the Centers as the Secretary determines appropriate, there is evidence that the model addresses a defined

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

''(B) APPLICATION TO OTHER DEMONSTRATIONS.—The Secretary shall operate the demonstration programs under sections 1222 and 1236 of the America's Affordable Health Choices Act of 2009 through the CMPI in accordance with the rules applicable under this section, including those relating to evaluations, terminations, and expansions.

''(3) BUDGET NEUTRALITY.—

''(A) INITIAL PERIOD.—The Secretary shall not require as a condition for testing a model under paragraph (1) that the design of the model ensure that the model is budget neutral initially with respect to expenditures under titles XVIII and XIX.

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

tation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under such titles, certifies), after testing has begun, that the model is expected to—

''(i) improve the quality of patient care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under such titles;

''(ii) reduce spending under such titles without reducing the quality of patient care; or

''(iii) do both.

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

''(4) EVALUATION.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

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

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

The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion.

''(c) EXPANSION OF MODELS (PHASE II).—The Secretary may expand the duration and the scope of a model that is being tested under subsection (b) (including implementation on a nationwide basis), to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected—

''(A) to improve the quality of patient care without increasing spending under titles XVIII and XIX;

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

''(C) to do both; and

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or not result in any increase in) net program spending under such titles.

''(d) IMPLEMENTATION.—

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

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

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

''(A) the selection of models for testing or expansion under this section;

''(B) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(C) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(D) determinations about expansion of the duration and scope of a model under subsection (c) including the determination that a model is not expected to meet criteria described in paragraphs (1) or (2) of such subsection.

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

''(4) FUNDING FOR TESTING ITEMS AND SERVICES AND ADMINISTRATIVE COSTS.—There shall be available from the Federal Supplementary Medical Insurance Trust Fund for payments for designing, conducting, and evaluating payment models, as well as for additional benefits for items and services under models tested under subsection (b) not otherwise covered under this title and the evaluation of such models, $350,000,000 for fiscal year 2010 and, for a subsequent fiscal year, the amount determined under this sentence for the preceding fiscal year increased by the annual percentage rate of increase in total expenditures under this title for the previous fiscal year. There are also appropriated, from any amounts in the Treasury not otherwise appropriated, $25,000,000 for each fiscal year (beginning with fiscal year 2010) for administrative costs of administering this section with respect to the Medicaid program under title XIX of the Social Security Act.

''(e) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the payment models tested under subsection (b), any models chosen for expansion under subsection (c), and the results

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

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

(1) in paragraph (77), by striking ''and'' at the end;

(2) in paragraph (78), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (78) the following new paragraph:

''(79) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

**[**end-of-life planning**]** Add at the end of subtitle D of title I of division A the following:

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

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

(1) shall provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in Exchange-participating health benefits plans offered through the Exchange;

(2) shall present such individuals with—

(A) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

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

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

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

(1) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(2) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health benefits plan; or

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

(c) ADVANCED DIRECTIVE DEFINED.—In this section, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care

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

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide or the intentional hastening of death regardless of legality.

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

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

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

(C) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(3) EXEMPTION.—The requirements of subsection (a) shall not apply to any State that as of August 1, 2009, requires the inclusion of information prohibited in such paragraph in advanced directives or other planning tools.

[Public option enrollment voluntary; sense of Committee on Congressional option:] At the end of subtitle B of title II of division A, add the following:

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

Nothing in this division shall be construed as requiring anyone to enroll in the public health insurance option. Enrollment in such option is voluntary.

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

It is the sense of the Committee on Energy and Commerce of the House of Representatives that Members of Congress should have the option to enroll in the public health insurance option.

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