I

110TH CONGRESS
2D SESSION

H. R. 7129

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 2008

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

---

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Several Approaches to Reduce the Uninsured Act of 2008''.

(b) TABLE OF CONTENTS.—The table of contents of 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 demonstration 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 insurance coverage in the individual market.

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.

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

(1) by redesignating paragraph (9) as paragraph (10); and

(2) by inserting after paragraph (8) the following new paragraph:

''(9)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to any program established by or under the laws of any State which is listed pursuant to section 721 as a State comprehensive health care program (as defined in section 722(a)).

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

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

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

(b) STATE COMPREHENSIVE HEALTH CARE PROGRAMS.—

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

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

(B) by inserting after subpart B the following new subpart:

"Subpart C—State Comprehensive Health Care Programs

"SEC. 721. DESIGNATION OF STATE COMPREHENSIVE HEALTH CARE PROGRAMS EXEMPT FROM FEDERAL PREEMPTION.

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

Secretary shall undertake an ongoing review of such list so as to ensure such list remains comprehensive and exclusive of any programs which may have ceased to be State comprehensive health care programs. Such list shall be periodically published in the Federal Register and maintained so as to be readily accessible to the general public.

"SEC. 722. REQUIREMENTS.

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

''(1) residents of such State are required to obtain and maintain health insurance coverage meeting the Federal threshold of adequate medical care,

''(2) each employer employing individuals in such State—

''(A) that is not a small employer within the meaning of subsection (c) for a calendar year,

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

"(C) in whose case the Secretary has not waived the requirements of this subsection for such calendar year pursuant to subsection (e) on the basis of substantial business hardship,

is required to establish and maintain a group health plan for such employees for such calendar year providing benefits which meet the Federal threshold of adequate medical care.

"(b) SINGLE PROGRAM PER STATE.—A program may be considered a State comprehensive health care program in connection with any State only if it is the only such program in effect by or under the laws of such State.

"(c) FEDERAL THRESHOLD OF ADEQUATE MEDICAL CARE.—For purposes of this section, the term 'Federal threshold of adequate medical care' means the package of benefits constituting medical care which the Comprehensive Health Care Commission currently maintains as the Federal threshold of adequate medical care as prescribed pursuant to section 723(f)(1).

"(d) SMALL EMPLOYERS.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the term `small employer' means, with respect to a calendar year, an employer who employed an average of at least 2 but not more than 100 employees on business days during the preceding cal-

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

''(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

''(e) EXCEPTION ALLOWED FOR EMPLOYERS OTHERWISE PROVIDING GROUP HEALTH PLAN COVERAGE.—For purposes of subsection (a)(2), an employer shall be treated, for any current calendar year, as otherwise providing coverage of an employee under a group health plan for its employees which meets the criteria for the Federal threshold of adequate medical care if, with respect to such calendar year, such employee—

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

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

''(f) WAIVER IN CASES OF SUBSTANTIAL BUSINESS HARDSHIP.—

''(1) IN GENERAL.—If an employer is unable to satisfy the requirements of subsection (a) for any calendar year without substantial business hardship and application of such requirements for such calendar year would be adverse to the interests of plan participants in the aggregate, the Secretary may waive the requirements of subsection (a) for such calendar year. The Secretary shall not waive such requirements with respect to a plan for more than 3 of any 15 consecutive calendar years.

''(2) DETERMINATION OF SUBSTANTIAL BUSINESS HARDSHIP.—For purposes of this section, the factors taken into account in determining substantial business hardship shall include (but shall not be limited to) whether or not—

''(A) the employer is operating at an economic loss,

''(B) there is substantial unemployment or under-employment in the trade or business and in the industry concerned,

''(C) the sales and profits of the industry concerned are depressed or declining, and

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

''SEC. 723. COMPREHENSIVE HEALTH CARE COMMISSION.

''(a) ESTABLISHMENT.—The Secretary, in consultation with the Secretary of Health and Human Services, shall establish a commission to be known as the Comprehensive Health Care Commission (referred to in this section as the 'Commission').

''(b) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Secretary, in consultation with the Secretary of Health and Human Services.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include—

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

ment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through medicare and medicaid; and

''(ii) individuals with expertise in financing and paying for benefits and access to care, business and labor perspectives, and providers of health care. The membership shall reflect a broad geographic representation and a balance between urban and rural representatives.

''(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected government officials (Federal, State, or local). Individuals appointed to the Commission shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

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

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

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

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

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

''(d) DESIGNATION OF THE CHAIRPERSON.—The Secretary shall designate the chairperson of the Commission.

''(e) SUBCOMMITTEES.—The Commission may establish subcommittees if doing so increases the efficiency of the Commission in completing its tasks.

''(f) DUTIES.—

''(1) IN GENERAL.—The Commission shall prescribe, and from time to time revise as the Commission deems appropriate, a package of benefits constituting medical care which it determines to be, for purposes of this part, the Federal threshold of adequate medical care.

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

''(3) COMMUNITY MEETINGS.—

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

section (b)(1) and appropriations are first made available to carry out this section, the Commission shall annually provide for health care community meetings throughout the United States (in this paragraph referred to as 'community meetings'). Such community meetings may be geographically or regionally based.

''(B) FREQUENCY OF MEETINGS.—The Commission shall ensure that community meetings are held with such frequency as to ensure that the Commission receives information that reflects, on an ongoing basis—

''(i) the geographic differences throughout the United States;

''(ii) diverse populations; and

''(iii) a balance among urban and rural populations.

''(C) MEETING REQUIREMENTS.—

''(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

''(ii) ATTENDANCE.—At least 1 member of the Commission shall attend and serve as chair of each community meeting.

Other members may participate through interactive technology.

''(iii) TOPICS.—The community meetings shall, at a minimum, address the following questions:

''(I) What health care benefits and services should be provided?

''(II) How does the American public want health care delivered?

''(III) How should health care coverage be financed?

''(IV) What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

''(iv) INTERACTIVE TECHNOLOGY.—The Commission may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Commission.

''(g) ADMINISTRATION.—

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

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

''(2) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the Senate.

''(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Commission, the head of such department or agency shall furnish such information.

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

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

''(h) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Commission under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

''(i) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

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

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

$3,000,000 for each fiscal year beginning on or after October 1, 2008.''.

(2) CONFORMING AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following 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.''.

SEC. 102. STATE COVERAGE BUY-IN ARRANGEMENTS AND SMALL EMPLOYER COVERAGE BUY-IN ARRANGEMENTS.

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

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

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

''(2) For purposes of paragraph (1), the term 'State coverage buy-in arrangement' means an arrangement entered into between the plan administrator of a group health plan and a State pursuant to which—

''(A) individuals who are residents of such State, are identified under the arrangement, and are not otherwise participants (within the meaning of section 3(7)(A)) in the plan are treated as participants in the plan,

''(B) premiums are payable to the plan, by such individuals, by the State on behalf of such individuals, or by both, in total amounts equivalent to the total cost of coverage of the individuals and their beneficiaries under the plan, and

''(C) the Secretary determines, under a procedure providing for determinations prior to the entry into the arrangement, and annually thereafter during the term of the arrangement, that the arrangement is—

''(i) administratively feasible,

''(ii) in the interests of the plan and of its participants and beneficiaries, and

''(iii) protective of the rights of participants and beneficiaries of the plan.

''(3) A fiduciary of a group health plan shall have the same fiduciary duties with respect to participants and their beneficiaries who are covered under a group health plan solely by reason of a State coverage buy-in arrangement as are applicable with respect to individuals who are otherwise participants or beneficiaries under the plan.''.

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

''(f)(1) Any requirement of the preceding provisions of this section or any other provision of this title shall not be treated as violated by reason of the entry of a small employer into a small employer coverage buy-in arrangement with the plan administrator of a large employer group health plan or the treatment as a participant under the plan, pursuant to such an arrangement, of an individual who is an employee of the small employer and who is not an employee or former employee of the plan sponsor of the plan or a member or former member of an employee

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

''(2) For purposes of paragraph (1), the term 'small employer coverage buy-in arrangement' means an arrangement entered into between a small employer referred to in paragraph (1) and a plan administrator of a large employer group health plan referred to in paragraph (1) pursuant to which—

''(A) individuals who are employees of the small employer, are identified under such arrangement, and are not otherwise participants (within the meaning of section 3(7)(A)) in the plan are treated as participants in the plan,

''(B) premiums are payable to the plan, by such individuals, by the small employer, or by both, in total amounts equivalent to the total cost of coverage of such individuals and their beneficiaries under the plan, and

''(C) the Secretary determines, under a procedure providing for determinations prior to the entry into the arrangement, and annually thereafter during the term of the arrangement, that the arrangement is—

''(i) administratively feasible,

''(ii) in the interests of the plan and of its participants and beneficiaries, and

''(iii) protective of the rights of participants and beneficiaries of the plan.

''(3) A fiduciary of a group health plan shall have the same fiduciary duties with respect to participants and their beneficiaries who are covered under a group health plan solely by reason of a small employer coverage buy-in arrangement as are applicable with respect to individuals who are otherwise participants or beneficiaries under the plan.

''(4) For purposes of this subsection—

''(A)(i) The term 'small employer' means, in connection with the calendar year in which the arrangement referred to in paragraph (1) is entered into, an employer who, on business days during the period commencing with the preceding calendar year and ending on the date on which the arrangement referred to in paragraph (1) is entered into, employed an average of at least 2 but not more than 50 employees.

''(ii) For purposes of this subparagraph—

''(I) rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply

for purposes of treating persons as a single employer;

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

''(III) any reference in this subparagraph to an employer shall include a reference to any predecessor of the employer.

''(B) The term 'large employer group health plan' means a group health plan with respect to which the plan sponsor is not a small employer in connection with the calendar year in which the arrangement referred to in paragraph (1) is entered into.''.

(c) CONFORMING AMENDMENTS.—

(1) INCLUSION IN DEFINITION OF PARTICIPANT.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended—

(A) by inserting ''(A)'' after ''(7)''; and

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

''(B) In connection with a group health plan (as defined in section 733(a)), the term 'participant' includes any individual not described in subparagraph (A) who is treated as a participant in connection with a State coverage buy-in arrangement entered into pursuant to section 404(e) or a small employer coverage buy-in arrangement entered into pursuant to section 404(f).''.

(2) EXCLUSION FROM DEFINITION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—Section 3(40)(A) of such Act (29 U.S.C. 1002(40((A)) is amended—

(A) in clause (ii), by striking ''or'';

(B) in clause (iii), by striking ''association.'' and inserting ''association, or''; and

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

''(iv) pursuant to subsection (e) or (f) of section 404.''.

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

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

amended by adding at the end the following new section:

"SEC. 45Q. PREMIUMS PAID UNDER QUALIFIED COVERAGE BUY-IN ARRANGEMENTS.

''(a) GENERAL RULE.—For purposes of section 38, the qualified coverage buy-in arrangement credit determined under this section for any taxable year is the aggregate amount paid in the taxable year as premiums for qualified participants under a qualified coverage buy-in arrangement.

''(b) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED COVERAGE BUY-IN ARRANGEMENT.—The term 'qualified coverage buy-in arrangement' means—

''(A) a State coverage buy-in arrangement, and

''(B) a small employer coverage buy-in arrangement.

''(2) STATE COVERAGE BUY-IN ARRANGEMENT; SMALL EMPLOYER COVERAGE BUY-IN ARRANGEMENT.—The terms 'State coverage buy-in arrangement' and 'small employer coverage buy-in arrangement' have the respective meanings given such terms by subsections (e)(2) and (f)(2) of section 404 of the Employee Retirement Income Security Act of 1974.

''(3) QUALIFIED PARTICIPANT.—The term 'qualified participant' means a participant (as defined in section 3(7)(B) of the Employee Retirement Income Security Act of 1974).

''(4) PREMIUM.—The term 'premium' means the applicable premium (as defined in section 4980B(f)(4)).''.

(2) CREDIT ALLOWED AS PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of such Code (defining current year business credit) is amended by striking ''plus'' at the end of paragraph (32), by striking the period at the end of paragraph (33) and inserting '', plus'', and by adding at the end the following new paragraph:

''(34) State coverage buy-in arrangement credit determined under section 45Q(a).''.

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

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

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

paid or incurred in taxable years beginning after December 31, 2008.

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

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

(1) by redesignating paragraph (10) as paragraph (11); and

(2) by inserting after paragraph (9) the following new paragraph:

''(10) Subsection (a) shall not apply to any provision of State law to the extent it provides an assessment against an employer, or a credit against an otherwise applicable assessment against an employer, based on whether, or the extent to which, such employer makes contributions to a group health plan established or maintained by such employer, if such provision does not condition the applicability of the assessment or credit on the satisfaction of any requirement applicable to such plan.''.

SEC. 104. EXEMPTION FROM PREEMPTION TO PERMIT MANDATES FOR DATA COLLECTION UNDER STATE LAW RELATING TO GROUP HEALTH PLANS.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this title) is amended further—

(1) by redesignating paragraph (11) as paragraph (12); and

(2) by inserting after paragraph (10) the following new paragraph:

''(10)(A) Subsection (a) shall not apply to any provision of State law to the extent such provision—

''(i) provides for the collection from the plan sponsor or plan administrator of a group health plan, by the agency or instrumentality of the State responsible for the administration or enforcement of any State law regulating insurance or medical care (as defined in section 733(a)(2)), of information relating to the cost and availability of such medical care through group health insurance coverage or access of individuals to such coverage, or

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

''(B) For purposes of subparagraph (A), any provision of State law providing for the extent of the information described in subparagraph (A)(i) to be collected or

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

TITLE II—HEALTH PARTNERSHIP THROUGH CREATIVE FEDERALISM

SEC. 201. SHORT TITLE.

This title may be cited as the ''Health Partnership Through Creative Federalism Act''.

SEC. 202. STATE HEALTH REFORM PROJECTS.

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

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

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

(B) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this title.

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

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

(B) taken as a whole, such programs should be diverse and balanced in their approaches to covering the uninsured; and

(C) each such program should be rigorously and objectively evaluated, so that the State programs developed pursuant to this title may guide the development of future State and national policy.

(b) APPLICATIONS BY STATES AND LOCAL GOVERNMENTS.—

(1) ENTITIES THAT MAY APPLY.—

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

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

(C) STATE DEFINED.—In this title, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto

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

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State or regional entity desiring to implement a State health care expansion and improvement program may submit an application to the State Health Coverage Innovation Commission under subsection (c) for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—Where a State fails to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(c) STATE HEALTH COVERAGE INNOVATION COMMISSION.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a State Health Coverage Innovation Commission (referred to in this section as the ''Commission'').

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

(A) The Secretary.

(B) Four State governors to be appointed by the National Governors Association on a bipartisan basis.

(C) Two members of a State legislature to be appointed, on a joint and bipartisan basis, by the National Conference of State Legislators and the American Legislative Exchange Council.

(D) Two county officials to be appointed by the National Association of Counties on a bipartisan basis.

(E) Two mayors to be appointed, on a joint and bipartisan basis, by the National League of Cities and by the United States Conference of Mayors.

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

(G) Two individuals to be appointed by the minority leader of the House of Representatives.

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

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

(3) DUTIES.—The Commission—

(A) shall request States to submit proposals, which may include a variety of reform options such as tax credit approaches, expansions of public programs such as Medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this subparagraph, or other alternatives determined appropriate by the Commission, including options suggested by States or the public, and nothing in this subparagraph shall be construed to prevent the Commission from approving a reform proposal not included in this subparagraph;

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

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

(D) shall be responsible for receiving information to determine the status and progress achieved under the program or projects granted under this section;

(E) shall report to the public concerning progress made by States with respect to the performance measures and goals established under this title, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

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

(G) shall be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of differing State requirements under the programs; and

(H) may require States to submit additional information or reports concerning the status and progress achieved under health care expansion and improvement programs granted under this section, as needed.

(4) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (2), the designated appointing individuals shall ensure the representation of urban and rural areas and an appropriate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(5) CHAIRPERSON, MEETINGS.—

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

(B) QUORUM.—Two-thirds of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

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

sion shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(6) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(C).

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a) and for an exchange of information.

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

agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(7) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission

who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without

interruption or loss of civil service status or privilege.

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

(8) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2009 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b)(2), a State plan that shall have as its goal increased health care coverage, and in service of that goal such additional goals as improvements in health care quality, efficiency, cost-effectiveness, and the appropriate use of information

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

(A) COVERAGE.—

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

(I) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number or proportion of uninsured individuals through either private or public program expansion, or both, in accordance with or in addition to the options established by the Commission;

(II) describe the number and percentage of current uninsured individuals who will achieve coverage under a State health program;

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

(IV) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with a State health program, to the extent practicable; and

(V) provide for improvements in the availability of appropriate health care coverage that will increase access to care in urban, suburban, rural, and frontier areas of the State with medically underserved populations or where there may be an inadequate supply of health care providers.

(ii) COVERAGE OPTIONS.—The coverage under the State plan may be—

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

(II) a combination of health insurance coverage and a consumer-directed health care spending account, if

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

(III) health care access not less on average than that provided through coverage described in subclause (I).

(iii) CONSTRUCTION.—Nothing in this clause shall be construed to limit in any way the authority of the Secretary of Health and Human Services to issue waivers under section 1115 of the Social Security Act.

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

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

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

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

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

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

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information technology, the State plan may describe efforts to improve the appropriate use of health information technology, including an explanation of how such efforts would change (if at all) under the State plan.

(E) EXCEPTIONS TO FEDERAL POLICIES.—

(i) IN GENERAL.—Subject to clause (ii), the State plan shall describe the exceptions to otherwise applicable Federal statutes, regulations, and policies that

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

(ii) RECOGNITION OF ERISA REQUIREMENTS.—Except to the extent authorized under subsection (j)(4), the State plan may not include exceptions to the provisions of the Employee Retirement Income Security Act of 1974 but may take into account the amendments made by title I of this Act.

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application under subsection (b)(2), the Secretary and the Commission shall complete an initial review of such State application not later than 60 days after the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall advise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—In a timely manner consistent with subparagraph (C), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are present and eligible to vote and a majority of the entire Commission.

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member serves as a State or local official or as a Member of Congress.

(C) SUBMISSION.—Not later than 90 days before October 1 of each fiscal year, the Commission may submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

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

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND EXPEDITED CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) INTRODUCTION IN HOUSE OF REPRESENTATIVES.—The legislative proposal submitted pursuant to subsection (d)(4)(C) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker immediately upon receipt of the language and shall be referred non-sequentially to the appropriate committee (or committees) of House of Representatives. If the resolution is not introduced in ac-

cordance with the preceding sentence, the resolution may be introduced by any member of the House of Representatives.

(B) COMMITTEE CONSIDERATION.—Not later than 15 calendar days after the introduction of the resolution described in subparagraph (A), each committee of the House of Representatives to which the resolution was referred shall report the resolution. The report may include, at the committee's discretion, a recommendation for action by the House. If a committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such resolution and such resolution shall be placed on the appropriate calendar of the House of Representatives.

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

er's designee, shall move to proceed to the consideration of the resolution. It shall also be in order for any member of the House of Representatives to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives until disposed of. A motion to recommit the resolution shall not be in order. Upon its passage in the House, the

clerk of the House shall provide for its immediate transmittal to the Senate.

(2) EXPEDITED CONSIDERATION IN THE SENATE.—

(A) REFERRAL TO COMMITTEE.—If the resolution is agreed to by the House of Representatives, upon its receipt in the Senate the majority leader of the Senate, or the leader's designee, the resolution shall be referred to the appropriate committee of Senate.

(B) COMMITTEE CONSIDERATION.—Not later than 15 calendar days after the referral of the resolution under subparagraph (A), the committee of the Senate to which the resolution was referred shall report the resolution. The report may include, at the committee's discretion, a recommendation for action by the Senate. If a committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its referral or at the end of the first day after there has been reported to the Senate a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such resolution

and such resolution shall be placed on the appropriate calendar of the Senate.

(C) EXPEDITED FLOOR CONSIDERATION.—Not later than 5 legislative days after the date on which all committees have been discharged from consideration of a resolution, the majority leader of the Senate, or the majority leader's designee, shall move to proceed to the consideration of the resolution. It shall also be in order for any member of the Senate to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution in the Senate is privileged and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the Senate shall immediately proceed to consideration of the resolu-

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

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

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution under this subsection, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

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

pursuant to subsection (d)(4)(C) may not increase the cumulative, net Federal budget deficit during the multi-year operation of all the State applications contained therein, taking into account such applications' impact on Federal mandatory and discretionary spending, Federal revenue, and Federal tax expenditures.

(f) FUNDING.—

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

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

(3) PERFORMANCE-BASED FUNDING ALLOCATION.—In awarding grants under paragraph (1), the Commission shall direct the Secretary to—

(A) fund a balanced diversity of approaches as provided for by the Commission in subsection (c)(1)(B); and

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

(4) REPORT.—One year before the end of the 5-year period beginning on the date on which the first State begins to implement a plan approved under subsection (e), the Commission shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States in meeting the goals of expanded coverage and cost containment through performance measures established during the 5-year period of the State plan. Such report may contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

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

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

spective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

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

(2) EVALUATIONS BY COMMISSION.—The Commission shall prepare and submit to Congress annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

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

(C) an independent evaluation of the effectiveness of such reforms in—

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

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

as well as other relevant or significant findings;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program ini-

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

(E) as required by the Commission or the Secretary under this section, a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirement of this section, the Commission, on recommendation of the Secretary, shall develop a corrective action plan for such State.

(2) TERMINATION.—The Commission, on recommendation of the Secretary, may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

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

(A) the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title or,

(B) except as authorized in subsection (j)(4), the provisions of the Employee Retirement Income Security Act of 1974 (as amended by this Act) or the regulations implementing such Act.

(2) MAINTENANCE OF EFFORT.—No payment may be made under subsection (f)(1) if the State adopts criteria for benefits or criteria for standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those required under Federal law and applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

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

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclu-

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

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under subsection (f)(1) for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

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

tions) under any other federally operated or financed health care insurance program. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following provisions of the Social Security Act shall apply to States under subsection (f)(1) in the same manner as they apply to a State under such title XIX:

(A) TITLE XIX PROVISIONS.—

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

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

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE XI PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

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

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

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

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

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

Amounts appropriated for a fiscal year under this subsection and not expended may be used in subsequent fiscal years to carry out this section.

SEC. 203. EFFECTIVE DATE.

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

TITLE III—DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN

SEC. 301. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

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

"SEC. 2111. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project under which up to 10 States (each referred to in this section as a 'participating State') that meet the conditions of paragraph (2) may provide, under its State child health plan (notwithstanding section 2102(b)(3)(C)) for a period of 5 years, for child health assistance in relation to family coverage described in subsection (d) for children who would be targeted low-income children but

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

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

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

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

''(3) QUALIFYING EMPLOYER DEFINED.—In this section, the term 'qualifying employer' means an employer that has a majority of its workforce composed of full-time workers with family incomes reasonably estimated by the employer (based on wage information available to the employer) at or below 200 percent of the poverty line. In applying the previous sentence, two part-time workers shall be treated as a single full-time worker.

''(b) FUNDING.—A demonstration project under this section in a participating State shall be funded, with respect to assistance provided to children described in subsection (a)(1), consistent with the following:

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

''(2) MINIMUM EMPLOYER CONTRIBUTION.—The qualifying employer involved shall be responsible for providing payment to the State child health plan in the State of at least 50 percent of the portion of the cost (as determined by the State) of the family coverage in which the employer is enrolling the family that exceeds the amount of the family contribution under paragraph (1) applied towards such coverage.

''(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—In no case shall the Federal financial participation under section 2105 with respect to a demonstration project under this section be made for

any portion of the costs of family coverage described in subsection (d) (including the costs of administration of such coverage) that are not attributable to children described in subsection (a)(1).

''(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

''(1) a State shall establish uniform rules of eligibility for families to participate; and

''(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

''(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.''.

TITLE IV—ACCESS TO HEALTH BENEFITS THROUGH REGIONAL STATE ARRANGEMENTS

SEC. 401. PROMOTING ACCESS THROUGH REGIONAL STATE ARRANGEMENTS UNDER A DEMONSTRATION PROJECT.

(a) IN GENERAL.—

(1) REGIONAL STATE ARRANGEMENTS.—Under this title the Secretary of Health and Human Services, in collaboration with the Secretary of Labor, shall facilitate the establishment of regional State arrangements (each in this title referred to as a ''regional State arrangement'') under which two or more States ban together in order to increase their purchasing pooling power and offer affordable health insurance to citizens of those States consistent with paragraph (2). Such arrangements shall include the following components:

(A) The appointment of a Benefits Administrator under subsection (b)

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

(C) The charging of premiums using a modified community-rated premiums under subsection (d).

(D) A requirement for individual health insurance coverage under subsection (e).

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

(F) Employer rule in funding health benefit plans under subsection (g).

(2) APPLICATION ON A DEMONSTRATION BASIS.—This title shall be implemented on a demonstration basis so that—

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

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

(3) COLLABORATIVE FEDERAL IMPLEMENTATION.—

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

(i) the Secretary of Labor shall be primarily responsible for implementation with respect to employees and dependents; and

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

sible for implementation for all other individuals.

(B) REFERENCE TO SECRETARY.—Except as otherwise provided, in this title, the term ''Secretary'' means the Secretary of Health and Human Services working in collaboration with the Secretary of Labor.

(4) REPORT.—The Secretary shall jointly submit to Congress a biannual report on the implementation of this title and shall include in such report recommendations regarding the expansion and extension of the program under this title.

(b) BENEFIT ADMINISTRATOR.—

(1) IN GENERAL.—Each regional State arrangement shall be administered by a Benefit Administrator who shall be responsible for the administration of this title under the arrangement.

(2) DISCLOSURE OF PERFORMANCE OF BENEFIT ADMINISTRATORS.—The Secretary shall make available to the public information on the relative administrative performance of each Benefit Administrator.

(c) STANDARD HEALTH BENEFIT PLANS.—

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

State, the Benefit Administrator shall, through a bidding process determined and administered by the Secretary, offer, directly or indirectly, three to five standard health benefit plans to all individuals, regardless of employment, who reside in a State covered by the arrangement.

(2) STANDARD HEALTH BENEFIT PLANS.—In this title, the term ''standard health benefit plan'' means a health benefits plan that meets standards relating to benefits recognized by the Secretary. The Secretary shall request the National Association of Insurance Commissioners or another appropriate entity to develop such standards for such plans in a manner consistent with the model for standards development used under section 1881 of the Social Security Act (42 U.S.C. 1395rr) for medicare supplemental policies. Such standards shall be designed to permit the offering of low-cost benefit options.

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

(1) IN GENERAL.—The premiums for the standard health benefit plans offered under a regional State arrangement within a defined service area (as identified under paragraph (2)) shall be established consistent with the following:

(A) All such plans in the area shall uniformly bear the cost of disease and injury.

(B) Except as otherwise provided in this paragraph, the premiums shall be uniform within such area for family coverage and for individual coverage for each plan in such area.

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

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

(E) Adjustments related to self-imposed lifestyle risks, such as smoking, alcohol consumption, and avoidance of personal risk, may be made.

(F) Premiums may be varied among standard health benefit plans based on efficiencies

generated by better administrator practices, including efficiencies derived from superior disease management, utilization management, case management, lifestyle management, ''pay-for-performance'' systems, and other innovative initiatives designed to lower costs, increase quality, and improve accountability.

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

(e) INDIVIDUAL COVERAGE MANDATE.—

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

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

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

(2) CERTIFICATION.—Each Benefit Administrator for a regional State arrangement shall develop a satisfactory method for certifying compliance with the provisions of individuals residing in the area covered by the arrangement with the requirement of paragraph (1).

(3) EXCEPTIONS.—The Secretary may establish exceptions to the requirement of paragraph (1) in appropriate cases, such as in the case of individuals who are financially unable to afford to pay the premiums required to enroll in a standard health benefit plan.

(4) UNINSURED INDIVIDUAL DEFINED.—In this subsection, the term ''uninsured individual'' means, with respect to a regional State arrangement, an individual who—

(A) resides in a State included in a regional State arrangement;

(B) is not enrolled for benefits under—

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

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

(C) does not have coverage that is otherwise found to be qualifying by the Secretary.

(f) SUBSIDIES FOR FINANCIALLY DISADVANTAGED PERSONS.—The Secretary shall establish a system of subsidies to assist in the payment of premiums and cost-sharing for individuals who are required under subsection (e) (but for paragraph (3)) to be covered under a standard health benefit plan but who are financially unable to afford to pay such premiums..

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

(1) IN GENERAL.—Nothing in this title shall prevent an employer from providing health benefits coverage to employees and their dependents through existing arrangements or through a standard health benefit plan offered through a regional State arrangement under this title.

(2) REQUIRED REGISTRATION WITH BENEFITS ADMINISTRATOR.—Each employer with employees residing in an area covered by a regional State arrangement shall register with the Benefits Administrator for such arrangement.

SEC. 402. TRANSPARENCY AND ACCOUNTABILITY FOR HEALTH BENEFIT PLANS.

(a) PLAN COMPARISONS.—The Secretary shall establish a method for making available, in comparative form, to health consumers, providers, employers, and health plans, how health benefit plans offered under this title compare to each other within a regional State arrangement.

(b) PROVIDER TRANSPARENCY AND ACCOUNTABILITY.—

(1) QUALITY STANDARDS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop definitions and standards for quality care in collaboration with providers, public and private-sector representatives, payers, and consumers.

(2) COVERAGE.—The quality standards developed under paragraph (1) shall cover both process and outcome measures and shall be applied to health care entities, including individual physicians, groups of physicians, hospitals, integrated systems, and, to the extent specified by the Secretary, an entire enterprise. Such standards shall be based on evidence-based medicine and shall be continuously updated and expanded.

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

(c) HEALTH PLAN TRANSPARENCY AND ACCOUNTABILITY.—

(1) ACCOUNTABILITY.—The Secretary shall develop standards to hold administrators of health benefit plans accountable for their claims administrative practices, including overhead costs, delayed claims payments, errors, lost claims, and aggressive denial of claims.

(2) DEVELOPMENT OF STANDARDS.—The Secretary shall develop such standards through a collaborative process between the public-sector and private-sector stakeholders to measure and make available to the public information on the performance of health benefit plan administrators during the period measured. Such information for each health benefit plan administrator shall include, for each health plan administered for each measurement period, the following:

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

keting support costs, and other similar expenses.

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

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

(D) The average out-of-pocket expense incurred by participants.

(E) Consumer assessments regarding plan administration.

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

(d) OVERSIGHT.—The Secretary shall have oversight responsibility to ensure that health benefit plans are administered properly.

TITLE V—AMENDMENTS RELATING TO PREEXISTING CONDITION EXCLUSION

SEC. 501. SHORT TITLE.

This Act may be cited as the ''Preexisting Condition Exclusion Patient Protection Act of 2008''.

SEC. 502. AMENDMENTS RELATING TO PREEXISTING CONDITION EXCLUSIONS UNDER GROUP HEALTH PLANS.

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking ''6-month period'' and inserting ''30-day period''.

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

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)) is amended by striking ''6-month period'' and inserting ''30-day period''.

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

months'', and by striking ''18 months'' and inserting ''9 months''.

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

(1) REDUCTION IN LOOK-BACK PERIOD.—Paragraph (1) of section 9801(a) of the Internal Revenue Code of 1986 (relating to limitation on preexisting condition exclusion period and crediting for periods of previous coverage) is amended by striking ''6-month period'' and inserting ''30-day period''.

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

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning after the end of the 12th calendar month following the date of the enactment of this Act.

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

lective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) 3 years after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendments made by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 503. AMENDMENTS RELATING TO PREEXISTING CONDITION EXCLUSIONS IN HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET.

(a) APPLICABILITY OF GROUP HEALTH INSURANCE LIMITATIONS ON IMPOSITION OF PREEXISTING CONDITION EXCLUSIONS.—

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

(A) by redesignating the second subsection (e) (relating to market requirements) and subsection (f) as subsections (f) and (g), respectively; and

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

''(h) APPLICATION OF GROUP HEALTH INSURANCE LIMITATIONS ON IMPOSITION OF PREEXISTING CONDITION EXCLUSIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), a health insurance issuer that provides individual health insurance coverage may not impose a preexisting condition exclusion (as defined in subsection (b)(1)(A) of section 2701) with respect to such coverage except to the extent that such exclusion could be imposed consistent with such section if such coverage were group health insurance coverage.

''(2) LIMITATION.—In the case of an individual who—

''(A) is enrolled in individual health insurance coverage;

''(B) during the period of such enrollment has a condition for which no medical advice, diagnosis, care, or treatment had been recommended or received as of the enrollment date; and

''(C) seeks to enroll under other individual health insurance coverage which provides benefits different from those provided under the coverage referred to in subparagraph (A) with respect to such condition,

the issuer of the individual health insurance coverage described in subparagraph (C) may impose a preexisting condition exclusion with respect to such condition and any benefits in addition to those provided under the coverage referred to in subparagraph (A), but such exclusion may not extend for a period of more than 3 months.''.

(2) ELIMINATION OF COBRA REQUIREMENT.—Subsection (b) of such section is amended—

(A) by adding ''and'' at the end of paragraph (2);

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

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

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

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

○