TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Effective Coverage for All Americans

[Note: Further revisions are needed to complete the work of integrating provisions into the existing HIPAA structure]

PART I—PROVISIONS APPLICABLE TO THE INDIVIDUAL AND GROUP MARKETS

SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";

(2) in section 2701 (42 U.S.C. 300gg)—

(A) by striking the section heading and subsection (a) and inserting the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "American Health Choices Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows: [to be supplied]

SEC. 2. DECLARATION OF RIGHTS.

(a) RIGHTS OF PATIENTS TO CHOOSE THEIR DOCTOR.—It is the right of patients to select the doctor of their choice.

(b) DOCTOR-PATIENT RELATIONSHIP.—A strong doctor-patient relationship is essential to the practice of medicine, and patients have a right to an effective doctor-patient relationship.

(c) HEALTH PROFESSIONALS SHOULD JUDGE WHAT IS BEST FOR THEIR PATIENTS.—Doctors, nurses, and other health professionals have the right to judge what is best for their patients.

(d) NO INTERFERENCE WITH THESE RIGHTS.—Nothing in the this Act or the amendments made by this Act interferes with the rights described in this section.

"SEC. 2705. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."; and

(2) by transferring such section so as to appear after the section 2704 as added by paragraph (3);

(3) by redesignating existing sections 2704 through 2707 as sections 2715 through 2718; and

(4) by amending the remainder of subpart 1 of such part to read as follows:

"Subpart 1—General Reform

"SEC. 2701. FAIR INSURANCE COVERAGE.

"(a) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or group market—

"(1) such rate shall vary only by—

"(A) family structure;

"(B) community rating area;

"(C) the actuarial value of the benefit;

"(D) age, except that such rate shall not vary by more than [2 to 1]; and

"(2) such rate shall not vary by health status-related factors, gender, class of business, claims experience, or any other factor not described in paragraph (1).

"(b) COMMUNITY RATING AREA.—[Taking into account the applicable recommendations of the National Association of Insurance Commissioners, the Secretary shall by regulation establish a minimum size for community rating areas for purposes of this section./A State shall define the size of a community rating area, provided that no such area is smaller than [an MSA?].]

"[Further conforming changes to section 2701 may be needed]

"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

"(a) ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

"(b) ENROLLMENT.—

"(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

"(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment period for qualifying life events (under section 125 of the Internal Revenue Code of 1986).

"(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

"[Further conforming changes to section 2702 may be needed]

"SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

"Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan, or the individual, as applicable.

"[Further conforming changes to section 2703 may be needed.]

"SEC. 2704. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary a report con-

cerning the percentage of total premium revenue that such coverage expends—

"(1) on reimbursement for clinical services provided to enrollees under such plan or coverage;

"(2) for activities that improve health care quality; and

"(3) on all other non-claims costs, including an explanation of the nature of such costs.

"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall provide an annual rebate to each enrollee under such plan or coverage on a pro rata basis in the amount by which the amount of premium revenue expended on activities described in subsection (a)(3) exceeds—

"(A) with respect to a health insurance issuer offering group insurance coverage, 20 percent, or such lower percentage as the Secretary may by regulation determine; or

"(B) with respect to a health insurance issuer offering individual insurance coverage, 25

percent, or such lower percentage as the Secretary may by regulation determine

"(c) DEFINITION.—In this section, the term 'activities to improve health care quality' means activities described in section 2705.

"(d) NOTIFICATION BY PLANS NOT PROVIDING MINIMUM QUALIFYING COVERAGE.—Not later than 1 year after the date on which the recommendation of the Council with respect to minimum qualifying coverage become effective under section 3103, each health plan that fails to provide such minimum qualifying coverage to enrollees shall notify such enrollees of such failure prior to any such enrollment restriction.

"(e) EFFECTIVE DATE.—This section shall take effect on the date of enactment of this section.

"SEC. 2706. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

"(1) Health status.

"(2) Medical condition (including both physical and mental illnesses).

"(3) Claims experience.

"(4) Receipt of health care.

"(5) Medical history.

"(6) Genetic information.

"(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

"(8) Disability.

"[Further conforming changes to section 2706 may be needed]

"SEC. 2707. ENSURING THE QUALITY OF CARE.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall develop and implement a reimbursement structure that provides incentives for—

"(1) the provision of high quality health care under the plan or coverage in a manner that includes—

"(A) the implementation of case management, care coordination, and chronic disease management activities for treatment or services under the plan or coverage;

"(B) the implementation of activities to reduce preventable hospital readmissions through discharge planning under the plan or coverage;

"(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

"(D) the implementation of wellness and health promotion activities;

"(E) child health measures under section 1139A of the Social Security Act; and

"(F) culturally and linguistically appropriate care, as defined by the Secretary; and

"(2) substantially reflects the payment policy of the Medicare program under title XVIII of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to any generally implemented incentive policy to promote high quality health care.

"(b) REGULATIONS.—Not later than [____] after the date of enactment of the American Health Choices Act, the Secretary shall promulgate regulations—

"(1) that define the term 'generally implemented' for purposes of subsection (a)(2); and

"(2) that require the expiration of a minimum period of time between the date on which a policy is generally implemented for purposes of subsection (a)(2) and the date on which such policy shall apply with respect to health insurance coverage offered in the individual or group market.

"SEC. 2708. COVERAGE OF PREVENTIVE HEALTH SERVICES.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements (other than minimal cost sharing in accordance with guidelines developed by the Secretary) for—

"(1) items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

"(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

"(3) with respect to infants, children and adolescents, preventive care and screenings provided for

in the comprehensive guidelines supported by the Health Resources and Services Administration.

"(b) SITES OF CARE.—Nothing in subsection (a) shall be construed to prohibit a group health plan or a health insurance issuer offering group or individual health insurance coverage from establishing conditions for coverage for the services described in subsection (a) that requires that such services be [performed by providers with appropriate expertise?].

"(c) INTERVAL.—

"(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the date on which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

"(2) MINIMUM.—The Secretary shall provide that the interval described in paragraph (1) is not less than [____].

"SEC. 2709. EXTENSION OF DEPENDENT COVERAGE.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependant coverage of chil-

dren shall make available such coverage for children who are not more than 26 years of age.

"(b) REGULATIONS.—The Secretary shall promulgate regulations to define the scope of the dependants to which coverage shall be made available under subsection (a).

"SEC. 2710. NO LIFETIME OR ANNUAL LIMITS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish lifetime or annual limits on benefits for any participant or beneficiary.".

PART II—PROVISION APPLICABLE TO THE GROUP MARKET

SEC. 121. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

"SEC. 2719. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group health insurance coverage may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any

full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee.

"(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a group health plan or health insurance issuer from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of a similarly situated employees with a higher hourly or annual compensation.".

(b) TECHNICAL AMENDMENTS.—Subpart 3 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-11 et seq.) is repealed.

PART III—OTHER PROVISIONS

SEC. 131. APPLICABILITY.

(a) EXCLUSION OF CERTAIN PLANS.—Section 2721 of the Public Health Service Act (42 U.S.C. 300gg-21) is amended—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking "1 through 3" and inserting "1 and 2"; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking "subparagraph (D)" and inserting "subparagraph (D) or (E)";

(ii) by striking "1 through 3" and inserting "1 and 2"; and

(iii) by adding at the end the following:

"(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.";

(3) in subsection (c), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group"; and

(4) in subsection (d)—

(A) in paragraph (1), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking "1 through 3 shall not apply to any group" and inserting "1

and 2 shall not apply to any individual coverage or any group"; and

(ii) in subparagraph (C), by inserting "or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer"; and

(C) in paragraph (3), by striking "any group" and inserting "any individual coverage or any group".

(b) ENFORCEMENT.—Section 2722(a) of the Public Health Service Act (42 U.S.C. 300gg-22(a)) is amended—

(1) in paragraph (1), by striking "the small or" and inserting "the individual, small, or"; and

(2) in paragraph (2), by inserting "or individual health insurance coverage" after "group health plans".

(c) PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-23(a)(1)) is amended by striking "group" and inserting "individual or group".

(d) NO CHANGES TO EXISTING POLICIES.—

(1) OPTION TO RETAIN CURRENT INSURANCE COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was

enrolled prior to the effective date of this title, this subtitle (and the amendments made by this subtitle) shall not apply to such plan or coverage.

(2) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled prior to the effective date of this title and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan coverage.

(3) NO ADDITIONAL BENEFIT.—Paragraph (1) shall only apply to individuals described in such paragraph and the family members of such individuals (as provided for in paragraph (2)).

SEC. 132. LIMITATION ON SELF-INSURING.

Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 121, is further amended by adding at the end the following:

"SEC. 2720. LIMITATION ON SELF-INSURING.

"A group health plan that has 250 or fewer members of the group shall not self-insure such group. The Secretary shall establish guidelines for determining the number of members in a group for purposes of this section.".

SEC. 133. CONFORMING AMENDMENTS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following: [Note, additional conforming changes to ERISA could go here.]

"SEC. 735. APPLICATION OF CERTAIN SUPERCEDING PROVISIONS.

"Except as otherwise provided in part A title XXVII of the Public Health Service Act, effective beginning January 1, 20____, any provision of this part that conflicts with a provisions of such part A shall be superceded by such provision of such part A.".

(b) INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter C of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following: [Note, additional conforming changes to the IRC could go here.]

"SEC. 9835. APPLICATION OF CERTAIN SUPERCEDING PROVISIONS.

"Except as otherwise provided in part A of title XXVII of the Public Health Service Act, effective beginning January 1, 20____, any provision of this subchapter

that conflicts with a provisions of such part A shall be superceded by such provision of such part A.".

(2) CLERICAL AMENDMENT.—The table of sections for subchapter C of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 9835. Application of certain superceding provisions.".

SEC. 134. MISCELLANEOUS.

(a) IN GENERAL.—Except as otherwise provided in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective with respect to a State on the earlier of—

(1) the date that such State enacts or modifies their State laws to conform such laws to the requirements of this subtitle (and amendments); or

(2) the date that is [__] years after the date of enactment of this Act.

(b) IMMEDIATE APPLICABILITY.—Section 2704 of the Public Health Service Act (as added by section 101) shall become effective on the date of enactment of this section.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment

of this Act, the provisions of this subtitle (and the amendments made by this subtitle) shall not apply to plan years beginning before the later of—

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

(2) the date that is after the end of the 12th calendar month following the date of enactment of this Act.

For purposes of paragraph (1), any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle (or amendments) shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Available Coverage for All Americans

SEC. 141. BUILDING ON THE SUCCESS OF THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM SO ALL AMERICANS HAVE AFFORDABLE HEALTH BENEFIT CHOICES.

(a) FINDINGS.—The Senate finds that—

(1) the Federal employees health benefits program under chapter 89 of title 5, United States Code, allows Members of Congress to have affordable choices among competing health benefit plans;

(2) the Federal employees health benefits program ensures that the health benefit plans available to Members of Congress meet minimum standards of quality and effectiveness;

(3) millions of Americans have no meaningful choice in health benefits, because health benefit plans are either unavailable or unaffordable; and

(4) all Americans should have the same kinds of meaningful choices of health benefit plans that Members of Congress, as Federal employees, enjoy through the Federal employees health benefits program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Congress should establish a means for all Americans to enjoy affordable choices in health benefit plans, in the same manner that Members of Congress have such choices through the Federal employees health benefits program.

SEC. 142. AFFORDABLE HEALTH CHOICES FOR ALL AMERICANS.

(a) PURPOSE.—It is the purpose of this section to facilitate the establishment of Affordable Health Benefit Gateways in each State, with appropriate flexibility for States in establishing and administering the Gateways.

(b) AMERICAN HEALTH BENEFIT GATEWAYS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—AFFORDABLE HEALTH CHOICES FOR ALL AMERICANS

"Subtitle A—Affordable Choices

"SEC. 3101. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

"(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT GATEWAYS.—

"(1) PLANNING AND ESTABLISHMENT GRANTS.—Not later than 60 days after the date of enactment of this section, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

"(2) AMOUNT SPECIFIED.—

"(A) TOTAL DETERMINED.—For each fiscal year, the Secretary shall determine the total

amount that the Secretary will make available for grants under this subsection.

"(B) STATE AMOUNT.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary under which each State shall receives an award in an amount that is based on the following two components:

"(i) A minimum amount for each State.

"(ii) An additional amount based on population.

"(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Gateway, as described in subsection (b).

"(4) RENEWABILITY OF GRANT.—

"(A) IN GENERAL.—The Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

"(i) is making progress, as determined by the Secretary, toward—

"(I) establishing a Gateway; and

"(II) implementing the reforms described subtitle A of title I of the American Health Choices Act; and

"(ii) is meeting such other benchmarks as the Secretary may establish.

"(B) LIMITATION.—If a State is an establishing State or a participating State (as defined in section ____), such State shall not be eligible for a grant renewal under subparagraph (A) as of the second fiscal year following the date on which such State was deemed to be an establishing State or a participating State.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection in each of fiscal years 2009 through [20____].

"(b) AMERICAN HEALTH BENEFIT GATEWAYS.—An American Health Benefit Gateway (referred to in this section as a 'Gateway') means a mechanism that—

"(1) facilitates the purchase of health insurance coverage and related insurance products through the Gateway at an affordable price by qualified individuals and qualified employer groups; and

"(2) meets the requirements of subsection (c).

"(c) REQUIREMENTS.—

"(1) VOLUNTARY NATURE OF GATEWAY.—

"(A) CHOICE TO ENROLL OR NOT TO ENROLL.—A qualified individual shall have the choice to enroll or not to enroll in a qualified health plan or to participate in a Gateway.

"(B) PROHIBITION ON COMPELLED ENROLLMENT.—No individual shall be compelled to enroll in a qualified health plan or to participate in a Gateway.

"(2) ESTABLISHMENT.—A Gateway shall be established by—

"(A) a State, in the case of an establishing State (as described in section 3104); or

"(B) the Secretary, in the case of a participating State (as described in section 3104).

"(3) OFFERING OF COVERAGE.—

"(A) IN GENERAL.—A Gateway shall make available qualified health plans to qualified individuals and qualified employers.

"(B) INCLUSION.—In making available coverage pursuant to subparagraph (A), a Gateway shall include 1 or more affordable access plans.

"(C) LIMITATION.—A Gateway may not make available any health plan or other health

insurance coverage that is not a qualified health plan.

"(D) ALLOWANCE TO OFFER.—A Gateway may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 3103(h).

"(4) FUNCTIONS.—A Gateway shall, at a minimum—

"(A) establish procedures for the certification of qualified health plans for the offering of such plans through the Gateway;

"(B) carry out the activities described in paragraph (7);

"(C) develop and make available tools to allow consumers to receive accurate information on—

"(i) expected premiums and out of pocket expenses;

"(ii) the availability of in-network and out-of-network providers;

"(iii) the costs of any surcharge assessed under paragraph (5); and

"(iv) such other matters relating to consumer costs and expected experience

under the plan as a Gateway may determine necessary;

"(D) utilize the administrative simplification measures and standards developed under section [____];

"(E) enter into agreements, to the extent determined appropriate by the Gateway, with navigators, as described in section 3105;

"(F) facilitate the purchase of coverage for long-term services and supports; and

"(G) collect, analyze, and respond to complaints and concerns from enrollees regarding coverage provided through the Gateway.

"(5) SURCHARGES.—

"(A) IN GENERAL.—A Gateway may assess a surcharge on all health insurance issuers offering qualified health plans through the Gateway to pay for the administrative and operational expenses of the Gateway.

"(B) LIMITATION.—A surcharge described in subparagraph (A) may not exceed [__] percent of the premiums collected by a qualified health plan.

"(6) RISK ADJUSTMENT PAYMENT.—

"(A) ESTABLISHING STATES.—

"(i) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in section 3104) shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

"(ii) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in section 3104) shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all en-

rollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

"(B) CRITERIA AND METHODS.—The Secretary, in consultation with States shall establish criteria and methods to be used in carrying out the risk adjustment activities under this paragraph. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part D of title XVIII of the Social Security Act.

"(C) RETROSPECTIVE ADJUSTMENT.—The criteria and methods developed under subparagraph (B) shall provide for payments under subparagraph (A) to be calculated on a retrospective basis.

"(7) FACILITATING ENROLLMENT.—

"(A) IN GENERAL.—A Gateway shall implement policies and procedures to—

"(i) facilitate the identification of individuals who lack qualifying coverage; and

"(ii) assist such individuals in enrolling in—

"(I) a qualified health plan that is affordable and available to such individual, if such individual is a qualified individual;

"(II) the medicaid program under title XIX of the Social Security Act, if such individual is eligible for such program;

"(III) the CHIP program under title XXI of the Social Security Act, if such individual is eligible for such program; or

"(IV) other Federal health care programs including low-income cost-sharing programs provided under titles XVIII and XIX of the Social Security Act.

"(B) CHOICE FOR INDIVIDUALS ELIGIBLE FOR CHIP.—A qualified individual who is eligible for the Children's Health Insurance Program under title XXI of the Social Security Act may elect to enroll in such program or in a qualified health plan. Where such individual is a minor child, such election shall be made by the parent or guardian of such child.

"(C) OVERSIGHT.—The Secretary shall oversee the implementation of subparagraph (A)(iii) to ensure that individuals are directed to enroll in the program most appropriate under such subparagraph for each such individual.

"(D) ACCESSIBILITY OF MATERIALS.—Any materials used by a Gateway to carry out this paragraph shall be provided in a form and manner calculated to be understood by individuals who may apply to be enrollees in a qualified health plan, taking into account potential language barriers and disabilities of individuals.

"(8) CONSULTATION.—

"(A) IN GENERAL.—A Gateway shall consult with stakeholders relevant to carrying out the activities under this subsection, including—

"(i) consumers who are enrollees in qualified health plans;

"(ii) individuals with experience in facilitating enrollment in plans described in section [____];

"(iii) State Medicaid offices; and

"(iv) advocates for enrolling hard to reach populations.

"(B) PROCESS.—[Note that someone wanted a process here]

"(9) LINKAGE.—A Gateway shall (through, to the extent practicable, the use of information technology) implement procedures and policies to facilitate the enrollment of individuals, where eligible, in other public programs, such as the Temporary Assistance for Needy Families program established under part A of title IV of the Social Security Act, and the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008, or other Federal program identified by the Secretary..

"(10) STANDARDS AND PROTOCOLS.—The Secretary, in consultation with the Office of the National Coordinator for Health Information Technology, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs. The Secretary shall facilitate enrollment of individuals in such programs through methods which shall include—

"(A) electronic matching against existing Federal and State data to serve as evidence of

eligibility and in lieu of paper-based documentation;

"(B) capability for individuals to apply, recertify, and manage eligibility information online; and

"(C) other functionalities necessary to provide eligible individuals with a streamlined enrollment process.

"(11) NOTIFICATION.—With respect to the standards and protocols developed under subsection (11), the Secretary—

"(A) shall notify States of such standards and protocols; and

"(B) may require, as a condition of receiving Federal funds, that States or other entities incorporate such standards and protocols into such investments.

"(d) CERTIFICATION.—

"(1) HEALTH PLANS.—A Gateway may certify a health plan if—

"(A) such health plan meets the requirements of section [____]; and

"(B) the Gateway determines that making available such health plan through such Gateway is in the interests of qualified individuals

and qualified employers in the States or States in which such Gateway operates.

"(2) AFFORDABLE ACCESS PLANS.—An affordable access plan is deemed to have a certification under paragraph (1) with respect to each Gateway.

"(e) GUIDANCE.—The Secretary shall develop guidance that may be used by a Gateway to carry out the activities described in subsection (c).

"(f) FLEXIBILITY.—

"(1) REGIONAL OR OTHER INTERSTATE GATEWAYS.—A Gateway may operate in more than one State, provided that each State in which such Gateway operates permits such operation.

"(2) SUBSIDIARY GATEWAYS.—A State may establish one or more subsidiary Gateway, provided that—

"(A) each such Gateway serves a geographically distinct area; and

"(B) the area served by each such Gateway is at least as large as a community rating area described in [section ____].

"(g) PORTALS TO STATE GATEWAY.—The Secretary shall establish a mechanism, including an Internet website, through which a resident of any State may identify any Gateway operating in such State.

"(h) CHOICE.—

"(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

"(2) QUALIFIED EMPLOYERS.—A qualified employer may choose to offer to employees any qualified health plan.

"(3) SELF-EMPLOYED INDIVIDUALS.—

"(A) DEEMING.—An individual who is self-employed (as defined for purposes of the Internal Revenue Code of 1986) shall be deemed to be a qualified employer unless such individual notifies the applicable Gateway that such individual elects to be considered a qualified individual.

"(B) ELIGIBILITY.—In the case of a self-employed individual making the election described in subparagraph (A)—

"(i) the income of such individual for purposes of section 3111 shall be deemed to be the total business income of such individual as described in [IRC definition to be supplied]; and

"(ii) premium payments made by such individual to a qualified health plan shall

not be treated as income for purposes of [insert appropriate reference to Internal Revenue Code of 1986].

"(i) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

"(j) SINGLE RISK POOL.—A health insurance issuer shall consider each enrollee in [_____] to be a member of a single risk pool.

"(k) EMPOWERING CONSUMER CHOICE.—

"(1) CONTINUED OPERATION OF MARKET OUTSIDE GATEWAYS.—Nothing in this title shall be construed to prohibit a health insurance issuer from offering a health insurance policy or providing coverage under such policy to a qualified individual where such policy is not a qualified health plan.

"(2) CONSUMER CHOICE OF PLAN.—Nothing in this title shall be construed to prohibit a qualified individual from enrolling in a health insurance plan where such plan is not a qualified health plan.

"(3) CONTINUED OPERATED OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the oper-

ation of any requirement under State law with respect to any policy or plan that is not a qualified health plan to offer benefits required under State law.

"(l) REGULATIONS.—The Secretary shall issue regulations with respect to qualified health plans regarding at least the following:

"(1) Marketing practices.

"(2) Methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice.

"(3) Network adequacy.

"[Note: The following subsection is a placeholder; more discussion is needed regarding State and Federal roles.]

"(m) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law regarding market conduct or related consumer protections.

"(n) RESPONSIBILITY OF THE SECRETARY TO FACILITATE ENROLLMENT.—

"(1) ENROLLMENT.—The Secretary shall implement policies and procedures to—

"(A) facilitate the identification of individuals who lack qualifying coverage;

"(B) assist in the enrollment of an individual identified under subparagraph (A) in a qualified health plan that is affordable and available to such individual if such individual is a qualified individual;

"(C) facilitate enrollment in health plans offered through a Gateway through existing programs supported or administered by the Federal government, where appropriate;

"(D) facilitate the enhanced use of electronic enrollment, including overseeing the establishment of Federal standards for computer-based screening and enrollment, including electronic signature requirements;

"(E) provide grants to enhance community-based enrollment to—

"(i) States to assist such States in—

"(I) contracting with qualified technology vendors to develop electronic enrollment software systems;

"(II) establishing Statewide helplines for enrollment assistance and referrals; and

"(III) establishing public education campaigns through grants to

States and qualifying organizations to design and implement public education campaigns targeting uninsured and traditionally underserved communities; and

"(ii) community-based organizations for infrastructure and training to establish electronic assistance programs.

"(2) VOLUNTARY CERTIFICATION.—

"(A) VOLUNTARY REQUESTS.—A health plan or health insurance issuer may request that the Secretary certify that such health plan is a qualified health plan.

"(B) METHODS.—The Secretary may establish common processes for providing the certifications described in subparagraph (A).

"(C) FEES.—The Secretary may charge a reasonable fee for conducting providing a certification described in subparagraph (A).

"(o) QUALITY IMPROVEMENT.—

"(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, [20____] a qualified health plan may contract with—

"(A) a hospital with greater than [____] beds only if such hospital—

"(i) utilizes a patient safety evaluation system as described in part C of title IX; and

"(ii) implements a mechanism to ensure that each patient receives counseling and comprehensive discharge planning that includes an after-care plan by an appropriate health care professional; or

"(B) a health care provider if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

"(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

"SEC. 3102. FINANCIAL INTEGRITY.

"(a) ACCOUNTING FOR EXPENDITURES.—

"(1) IN GENERAL.—A State shall keep an accurate accounting of all activities, receipts, and expenditures of any Gateway operating in such State and shall annually submit to the Secretary a report concerning such accountings.

"(2) INVESTIGATIONS.—The Secretary may investigate the affairs of a Gateway, may examine the properties and records of a Gateway, and may re-

quire periodical reports in relation to activities undertaken by a Gateway. A Gateway shall fully cooperate in any investigation conducted under this paragraph.

"(3) AUDITS.—A Gateway shall be subject to annual audits by the Secretary.

"(4) PATTERN OF ABUSE.—If the Secretary determines that a Gateway or a State has engaged in repeated acts of serious misconduct with respect to compliance with, or carrying out activities required, under this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

"(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall implement any measure or procedure that—

"(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

"(B) the Secretary has authority for under this title or any other Act;

"(b) GAO OVERSIGHT.—Not later than [_____], the Comptroller General shall conduct an ongoing study of Gateway activities and the enrollees in qualified health plans offered through Gateways. Such study shall review—

"(1) the operations and administration of Gateways, including surveys and reports of qualified health plans offered through Gateways and on the experience of such plans (including data on enrollees in Gateways and individuals purchasing health insurance coverage outside of Gateways), the expenses of Gateways, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Gateways meets their goals;

"(2) any significant observations regarding the utilization and adoption of Gateways; and

"(3) where appropriate, recommendations for improvements in the operations or policies of Gateways.

"SEC. 3103. SEEKING THE BEST MEDICAL ADVICE.

"(a) SEEKING THE BEST MEDICAL ADVICE.—Secretary, in consultation with medical experts at the Na-

tional Institutes of Health, the Centers for Disease Control and Prevention, and other centers of excellence, shall—

"(1) establish a council to be known as the 'Medical Advisory Council' (referred to in this section as the 'Council') to make recommendations to the Secretary on the matters described in subsections (h) and (i); or

"(2) contract with the Institute of Medicine of the National Academies of Science to establish the Council described in paragraph (1).

"(b) COMPOSITION.—

"(1) IN GENERAL.—The Council shall be composed of members with appropriate expertise in order to carry out subsections (h) and (i).

"(2) TERMS.—Each member appointed to the Council shall serve for a term of [____] years, except that an individual appointed to fill a vacancy on the Council shall serve for the unexpired term of the vacancy for which such individual is appointed. A member may be reappointed to the Council.

"(c) ADMINISTRATIVE PROVISIONS.—

"(1) QUORUM.—A majority of the members of the Council shall constitute a quorum for purposes of conducting business, and the affirmative vote of

a majority of members shall be necessary and sufficient for any action taken. No vacancy in the membership of the Council shall impair the right of a quorum to exercise all the rights and duties of the Council.

"(2) COMPENSATION AND EXPENSES.—Members of the Council shall serve without compensation, except that while serving away from home and the member's regular place of business, such a member may be allowed travel expenses, as authorized by the Chairperson of the Council.

"(3) STAFF, ETC..—The Council shall have the authority to employ such staff as may be necessary to carry out its duties under this section.

"(4) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Council without reimbursement. The detail of the employee shall be without interruption or loss of civil service status or privilege.

"(5) HEARINGS.—The Council may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Council considers advisable to carry out this title.

"(d) SUBMISSION OF REPORTS.—Not later than [_____] after the date of enactment of this title, and annually thereafter, the Council shall submit to the Secretary a report containing the recommendations described in subsection (a).

"(e) REVIEW OF REPORTS BY SECRETARY.—

"(1) SCIENTIFIC AND MEDICAL VALIDITY.—Not later than 30 days after receiving a report under subsection (d), the Secretary, in consultation with medical experts at the National Institutes of Health, the Centers for Disease Control and Prevention, and other centers of excellence, shall review such report for scientific and medical validity.

"(2) REVISION REQUESTED.—If the Secretary determines that any recommendation contained in a report received under subsection (d) is not scientifically or medically valid, the Secretary may request revisions to such report.

"(3) REVISED REPORT.—Not later than 30 days after the receipt of a request for revisions from the Secretary, as described in paragraph (2), the Council shall submit a report which may contain modifications to the recommendations made by the Council in response to such request.

"(f) SUBMISSION OF REPORT TO CONGRESS.—Not later than [____] days after receipt of a report as described in subsection (e)(1)(B) or subsection (e)(3), the Secretary shall formally submit such report to—

"(1) the Committee on Education and Labor, the Committee on Energy and Commerce, and the Committee on Ways and Means of the House Representatives; and

"(2) the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate.

"(g) CONGRESSIONAL REVIEW.—

"(1) RESOLUTION OF DISAPPROVAL.—For plan years beginning in the year described in paragraph (3), the recommendations contained in a report submitted under subsection (f) shall be considered to be applicable unless, within [____] calendar days after the date on which Congress receives such report, there is enacted into law a joint resolution disapproving such report in its entirety.

"(2) CONTENTS.—For the purpose of this section, the term 'joint resolution' means only a joint resolution—

"(A) that is introduced not later than [____] calendar days after the date on which

the report referred to in subsection (f) are received by Congress;

"(B) which does not have a preamble;

"(C) the title of which is as follows: [insert title language (Joint resolution relating to the disapproval of _____)]; and

"(D) the matter after the resolving clause of which is as follows: 'That Congress disapproves the recommendations submitted by the _____'.

"(3) YEAR DESCRIBED.—

"(A) TRANSMISSION BEFORE [DATE].—If a report is submitted to Congress under subsection (f) not later than [date], then the year described in this paragraph is the year following the year in which the report is submitted.

"(B) TRANSMISSION AFTER [DATE].—If the report is submitted to Congress under subsection (f) after [date], then the year described in this paragraph is the second year following the year in which the report is transmitted.

"(4) EFFECT OF DISAPPROVAL.—

"(A) GENERAL RULE.—If Congress disapproves a report submitted under subsection (f), then the recommendations contained in the

most previous report that was not disapproved under this subsection shall continue to apply.

"(B) DISAPPROVAL OF INITIAL REPORT.—If Congress disapproves the initial report submitted under subsection (f) in accordance with this subsection, the Secretary shall submit a report directly to Congress (and this section shall apply to such report).

"(h) ELEMENTS OF REPORT.—The report of the Council described in subsection (d) shall contain recommendations on at least the following:

"(1) The schedule of items and services (including the amount, duration, and scope of such items and services) that constitute the essential health care benefits eligible for credits under section 3111, where such schedule shall include items and services in at least the following general categories:

"(A) Ambulatory patient services.

"(B) Emergency services.

"(C) Hospitalization.

"(D) Maternity and newborn care.

"(E) Medical and surgical care.

"(F) Mental health and substance abuse services.

"(G) Prescription drugs.

"(H) Rehabilitative, habilitative, and laboratory services.

"(I) Preventive and wellness services.

"(J) Pediatric services.

"(2) The criteria that coverage must meet to be considered minimum qualifying coverage.

"(3) The conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels.

"(i) REQUIRED ELEMENTS FOR CONSIDERATION.—

"(1) ESSENTIAL BENEFITS.—In issuing recommendations on the matter described in subsection (h)(1), the Council shall—

"(A) ensure that recommendations on the matter described in subsection (h)(1) reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category; and

"(B) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

"(2) MINIMUM QUALIFYING COVERAGE.—In considering the matter described in subsection (h)(2), the Council—

"(A) shall—

"(i) exclude from meeting such criteria any coverage that—

"(I) provides reimbursement for the treatment or mitigation of—

"(aa) a single disease or condition; or

"(bb) an unreasonably limited set of diseases or conditions; or

"(II) has an out of pocket limit that exceeds the amount described in section 223 of the Internal Revenue Code of 1986 for the year involved; and

"(ii) establish such criteria (taking into account the requirements established under clause (i)) in a manner that results in the least practicable disruption of the health care marketplace, consistent with the goals and activities under this title; and

"(B) may provide for the application of different criteria with respect to young adults.

"(3) PROHIBITING DISCRIMINATORY BENEFIT DESIGN.—[Cross reference from part D?]

"(j) DEFINITIONS.—In this title:

"(1) QUALIFYING COVERAGE.—The term 'qualifying coverage' means—

"(A) a group health plan or health insurance coverage—

"(i) that an individual is enrolled in on the date of enactment of this title; or

"(ii) that is described in clause (i) and that is renewed by an enrollee;

"(B) a group health plan or health insurance coverage that—

"(i) is not described in subparagraph (A); and

"(ii) meets or exceeds the criteria for minimum qualifying coverage (as defined in subsection (d));

"(C) Medicare coverage under parts A and B of title XVIII of the Social Security Act or under part C of such title;

"(D) Medicaid coverage under a State plan under title XIX of the Social Security Act, other than coverage consisting solely of benefits

under section 1928 of such Act; [may need additional elements listed]

"(E) coverage under the SCHIP program under title XXI of the Social Security Act;

"(F) coverage under the TRICARE program under chapter 55 of title 10, United States Code;

"(G) coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary to be not less than the coverage provided under a qualified health plan, based on the individual's priority for services as provided under section 1705(a) of such title;

"(H) coverage under the Federal employees health benefits program under chapter 89 of title 5, United States Code;

"(I) a medical care program of the Indian Health Service or of a tribal organization;

"(J) a State health benefits high risk pool;

"(K) a health benefit plan under section 2504(e) of title 22, United States Code; or

"(L) coverage under a qualified health plan.

"(2) RELIGIOUS EXEMPTION.—For purposes of this section, individual shall be deemed to have qualifying coverage if such individual is an individual described in section 1402(e) and (g) of the Internal Revenue Code of 1986.

"SEC. 3104. ALLOWING STATE FLEXIBILITY.

"(a) OPTIONAL STATE ESTABLISHMENT OF GATEWAY.—During the [__]-year period following the date of enactment of this section, a State may—

"(1)(A) establish a Gateway (as defined for purposes of section 3101);

"(B) adopt the insurance reform provisions as provided for in title [fair insurance title]; and

"(C) agree to make employers who are State or local governments subject to section 3113 and 3114.

"(2)(A) request that the Secretary operate (for a minimum period of 5 years) a Gateway in such State;

"(B) adopt the insurance reform provisions as provided for in subtitle A of title I of the American Health Choices Act; and

"(C) agree to make employers who are state or local governments subject to section 3113 and 3114; or

"(3) elect not to take the actions described in paragraph (1) or (2).

"(b) ESTABLISHING STATES.—

"(1) IN GENERAL.—If the Secretary determines that a State has taken the actions described in subsection (a)(1), any resident of that State who is an eligible individual shall be eligible for credits under section [_____] beginning on the date that is [____] days after the date of such determination.

"(2) CONTINUED REVIEW.—The Secretary shall establish procedures to ensure continued review by the Secretary of the compliance of a State with the requirements of subsection (a). If the Secretary determines that a State has failed to maintain compliance with such requirements, the Secretary may revoke the determination under subparagraph (A).

"(3) DEEMING.—A State that is the subject of a positive determination by the Secretary under paragraph (1) (unless such determination is revoked under paragraph (2)) shall be deemed to be an 'establishing State' beginning on the date that is [_____] days after the date of such determination.

"(c) REQUEST FOR THE SECRETARY TO ESTABLISH A GATEWAY.—

"(1) IN GENERAL.—In the case of a State that makes the request described in subsection (a)(2), the Secretary shall determine whether the State has enacted and has in effect the insurance reforms provided for in subtitle A of title I of the American Health Choices Act.

"(2) OPERATION OF GATEWAY.—

"(A) POSITIVE DETERMINATION.—If the Secretary determines that the State has enacted and has in effect the insurance reforms described in paragraph (1), the Secretary shall establish a Gateway in such State as soon as practicable after making such determination.

"(B) NEGATIVE DETERMINATION.—If the Secretary determines that the State has not enacted or does not have in effect the insurance reforms described in paragraph (1), the Secretary shall establish a Gateway in such State as soon as practicable after the Secretary determines that such State has enacted such reforms.

"(3) PARTICIPATING STATE.—The State shall be deemed to be a 'participating State' on the date on which the Gateway established by the Secretary is in effect in such State.

"(4) ELIGIBILITY.—Any resident of a State described in paragraph (3) who is an eligible individual shall be eligible for credits under section 3111 beginning on the date that is [____] days after the date on which such Gateway is established in such State.

"(d) FEDERAL FALLBACK IN THE CASE OF STATES THAT REFUSE TO IMPROVE HEALTH CARE COVERAGE.—

"(1) IN GENERAL.—Upon the expiration of the [__]-year period following the date of enactment of this section, in the case of a State that is not otherwise a participating State or an establishing State—

"(A) the Secretary shall establish and operate a Gateway in such State;

"(B) the insurance reform provisions provided for in subtitle A of title I of the American Health Choices Act shall become effective in such State, notwithstanding any contrary provision of State law;

"(C) the State shall be deemed to be a 'participating State'; and

"(D) the residents of that State who are eligible individuals shall be eligible for credits under section 3111 beginning on the date that is [____] days after the date on which such Gateway is established, if the State agrees to

make employers who are State or local governments subject to section 3113 and 3114).

"(2) ELIGIBILITY OF INDIVIDUALS FOR CREDITS.—With respect to a State that makes the election described in subsection (a)(3), the residents of such State shall not be eligible for credits under section 3111 until such State becomes a participating State under paragraph (1).

"SEC. 3105. NAVIGATORS.

"(a) IN GENERAL.—The Secretary shall award grants to establishing States to enable the Gateway or Gateways in such States to enter into agreements with private and public entities under which such entities will serve as navigators in accordance with this section.

"(b) ELIGIBILITY.—

"(1) IN GENERAL.—To be eligible to enter into an agreement under subsection (a), an entity shall demonstrate that the entity has existing relationships with, or could readily establish relationships with, employers and employees, and self-employed individuals, likely to be eligible to participate in the program under this title.

"(2) TYPES.—Entities described in paragraph (1) may include trade, industry and professional associations, commercial fishing industry organiza-

tions, ranching and farming organizations, chambers of commerce, unions, small business development centers, and other entities that the Secretary determines to be capable of carrying out the duties described in subsection (c).

"(c) DUTIES.—An entity that serves as a navigator under an agreement under subsection (a) shall—

"(1) conduct public education activities to raise awareness of the program under this title;

"(2) distribute fair and impartial information concerning enrollment in an the availability of credits for qualified health plans;

"(3) assist with enrollment in a qualified health plan; and

"(4) provide information in a manner determined by the Secretary to be culturally and linguistically appropriate to the needs of the population served by the Gateway.

"(d) STANDARDS.—

"(1) IN GENERAL.—The Secretary shall establish standards for navigators under this section, including provisions to avoid conflicts of interest. Under such standards, a navigator may not—

"(A) be a health insurance issuer; or

"(B) receive any consideration directly or indirectly from any health insurance issuer in connection with the participation of any employer in the program under this title or the enrollment of any eligible employee in health insurance coverage under this title.

"(2) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop guidelines regarding the duties described in subsection (c).".

(c) REQUIREMENT FOR MEDICARE PROVIDERS TO ACCEPT AMOUNT OF PAYMENT UNDER AFFORDABLE ACCESS PLAN.—

(1) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by striking the period at the end and inserting ", and"; and

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

"(W) to accept as payment in full for an item or service furnished to a qualified individual (as defined in section 3100 of the Public

Health Service Act) under an affordable access plan (as defined in such section) the amount of payment for the item or service described under such section.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to agreements entered into or renewed on or after [to be supplied].

(d) MEDICAID STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (72), by striking "and" after the semicolon;

(B) in paragraph (73), by striking the period at the end and inserting "; and"; and

(C) by inserting after paragraph (73), the following:

"(74) that, in the case of an individual who applies for medical assistance under the State plan or for child health assistance or other health benefits coverage under a State child health plan under title XXI, and who is determined to not be eligible for assistance under either such plan, the State shall establish procedures for—

"(A) advising the individual of their options for coverage under a qualified health plan (as defined in section [31__] of the Public Health Service Act);

"(B) determining, in accordance with criteria established under section [____] of the Public Health Service Act, whether the individual is eligible for credits under section 3111 of such Act for coverage under a qualified health plan and if so, the amount of such credits; and

"(C) submitting to a qualified health plan selected by the individual the information necessary for the plan to enroll the individual.".

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on [_____].

SEC. 143. KEY NATIONAL INDICATORS.

[To be supplied]

Subtitle C—Affordable Coverage for All Americans

SEC. 151. SUPPORT FOR AFFORDABLE HEALTH COVERAGE.

(a) IN GENERAL.—Title XXXI of the Public Health Service Act, as added by section 142(a), is amended by inserting after subtitle A the following:

"Subtitle B—Making Coverage Affordable

"SEC. 3111. SUPPORT FOR AFFORDABLE HEALTH COVERAGE.

"(a) LEVELS OF COST SHARING.—

"(1) IN GENERAL.—The Secretary shall establish at least the following levels of cost sharing applicable to qualified health plans:

"(A) A level of benefit that—

"(i) provides for an actuarial value such that the cost sharing applicable to an enrollee of such plan is between [____] and [____] percent of the value of the benefit provided (as determined by the Secretary); and

"(ii) provides for a limit on out of pocket expenditures that is between [____] and [____] percent of the income of an individual with a family income that does not exceed [____] percent of the Federal poverty line for a family of the size involved.

"(B) A level of benefit that—

"(i) provides for an actuarial value such that the cost sharing applicable to an

enrollee of such plan is between [____] and [____] percent of the value of the benefit provided; and

"(ii) provides for a limit on out of pocket expenditures that is between [____] and [____] percent of the income of an individual with a family income that exceeds [____] percent, but not [____] percent, of the Federal poverty line for a family of the size involved.

"(C) A level of benefit that—

"(i) provides for an actuarial value such that the cost sharing applicable to an enrollee of such plan is between [____] and [____] percent of the value of the benefit provided (as determined by the Secretary); and

"(ii) provides for a limit on out of pocket expenditures that is between [____] and [____] percent of the income of an individual with a family income that exceeds [____] percent, but does not exceed [____] percent, of the Federal poverty line for a family of the size involved (as determined by the Secretary).

"(2) SELECTION OF VALUES WITHIN A RANGE.—The Secretary shall determine—

"(A) the level of cost sharing applicable to plans at the level described in subparagraphs (A), (B), and (C) of paragraph (1) within the range specified in clause (i) of each such subparagraph, respectively; and

"(B) the limit on out of pocket expenditures applicable to plans at the level described in subparagraphs (A), (B), and (C) of paragraph (1), within the range specified in clause (ii) of each such subparagraph, respectively.

"(3) OUT OF POCKET.—For purposes of paragraph (1), the term 'out of pocket' shall include all expenditures for covered benefits (as provided for with respect to high deductible health plans under section 223(d)(2) of the Internal Revenue Code of 1986).

"(b) PAYMENT OF CREDITS.—

"(1) IN GENERAL.—The Secretary shall, with respect to an eligible individual (as defined in subsection (i)) and on behalf of such individual, pay a premium credit to the Gateway through which the individual enrolled in the qualified health plan involved. Such Gateway shall remit an amount equal

to such credit to the qualified health plan in which such individual is enrolled. Subject to the limitation described in paragraph (2), the amount of such credit shall be—

"(A) with respect to an individual enrolling in coverage whose income exceeds 150 percent, but does not exceed 200 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium that exceeds [____] percent of the income (rounded to the nearest $100) of such individual or family;

"(B) with respect to an individual enrolling in coverage whose income exceeds 200 percent, but does not exceed 250 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium paid by such individual that exceeds [____] percent of the income (rounded to the nearest $100) of such individual or family;

"(C) with respect to an individual enrolling in coverage whose income exceeds 250 percent, but does not exceed 300 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium

paid by such individual that exceeds [____] percent of the income (rounded to the nearest $100) of such individual or family;

"(D) with respect to an individual enrolling in coverage whose income exceeds 300 percent, but does not exceed 350 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium paid by such individual that exceeds [____] percent of the income (rounded to the nearest $100)of such individual or family;

"(E) with respect to an individual enrolling in coverage whose income exceeds 350 percent, but does not exceed 400 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium paid by such individual that exceeds [____] percent of the income (rounded to the nearest $100) of such individual or family;

"(F) with respect to an individual enrolling in coverage whose income exceeds 400 percent, but does not exceed 450 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium paid by such individual that exceeds [____]

percent of the income (rounded to the nearest $100) of such individual or family; and

"(G) with respect to an individual enrolling in coverage whose income exceeds 450 percent, but does not exceed 500 percent, of the poverty line for a family of the size involved, an amount equal to that portion of the reference premium paid by such individual that exceeds [____] percent of the income (rounded to the nearest $100) of such individual or family.

"(2) REFERENCE PREMIUM.—In this section, the term 'reference premium' means—

"(A) with respect to an individual described in paragraph (1)(A), the weighted average annual premium of the 3 lowest cost qualified health plans that—

"(i) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(A); and

"(ii) are offered in the community rating area in which the individual resides;

"(B) with respect to an individual described in paragraph (1)(B) or (1)(C), the weighted average annual premium of the 3 lowest cost qualified health plans that—

"(i) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(B); and

"(ii) are offered in the community rating area in which the individual resides; and

"(C) with respect to an individual described in paragraph (1)(E) through (G), the weighted average annual premium of the 3 lowest cost qualified health plans that—

"(i) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(C); and

"(ii) are offered in the community rating area in which the individual resides.

"(3) METHOD OF CALCULATION.—

"(A) CALCULATION OF SUBSIDY BASED ON ESSENTIAL BENEFITS.—In the case of a qualified health plan that provides reimbursement for items or services that are not described in an applicable recommendation by the Medical Advisory Council under section 3103, the reference premium shall be determined for purposes of paragraph (2) without regard to such reimbursement.

"(B) RISK ADJUSTMENT.—The reference premium shall be determined after the application of any risk adjustment payment.

"(C) RULE IN CASE OF FEWER PLANS.—In any case in which there are less than 3 qualified health plans offered in the community rating area in which the individual resides, the determinations made under paragraph (2) shall be based on the number of such qualified plans that are actually offered in the area.

"(4) INDEXING.—The percentages described in paragraph (1) that specify the portion of the reference premium that an individual or family is responsible for paying shall be annually adjusted based on the percentage increase or decrease in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) during the preceding fiscal year.

"(c) STATE FLEXIBILITY.—A State may make payments to or on behalf of an eligible individual that—

"(1) are greater than the amounts required under this section; or

"(2) are intended to defray the costs of items or services not described in an applicable rec-

ommendation by the Medical Advisory Council under section 3103(h).

"(d) ELIGIBILITY DETERMINATIONS.—

"(1) RULE FOR ELIGIBILITY DETERMINATIONS.—The Secretary shall, by regulation, establish rules and procedures for—

"(A) the submission of applications for payments under this section [including electronic submission and documentation necessary for application];

"(B) making determinations with respect to the eligibility of individuals submitting applications under subparagraph (A) for payments under this section and informing individuals of such determinations;

"(C) resolving appeals of such determinations;

"(D) redetermining eligibility on a periodic basis, which shall be not more frequent than once per [____] and not less frequent than once per [____]; and

"(E) making payments under this section.

"(2) CALCULATION OF ELIGIBILITY.—For purposes of paragraph (1), the Secretary shall establish

rules that permit eligibility to be calculated based on—

"(A) the applicant's income for the previous tax year or the most recent period otherwise practicable; or

"(B) the applicant's declaration of estimated annual income for the year involved.

"(3) INFORMATION REQUIRED.—For purposes of paragraph (1), the Secretary may require, as a condition of eligibility, that an individual has made available the information described in section 6103(l)(21) of the Internal Revenue Code of 1986 (as added by section [____] of the American Health Choices Act).

"(4) DETERMINING ELIGIBILITY.—

"(A) AUTHORITY OF THE SECRETARY.—The Secretary shall have the authority to make determinations (including redeterminations) with respect to the eligibility of individuals submitting applications for credits under this section.

"(B) DELEGATION OF AUTHORITY.—Except under the conditions described in subparagraph (D), the Secretary shall delegate to a Gateway (and, upon request from such State or

States, to the State or States in which such Gateway operates) the authority to carry out the activities described in subparagraph (A).

"(C) REQUIREMENT FOR CONSISTENCY.—A Gateway (and, as applicable, the State or States in which such Gateway operates) shall carry out the activities described in subparagraph (B) in a manner that is consistent with the regulations promulgated under paragraph (1).

"(D) REVOCATION OF AUTHORITY.—If the Secretary determines that a Gateway (or the State or States in which such Gateway operates) is carrying out the activities described in subparagraph (A) in a manner that is substantially inconsistent with the regulations promulgated under paragraph (1), the Secretary may, after notice and opportunity for a hearing, revoke the delegation of authority under subparagraph (A). If the Secretary revokes the delegation of authority, the references to a Gateway in subparagraph (E) and (F) shall be deemed to be references to the Secretary.

"(E) REQUIREMENT TO REPORT CHANGE IN STATUS.—

"(i) IN GENERAL.—An individual that has been determined to be eligible for subsides shall notify the Gateway of any changes that may affect such eligibility in a manner specified by the Secretary.

"(ii) REDETERMINATION.—If the Gateway receives a notice from an individual under clause (i), the Gateway shall promptly redetermine the individual's eligibility for payments.

"(F) TERMINATION OF PAYMENTS.—The Gateway shall terminate payments for an individual (after providing notice to the individual) if—

"(i) the individual fails to provide information for purposes of subparagraph (E)(i) on a timely basis; or

"(ii) the Gateway determines that the individual is no longer eligible for such payments.

"(5) APPLICATION.—

"(A) METHODS.—The process established under paragraph (1)(A) shall permit applications in person, by mail, telephone, and the Internet.

"(B) FORM AND CONTENTS.—An application under paragraph (1)(A) shall be in such form and manner as specified by the Secretary, and may require documentation.

"(C) SUBMISSION.—An application under paragraph (1)(A) may be submitted to the Gateway, or to a State agency for a determination under this section.

"(D) ASSISTANCE.—A Gateway, or a State agency under this section, shall assist individuals in the filing of applications under paragraph (1)(A).

"(6) RECONCILIATION.—

"(A) FILING OF STATEMENT.—In the case of an individual who has received payments under this section for a year and who is claiming a significant decrease (as determined by the Secretary) in income from such year, such individual shall file with the Secretary an income reconciliation statement, at such time, in such manner, and containing such information as the Secretary may require.

"(B) RECONCILIATION.—

"(i) IN GENERAL.—Based on and using the income reported in the statement

filed by an individual under subparagraph (A), the Secretary shall compute the amount of payments that should have been provided to the individual for the year involved.

"(ii) OVERPAYMENT OF PAYMENTS.—If the amount of payments provided to an individual for a year under this section was significantly greater (as determined by the Secretary) than the amount computed under clause (i), the individual shall be liable to the Secretary for such excess amount.

"(iii) UNDERPAYMENT OF PAYMENTS.—If the amount of payments provided to an individual for a year under this section was less than the amount computed under clause (i), the Secretary shall pay to the individual the amount of such deficit.

"(C) FAILURE TO FILE.—In the case of an individual who fails to file a statement for a year as required under subparagraph (A), the individual shall not be eligible for further payments until such statement is filed. The Secretary shall waive the application of this sub-

paragraph if the individual establishes, to the satisfaction of the Secretary, good cause for the failure to file the statement on a timely basis.

"(7) OUTREACH.—The Gateway shall conduct outreach activities to provide information to individuals that may potentially be eligible for payments under this section. Such activities shall include information on the application process with respect to such payments.

"(e) STATE DETERMINATIONS.—As a condition of its State plan under title XIX of the Social Security Act, and the receipt of any Federal financial assistance under section 1903(a) of such Act, a State shall assist in making eligibility determinations under this title in accordance with this section.

"(f) EXCLUSION FROM INCOME.—Amounts received by an individual under this section shall not be considered income for purposes of making eligibility determinations based on income or assets with respect to any other Federal program.

"(g) NO FEDERAL FUNDING.—Nothing in this Act shall allow Federal payments for individuals who are not lawfully present in the United States.

"(h) APPROPRIATION.—Out of any funds in the Treasury of the United States not otherwise appropriated,

there are appropriated such sums as may be necessary to carry out this section for each fiscal year.".

(b) DISCLOSURE OF INFORMATION TO PROVIDE PREMIUM PAYMENTS.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(21) VOLUNTARY AUTHORIZATION FOR INCOME VERIFICATION.—

"(A) VOLUNTARY AUTHORIZATION.—The Secretary shall provide a mechanism for each taxpayer to indicate whether such taxpayer authorizes the Secretary to disclose to the Secretary of Health and Human Services (or, pursuant to a delegation described in section [____], to a State or a Gateway (as defined in section [____] of the Public Health Service Act) return information of a taxpayer who may be eligible for credits under section 3111 of the Public Health Service Act.

"(B) PROVISION OF INFORMATION.—If a taxpayer authorizes the disclosure described in subparagraph (A), the Secretary shall disclose to the Secretary of Health and Human Services

(or, pursuant to a delegation described in section [____], to a State or a Gateway) the minimum necessary amount of information necessary to establish whether such individual is eligible for credits under section 3111 of the Public Health Service Act.

"(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by the Secretary (or, pursuant to a delegation described in section [____], a State or a Gateway) only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any payments under section 3111 of the Public Health Service Act.".

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3) of section 6103(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking "(l)(10), (16), (18), (19), or (20)" each place it appears and inserting "(l)(10), (16), (18), (19), (20), or (21)".

(C) Paragraph (2) of section 7213(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".

SEC. 152. EXPANSION OF MEDICAID TO 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

[Language will reflect the policy intent described in the specs, with the addition that there is interest in defraying some of the expenditures of States that have already expanded eligibility.]

SEC. 153. SMALL BUSINESS CREDIT.

Subtitle B of title XXXI of the Public Health Service Act (as added by section 151) is amended by adding at the end the following:

"SEC. 3112. SMALL BUSINESS CREDIT.

"(a) CALCULATION OF CREDIT.—For each calendar year beginning in calendar year 2101, the Secretary shall make a payment in the amount described in subsection (b) to each qualified small employer that—

"(1) requests such credit; and

"(2) submits to the Secretary such materials (in such manner as the Secretary may require) as the Secretary may require to—

"(A) allow for the calculation of the credit amount as described in subsection (b); and

"(B) determine whether such employer is a qualified employer.

"(b) CREDIT AMOUNT.—For purposes of this section:

"(1) IN GENERAL.—The credit amount described in this subsection with respect to a qualified small employer shall be equal to the product of—

"(A) the base credit (as determined under paragraph (2));

"(B) a number equal to number of full time employees of the employer that is making a request for a credit under this section; and

"(C)(i) in the case of an employer that offered health care coverage to at least [____] percent of the full-time employees of such employer in the year preceding the year in which such employer requests a credit under this section, 0.5; or

"(ii) in the case of an employer that did not offer health care coverage to at least [____] percent of the full-time employees of such employer in the year preceding the year in which such employer requests a credit under this section, 1.25.

"(2) BASE CREDIT AMOUNT.—

"(A) BASE CREDIT.—The base credit amount with respect to a qualified small employer shall be an amount equal to the larger of—

"(i) the amount described in subparagraph (B) minus the amount described in subparagraph (C); or

"(ii) zero.

"(B) AVERAGE CONTRIBUTION.—The amount described in this subparagraph with respect to a qualified small employer shall be equal to 50 percent of the average contribution made by small employers for coverage offered by such employer in the State in which the employer requesting a credit under this section has its primary place of business (calculated as described in paragraph (5)).

"(C) REDUCTION.—The amount described in this subparagraph with respect to a qualified small employer is the sum of—

"(i) the product of the amount described in subparagraph (B) and the employer size factor described in paragraph (3); and

"(ii) the product of the amount described in subparagraph (B) and the wage adjustment factor described in paragraph (4).

"(3) EMPLOYER SIZE FACTOR.—With respect to a qualified small employer:

"(A) CALCULATION.—For purposes of paragraph (1), the employer size factor shall be the percentage that is equal to 100 minus the number described in subparagraph (B).

"(B) FACTOR.—The number described in this subparagraph shall be equal to 6 times the size number described in subparagraph (C).

"(C) SIZE NUMBER.—The number described in this subparagraph shall be equal to the number by which the average number of employees employed by the employer requesting a credit under this section exceeds 10.

"(4) WAGE ADJUSTMENT FACTOR.—

"(A) CALCULATION.—For purposes of paragraph (1), the wage adjustment factor shall be the percentage that is equal to 100 minus the number described in subparagraph (B).

"(B) FACTOR.—The number described in this subparagraph shall be equal to 5 times the number described in subparagraph (C).

"(C) FRACTION.—The number described in this subparagraph shall be equal to the amount described in subparagraph (D) divided by 1,000.

"(D) AMOUNT.—The number described in this subparagraph is the amount by which the average annual wage of the employer that is making a request for a credit under this section exceeds $20,000.

"(5) EMPLOYER CONTRIBUTION CALCULATION.—The Secretary of Labor shall annually conduct a survey of the average contribution made by small employers to health care coverage on behalf of their employees in each State. From the results of the survey conducted as described in the preceding sentence, the Secretary shall calculate the expected amount of such contribution for purposes of paragraph (2)(B).

"(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

"(1) QUALIFIED SMALL EMPLOYER.—The term 'qualified small employer' means an employer (as de-

fined in section 3001(a)(4) of the Public Health Service Act) that, with respect to the year for which such employer is requesting a credit under this section—

"(A) was—

"(i) an employer that employed an average of 27 or fewer full-time employees; or

"(ii) a self-employed individual that had not less than $5,000 in net earnings or not less than $15,000 in gross earnings from self-employment in the preceding taxable year; and

"(B) had, as its primary place of business, a location in an establishing State or a participating State.

"(2) SPECIAL RULE FOR SELF EMPLOYED INDIVIDUALS.—With respect to an employer requesting a credit under this section that is a self-employed individual, each reference to annual salary in this section shall be deemed to be a reference to net earnings.

"(3) FULL-TIME EMPLOYEE.—The term 'full time employee' means, with respect to any period, an employee (as defined in section 3001(a)(3) of the

[_____] Act) of an employer if the average number of hours worked by such employee in the preceding taxable year for such employer was at least 30 hours per week.

"(d) INFLATION ADJUSTMENT.—

"(1) IN GENERAL.—For each calendar year after 2009, the dollar amounts specified in this section (after the application of this paragraph) shall be the amounts in effect in the preceding calendar year or, if greater, the product of—

"(A) the corresponding dollar amount specified in such subsection; and

"(B) the ratio of the index of wage inflation (as determined by the Bureau of Labor Statistics) for August of the preceding calendar year to such index of wage inflation for August of 2008.

"(2) ROUNDING.—If any amount determined under paragraph (1) is not a multiple of $100, such amount shall be rounded to the next lowest multiple of $100.

"(e) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this section:

"(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—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 for the full preceding taxable year, the determination of whether such employer meets the requirements of this section shall be based on the average number of full-time employees that it is reasonably expected such employer will employ on business days in the employer's first full taxable year.

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

Subtitle D—Shared Responsibility for Health Care

SEC. 161. INDIVIDUAL RESPONSIBILITY.

(a) PAYMENTS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end the following new part:

"PART VIII—SHARED RESPONSIBILITY PAYMENTS

"SEC. 59B. SHARED RESPONSIBILITY PAYMENTS.

"(a) PAYMENT.—

"(1) IN GENERAL.—In the case of any individual who did not have in effect qualifying coverage (as defined in section 31____ of the Public Health Service Act) for any month during the taxable year, there is hereby imposed for the taxable year, in addition to any other amount imposed by this subtitle, an amount equal to the amount established under paragraph (2).

"(2) AMOUNT ESTABLISHED.—

"(A) REQUIREMENT TO ESTABLISH.—Not later than [date] of each calendar year, the Secretary, in consultation with the Secretary of Health and Human Services and with the States, shall establish an amount for purposes of paragraph (1).

"(B) EFFECTIVE DATE.—The amount established under subparagraph (A) shall be effective with respect to the taxable year following the date on which the amount under subparagraph (A) is established.

"(C) REQUIRED CONSIDERATION.—In establishing the amount under subparagraph (A), the Secretary shall seek to establish the minimum practicable amount that can accomplish the goal of enhancing participation in qualifying coverage (as so defined).

"(b) EXEMPTIONS.—Subsection (a) shall not apply to any individual—

"(1) with respect to any month if such month occurs during any period in which such individual did not have qualifying coverage (as so defined) for a period of less than [____] days,

"(2) who is a resident of a State that is not a participating State or an establishing State (as such terms are defined in section [____ of the Public Health Service Act]),

"(3) for whom affordable health care coverage is not available (as such terms are defined in an applicable recommendation of the Medical Advisory Council under section 3103 of the Public Health Service Act), or

"(4) for whom a payment under subsection (a) would otherwise represent an exceptional financial hardship, as determined by the Secretary.

"(c) COORDINATION WITH OTHER PROVISIONS.—

"(1) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(A) the amount of any credit allowable under this chapter, or

"(B) the amount of the minimum tax imposed by section 55.

"(2) TREATMENT UNDER SUBTITLE F.—For purposes of subtitle F, the amount imposed by this section shall be treated as if it were a tax imposed by section 1.

"(3) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the amount imposed by this section.

"(4) SECTION NOT TO AFFECT LIABILITY OF POSSESSIONS, ETC.—This section shall not apply for purposes of determining liability to any possession of the United States. For purposes of section 932 and 7654, the amount imposed under this section shall not be treated as a tax imposed by this chapter.

"(d) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this section.".

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end the following new item:

"PART VIII—SHARED RESPONSIBILITY PAYMENTS".

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 20[____].

(b) REPORTING OF HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart B the following new subpart:

"Subpart D—Information Regarding Health Insurance Coverage

"Sec. 6055. Reporting of health insurance coverage.

"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—Every person who provides health insurance that is qualifying coverage shall make a return described in subsection (b).

"(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary prescribes,

"(2) contains—

"(A) the name, address, and taxpayer identification number of each individual who is covered under health insurance that is qualifying coverage provided by such person, and

"(B) the number of months during the calendar year during which each such individual was covered under such health insurance, and

"(3) such other information as the Secretary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

"(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

"(A) the name, address, and phone number of the information contact of the person required to make such return, and

"(B) the number of months during the calendar year during which such individual was covered under health insurance that is qualifying coverage provided by such person.

"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(d) QUALIFYING COVERAGE.—For purposes of this section, the term 'qualifying coverage' has the meaning given such term under section 31____ of the Public Health Service Act.".

(2) CONFORMING AMENDMENTS.—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:

"SUBPART D—HEALTH INSURANCE COVERAGE".

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 20[____].

(c) NOTIFICATION OF NONENROLLMENT.—Not later than [_____] of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification each individual who files an individual income tax return and who is not enrolled in qualifying coverage (as defined in section 31____ of the Public Health Service Act). Such notification shall contain

information on the services available through the Gateway operating in the State in which such individual resides.

SEC. 162. SHARED RESPONSIBILITY OF EMPLOYER.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

"SEC. 18A. NOTICE TO EMPLOYEES.

"In accordance with guidelines prescribed by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employee, within [____] days of the date of enactment of this section, written notice informing the employee of the existence of the American Health Benefits Gateway, including a description of the services provided by such Gateway and the manner in which the employee may contact the Gateway to request assistance.".

SEC. 163. AMENDMENT TO PHSA REGARDING EMPLOYERS.

Subtitle B of title XXXI of the Public Health Service Act, as amended by section 153, is further amended by adding at the end the following:

"SEC. 3113. SHARED RESPONSIBILITY OF EMPLOYERS.

"(a) EMPLOYEES NOT OFFERED COVERAGE.—An employer shall make a payment to the Secretary in the amount described in subsection (b) with respect to each employee—

"(1) who is not offered qualifying coverage by such employer during each month where such employee is not offered qualifying coverage; and

"(2) on behalf of whom such employer is not contributing at least [____] percent of the monthly premiums for such coverage for each such month.

"(b) AMOUNT.—

"(1) IN GENERAL.—The amount described in this subsection shall be equal to [$____] for each full-time employee described in subsection (a) for the month involved.

"(2) PRO RATA APPLICATION FOR PART-TIME EMPLOYEES.—The provisions of paragraph (1) shall apply with respect to part-time employees employed by the employer, except that the payment amounts described in such paragraph shall be pro rated to reflect the number of hours worked per week by the employee involved (as determined by the Secretary based on a 30 hour workweek).

"(c) PROCEDURES.—The Secretary shall develop procedures for making determinations with respect to qualifying coverage and for making the payments required under subsection (a). Such procedures shall provide for the making of payments on a quarterly basis.

"(d) USE OF FUNDS.—Amounts shall be collected under subsection (a) and be available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Such amounts are authorized to remain available until expended.

"(e) INFLATION ADJUSTMENT.—The amounts described in subsection (b) shall be adjusted by the Secretary by notice, published in the Federal Register, for each fiscal year to reflect the total percentage change that occurred in the Consumer Price Index for all urban consumers (all items; U.S. city average) during the preceding fiscal year.

"(f) PAYMENTS TO DECLINE COVERAGE.—[Is a provision on this issue of value?]

"(g) EXEMPTION OF SMALL EMPLOYERS.—

"(1) IN GENERAL.—For purposes of this section, the term 'employer' shall mean an employer—

"(A) that employs more than [____] employees on business days during the preceding calendar year; or

"(B)(i) that employs fewer than [____] employees on business days during the preceding calendar year; and

"(ii) that has an average annual wage for all employees that exceed [$_____].

"(2) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—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.

"(3) 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 or large 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.

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

"(h) AUTHORITY TO VERIFY.—The Secretary, in collaboration with the Secretary of the Treasury and the Secretary of Labor, shall establish procedures for determining the number of employees of employers who are not offered qualifying coverage.

"(i) LIMITATION.—This section shall not apply with respect to any employee who has been employed by an employer for less than [____] days.

"SEC. 3114. FREE RIDER PENALTY.

"(a) IN GENERAL.—An employer described in subsection (e) shall make a monthly payment to the Secretary (in addition to any payment made under section 163) in an amount described in subsection (c) for each employee of the employer who is not offered qualifying coverage (as defined in section [____] by such employer during each month where such employee is not offered qualifying coverage.

"(b) PROCEDURES.—The Secretary shall develop procedures for making determinations with respect to qualifying coverage and for making the payments required under subsection (a).

"(c) AMOUNT.—The amount described in this subsection with respect to an employee shall be equal to [____] percent of the amount provided to, or on behalf of, the employee by the Federal Government for any health care coverage for the month involved.

"(d) USE OF FUNDS.—Amounts shall be collected under subsection (a) and be available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Such amounts are authorized to remain available until expended.

"(e) DEFINITIONS.—

"(1) IN GENERAL.—For purposes of this section, the term 'employer' means an employer that

employs more than [____] employees on business days during the preceding calendar year.

"(2) APPLICATION OF AGGREGATION RULES FOR EMPLOYERS.—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.

"(3) 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 or large 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.

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

"SEC. 3115. VOUCHER FOR TRANSFERRING EMPLOYEES.

"(a) VOUCHER.—An employer shall make a payment to the Secretary in the amount described in subsection (b) with respect to each employee who is—

"(1) described in section [____]; and

"(2) is enrolled in a qualified health plan.

"(b) AMOUNT DESCRIBED.—The amount described in this subsection shall be equal to the amount such employer would otherwise have paid for coverage on behalf of each full-time employee described in subsection (a) had such employee not enrolled in a qualified health plan.

"(c) PROCEDURES.—The Secretary shall develop procedures for making determinations with respect to making the payments required under subsection (a). Such procedures shall provide for the making of payments on a quarterly basis.

"(d) USE OF FUNDS.—Amounts shall be collected under subsection (a) and be available for obligation only to the extent and in the amount provided for in advance in appropriations Acts. Such amounts are authorized to remain available until expended.".

SEC. 164. RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.

Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

SEC. 165. DEFINITIONS.

Title XXXI of the Public Health Service Act, as amended by section 163, is further amended by adding at the end the following:

"Subtitle ____—Miscellaneous Provisions

"SEC. 31____. DEFINITIONS.

"(a) IN GENERAL.—In this title:

"(1) AFFORDABLE ACCESS PLAN.—

"(A) IN GENERAL.—The term 'affordable access plan' means a qualified health plan offered by the Secretary that meets the requirements of subparagraph (B).

"(B) REQUIREMENTS.—

"(i) PAYMENT.—The amount of payment for an item or service under an affordable access plan shall be equal to the amount of payment for such item or service under the medicare program under title XVIII of the Social Security Act plus 10 percent. For items or services not offered under the medicare program, the Secretary shall set a price consistent with the preceding sentence. [Unresolved question about incorporation of DME, IME, DSH payments in calculation]

"(ii) LICENSE.—An affordable access plan shall be deemed to be licensed and in good standing in each State.

"(iii) PREMIUMS.—The premiums assessed for an affordable access plan (and any subsidized provided with respect to such plan) shall be in an amount necessary to cover the costs under the plan. The Secretary may annually adjust such premium amount to comply with the previous sentence.

"(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is—

"(A) a citizen or national of the United States or an alien lawfully admitted to the United States for permanent residence or an alien lawfully present in the United States;

"(B) a qualified individual;

"(C) enrolled in a qualified health plan; and

"(D) not receiving full benefits coverage under a State child health plan under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) (or a waiver of such plan).

"(3) QUALIFIED EMPLOYER.—

"(A) IN GENERAL.—The term 'qualified employer' means an employer that—

"(i) elects to make all [full-time] employees of such employer eligible for a qualified health plan; and

"(ii)(I) in the case of an employer that elects to enroll in a qualified health plan made available through a Gateway in an establishing State, meets criteria (including criteria regarding the size of a qualified employer) established by such State; or

"(II) in the case of an employer that elects to enroll in a qualified health plan made available through a Gateway in a participating State—

"(aa) employs fewer than the number of employees specified in subparagraph (B); and

"(bb) meets criteria established by the Secretary.

"(B) NUMBER OF EMPLOYEES.—

"(i) ESTABLISHMENT.—The Secretary may by regulation establish the number of

employees described in subparagraph (A)(ii)(II)(aa).

"(ii) DEFAULT.—If the Secretary does not establish the number described in subparagraph (A)(ii)(II)(aa), such number shall be deemed to be [____].

"(4) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' means health plan that—

"(A) has in effect a certification (which may include a seal or other indication of approval) described in section 3101(d) issued by each Gateway through which such plan is offered; and

"(B) is offered by a health insurance issuer that—

"(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

"(ii) agrees to offer at least one qualified health plan at the level of cost sharing described in each of the following sections—

"(I) section3111(a)(1)(A);

"(II) section 3111(a)(1)(B); and

"(III) section 3111(a)(1)(C).

"(iii) complies with the regulations developed by the Secretary under section 3101(l) and such other requirements as an applicable Gateway may establish; and

"(iv) agrees to pay any surcharge assessed under section [____].

"(C) makes available to individuals enrolled in, or seeking to enroll in, such plan a detailed description of—

"(i) benefits offered, including maximums, limitations (including differential cost-sharing for out of network services), exclusions and other benefit limitations;

"(ii) the service area;

"(iii) premiums;

"(iv) cost-sharing;

"(v) access to providers; and

"(vi) grievance and appeals procedures;

"(D) provides coverage for at least the essential health care benefits established under section 3103(h);

"(E) [discussion on whether a priority listing or some kind of star or point system may

substitute in whole or in part for some provisions of (G) or (H);]

"(F)(i) is accredited by the National Committee for Quality Assurance or by any other entity recognized by the Secretary for the accreditation of health insurance issuers or plans; or

"(ii) receives such accreditation within a period established by a Gateway for such accreditation that is applicable to all qualified health plans;

"(G) implements incentives for high quality care and improving health outcomes through quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, and prevention of hospital readmissions through comprehensive discharge planning;

"(H) encourages patient safety and the reduction of medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology; and

"(I) has adequate procedures in place for appeals of coverage determinations.

"(5) QUALIFIED INDIVIDUAL.—

"(A) IN GENERAL.—The term 'qualified individual' means an individual who is—

"(i) residing in a participating State or an establishing State (as defined in section 3104);

"(ii) not incarcerated;

"(iii) not entitled to coverage under the Medicare program under part A of title XVIII of the Social Security Act;

"(iv) not enrolled in coverage under the Medicare program under part B of title XVIII of the Social Security Act or under part C of such title; and

"(v) not eligible for coverage under—

"(I) the Medicaid program under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or under a waiver under section 1115 of such Act;

"(II) the TRICARE program under chapter 55 of title 10, United States Code (as defined in section 1072(7) of such title);

"(III) the Federal employees health benefits program under chapter 89 of title 5, United States Code; or

"(IV) employer-sponsored coverage (except as provided under subparagraph (B)).

"(B) EMPLOYEE.—An individual who is eligible for employer-sponsored coverage shall be deemed to be a qualified individual under subparagraph (A) if such coverage—

"(i) does not meet the criteria established under section 3103 for minimum qualifying coverage; or

"(ii) is not affordable (as such term is defined under an applicable recommendation of the Council described in section 3103) for such employee.

"(C) AVAILABLE COVERAGE.—For purposes of section 59B of the Internal Revenue Code of 1986, a qualified health plan shall not be considered to be available to an individual described in subparagraph (B) unless such individual is enrolled in a qualified health plan.

"(b) INCORPORATION OF ADDITIONAL DEFINITIONS.—Unless specifically provided for otherwise, the

definitions contained in section 2791 shall apply with respect to this title.".

SEC. 166. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

"Subtitle C—Other Provisions Related to Health Information Technology

"SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

"(a) IN GENERAL.—

"(1) STANDARDS AND PROTOCOLS.—Not later than [TBD], the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

"(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing [individuals and third parties authorized by such individuals [Is this what you mean

by applicants and authorized third parties?]] notification of eligibility and verification of eligibility required under such programs.

"(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

"(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

"(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

"(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

"(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

"(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply stream-

lined verification and eligibility processes to other Federal and State programs, as appropriate.

"(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

"(7) Other functionality[ies?] necessary to provide eligibles with streamlined enrollment process.

"(c) APPROVAL AND NOTIFICATION.—Upon approval by the HIT Policy Committee, the HIT Standards Committee, and the Secretary of the standards and protocols developed under subsection (a), the Secretary—

"(1) shall notify States of such standards and protocols; and

"(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

"(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

"(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under

subsection (a) (referred to in this subsection as 'appropriate HIT technology').

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

"(A) be a State, political subdivision of a State, or a local governmental entity; and

"(B) submit to the Secretary an application at such time, in such manner, and containing—

"(i) a plan to adopt and implement appropriate enrollment technology that includes—

"(I) proposed reduction in maintenance costs of technology systems;

"(II) elimination or updating of [legacy systems]/[outdated computer systems or application programs] [Would you like to define this term in section 3000?]; and

"(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

"(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

"(iii) such other information as the Secretary may require.

"(3) AMOUNT OF GRANT; TERMS.—A grant under this subsection awarded to an eligible entity for a fiscal year may not exceed [$XXX]. Notwithstanding the preceding sentence, the Secretary may adjust such amount annually for any recipient, based on results under the grant to such recipient in the preceding fiscal year and the recipient's request for such adjustment. [Do you want to specify the terms of a grant - how many years?]

"(4) SHARING.—

"(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

"(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are quali-

fied to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.".

Subtitle E—Long-Term Services and Supports

SEC. 171. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Community Living Assistance Services and Supports Act" or the "CLASS Act".

PART I—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

SEC. 172. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORT.

(a) ESTABLISHMENT OF CLASS PROGRAM.—

(1) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 142(b), is amended by adding at the end the following:

"TITLE XXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

"SEC. 3201. PURPOSE.

"The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and support in order to—

"(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

"(2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs; and

"(3) alleviate burdens on family caregivers.

"SEC. 3202. DEFINITIONS.

"In this title:

"(1) ACTIVE ENROLLEE.—The term 'active enrollee' means an individual who is enrolled in the CLASS program in accordance with section 3204 and who has paid any premiums due to maintain such enrollment.

"(2) ACTIVELY AT WORK.—The term 'actively at work' means an individual who—

"(A) is reporting for work at the individual's usual place of employment or at another location to which the individual's employer requires the individual to travel (or in the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual's position); and

"(B) is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.

"(3) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

"(A) Eating.

"(B) Toileting.

"(C) Transferring.

"(D) Bathing.

"(E) Dressing.

"(F) Continence.

"(4) CLASS PROGRAM.—The term 'CLASS program' means the program established under this title.

"(5) CRITICAL LIFE FUNCTIONS.—The term 'critical life functions' means each of the following activities:

"(A) Communicating.

"(B) Taking medications.

"(C) Household management.

"(D) Basic money management.

"(6) DISABILITY DETERMINATION SERVICE.—The term 'Disability Determination Service' means, with respect to each State, the entity that has an agreement with the Commissioner of Social Security to make disability determinations for purposes of title II or XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.).

"(7) ELIGIBLE BENEFICIARY.—

"(A) IN GENERAL.—The term 'eligible beneficiary' means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

"(i) has paid premiums for enrollment in such program for at least 60 months; and

"(ii) has paid premiums for enrollment in such program for at least 12 consecutive months, if a lapse in premium

payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination.

"(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in either of the following clauses that is expected to last for a continuous period of more than 90 days:

"(i) The individual is unable to perform at least the minimum number of activities of daily living or to require supervision, cueing, or hands-on assistance to plan or perform at least the minimum number of such activities as are required to trigger the provision of benefits under the CLASS Independence Benefit Plan.

"(ii) Due to a cognitive or psychiatric impairment, the individual requires supervision, cueing, or hands-on assistance to engage in at least the minimum number of critical life functions activities as are required to trigger the provision of benefits

viduals, but the same premium shall be established for all such individuals who are the same age.

"(iv) OTHER REQUIREMENTS.—The premiums satisfy the additional requirements specified in subsection (b).

"(B) VESTING PERIOD.—A 5-year vesting period for eligibility for benefits.

"(C) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation described in either of the following clauses that is expected to last for a continuous period of more than 90 days:

"(i) The individual is determined to be unable to perform (or requires supervision, cueing, or hands-on assistance to plan or perform) not less than 2, but not more than 3, activities of daily living.

"(ii) Due to a cognitive or psychiatric impairment, the individual is determined to require supervision, cueing, or hands-on assistance to engage in not less than 2, but not more than 3, critical life functions.

"(D) CASH BENEFIT.—Payment of a cash benefit that satisfies the following requirements:

"(i) MINIMUM REQUIRED AMOUNT.—The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

"(ii) AMOUNT SCALED TO FUNCTIONAL ABILITY.—The benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.

"(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

"(iv) NO LIFETIME OR AGGREGATE LIMIT.—The benefit is not subject to any lifetime or aggregate limit.

"(E) COORDINATION WITH SUPPLEMENTAL COVERAGE OBTAINED THROUGH THE EXCHANGE.—[*Drafting note: will need to amend definition of quaqualified health plan for purposes of the Exchange to include a special rule that permits coverage offered by a health in-*

surance issuer that is supplemental coverage to benefits provided under a CLASS Independence Benefit Plan under title XXXIII of the PHSA]The benefits allow for coordination with any supplemental coverage purchased from a health insurance issuer (as defined in section 2791) through the [American Health Benefit Exchange] established under section [3101].

"(2) REVIEW AND RECOMMENDATION BY THE CLASS INDEPENDENCE ADVISORY COUNCIL.—The CLASS Independence Advisory Council shall—

"(A) evaluate the alternative benefit plans developed under paragraph (1); and

"(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

"(3) DESIGNATION BY THE SECRETARY.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the

CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in an interim final rule that allows for a period of public comment and subsequent response by the Secretary before being final.

"(b) ADDITIONAL PREMIUM REQUIREMENTS.—

"(1) ANNUAL ESTABLISHMENT OF PREMIUM FOR NEW ENROLLEES AFTER FIRST YEAR OF THE PROGRAM.—The Secretary shall annually establish the monthly premium for enrollment in the CLASS program during any year after the first year in which the program is in effect under this title. The Secretary shall determine such annual monthly premium based on the following:

"(A) The most recent report of the CLASS Independence Fund Board of Trustees under section 3105(d).

"(B) The advice and recommendations of the CLASS Independence Advisory Council.

"(C) The projected distribution and amount of benefits under the CLASS program.

"(D) Such other factors as the Secretary determines appropriate.

"(2) ADJUSTMENT OF PREMIUMS.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the amount of the monthly premium determined for an individual upon such individual's enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

"(B) RECALCULATED PREMIUM IF REQUIRED FOR PROGRAM SOLVENCY.—

"(i) IN GENERAL.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individuals enrolled in the CLASS program as necessary (but maintaining a nominal premium for enrollees whose income is below

the poverty line or who are full-time students actively at work).

"(ii) EXEMPTION FROM INCREASE.—Any increase in a monthly premium imposed as result of a determination described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

"(I) has attained age 65;

"(II) has paid premiums for enrollment in the program for at least 20 years; and

"(III) is not actively at work.

"(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER MORE THAN A 3-MONTH LAPSE.—

"(i) IN GENERAL.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual's enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

"(ii) CREDIT FOR PRIOR MONTHS.—An individual who reenrolls in the CLASS program after such a 90-day period shall be—

"(I) credited with any months of paid premiums that accrued prior to the individual's lapse in enrollment; and

"(II) notwithstanding the total amount of any such credited months, required to satisfy section 3201(7)(A)(ii) before being eligible to receive benefits.

"(D) NO LONGER STATUS AS A FULL-TIME STUDENT.—An individual subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(ii)(I)(bb) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligi-

bility for enrollment in the program or in a subsequent year).

"(3) ADMINISTRATIVE EXPENSES.—In determining the monthly premiums for the CLASS program the Secretary may factor in costs for administering the program, not to exceed—

"(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during each such year; and

"(B) in the case of subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

"(4) NO UNDERWRITING REQUIREMENTS.—No underwriting (other than on the basis of age in accordance with paragraph (3)) shall be used to—

"(A) determine the monthly premium for enrollment in the CLASS program; or

"(B) prevent an individual from enrolling in the program.

"(c) SELF-ATTESTATION AND VERIFICATION OF INCOME.—The Secretary shall establish procedures to—

"(1) permit an individual who is eligible for the nominal premium required under subsection

(a)(1)(A)(ii), as part of their automatic enrollment in the CLASS program, to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively at work;

"(2) verify the validity of such self-attestation; and

"(3) require an individual to confirm, on at least an annual basis, that their income does not exceed the poverty line or that they continue to maintain such status.

"SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

"(a) AUTOMATIC ENROLLMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall establish procedures under which each individual described in subsection (c) shall be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll employees in a plan under section 401(k), 403(b), or 457 of the Internal Revenue Code of 1986.

"(2) ALTERNATIVE ENROLLMENT PROCEDURES.—The procedures established under paragraph (1) shall provide for an alternative enrollment

process for an individual described in subsection (c) in the case of such an individual—

"(A) who is self-employed;

"(B) who has more than 1 employer;

"(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary; or

"(D) who is a spouse described in subsection (c)(2) of who is not subject to automatic enrollment.

"(3) ADMINISTRATION.—

"(A) IN GENERAL.—The Secretary shall, by regulation, establish procedures to—

"(i) ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer; and

"(ii) allow for an individual's employer to deduct a premium for a spouse described in subsection (c)(1)(B) who is not subject to automatic enrollment.

"(B) FORM.—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.

"(b) ELECTION TO OPT-OUT.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary shall prescribe.

"(c) INDIVIDUAL DESCRIBED.—For purposes of enrolling in the CLASS program, an individual described in this paragraph is—

"(1) an individual—

"(A) who has attained age 18;

"(B) who—

"(i) receives wages on which there is imposed a tax under section 3201(a) of the Internal Revenue Code of 1986; or

"(ii) derives self-employment income on which there is imposed a tax under section 1401(a) of the Internal Revenue Code of 1986;

"(C) who is actively at work; and

"(D) who is not—

"(i) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

"(ii) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 402(x)(1)(A)(ii)); or

"(2) the spouse of an individual described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

"(d) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

"(e) PAYMENT.—

"(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages or self-employment income of such individual in accordance with such procedures as the Secretary, in consultation with the Secretary of the Treasury, shall establish for employers who elect to

deduct and withhold such premiums on behalf of enrolled employees.

"(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

"(A) who does not have an employer who elects to deduct and withhold premiums in accordance with subparagraph (A); or

"(B) who does not earn wages or derive self-employment income.

"(f) TRANSFER OF PREMIUMS COLLECTED.—

"(1) IN GENERAL.—During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal, in the aggregate, to 100 percent of the premiums collected during that year.

"(2) TRANSFERS BASED ON ESTIMATES.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in

amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

"(g) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary shall establish procedures under which—

"(1) an individual who, in the year of the individual's initial eligibility to enroll in the CLASS program, has elected to waive enrollment in the program, is eligible to elect to enroll in the program, in such form and manner as the Secretary shall establish, only during an open enrollment period established by the Secretary that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment in the program; and

"(2) an individual shall only be permitted to disenroll from the program during an annual disenrollment period established by the Secretary and in such form and manner as the Secretary shall establish.

"SEC. 3205. BENEFITS.

"(a) DETERMINATION OF ELIGIBILITY.—

"(1) APPLICATION FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures

under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

"(2) ELIGIBILITY ASSESSMENTS.—

"(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall enter into agreements with—

"(i) the Disability Determination Service for each State to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

"(ii) the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

"(iii) public and private entities to provide advice and assistance counseling in accordance with subsection (e).

"(B) 30-DAY PERIOD FOR APPROVAL OR DISAPPROVAL.—An agreement under subparagraph (A) shall require that a Disability Determination Service determine within 30 days of the receipt of an application for benefits under the CLASS Independence Benefit Plan whether an applicant is eligible for a cash benefit under

the program and if so, the amount of the cash benefit in accordance the sliding scale established under the plan. An application that is pending after 45 days shall be deemed approved.

"(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED ENROLLEES PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

"(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

"(ii) is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

"(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution.

"(D) APPEALS.—The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Ben-

efit Plan shall be guaranteed the right to appeal an adverse determination.

"(b) BENEFITS.—An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

"(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1)(D) that—

"(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

"(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

"(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

"(3) ADVICE AND ASSISTANCE COUNSELING.—Advice and assistance counseling in accordance with subsection (e).

"(c) PAYMENT OF BENEFITS.—

"(1) LIFE INDEPENDENCE ACCOUNT.—

"(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

"(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support.

"(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

"(i) crediting an account established on behalf of a beneficiary with the beneficiary's cash daily benefit;

"(ii) allowing the beneficiary to access such account through debit cards; and

"(iii) accounting for withdrawals by the beneficiary from such account.

"(D) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

"(i) INSTITUTIONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary's daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary's personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility's cost of providing the beneficiary's care, and Medicaid shall provide secondary coverage for such care.

"(ii) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

"(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—If a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), subject to subclause (II), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

"(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary's daily or weekly cash benefit under subclause

(I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 1902(a)(10)(B) of such Act (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

"(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term 'home and community-based services' means any services which may be offered under a home and community-based waiver authorized for a State under section

1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

"(2) AUTHORIZED REPRESENTATIVES.—

"(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary's cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

"(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

"(3) COMMENCEMENT OF BENEFITS.—Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

"(4) ROLLOVER OPTION FOR LUMP-SUM PAYMENT.—An eligible beneficiary may elect to—

"(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

"(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

"(i) the total amount of the accrued deferred benefits; or

"(ii) the applicable annual benefit.

"(5) PERIOD FOR DETERMINATION OF ANNUAL BENEFITS.—

"(A) IN GENERAL.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive

such benefits, and each 12-month period thereafter.

"(B) INCLUSION OF INCREASED BENEFITS.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

"(C) RECOUPMENT OF UNPAID, ACCRUED BENEFITS.—

"(i) IN GENERAL.—The Secretary shall recoup any accrued benefits in the event of—

"(I) the death of a beneficiary; or

"(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

"(ii) PAYMENT INTO CLASS INDEPENDENCE FUND.—Any benefits recouped

in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 3206.

"(6) REQUIREMENT TO RECERTIFY ELIGIBILITY FOR RECEIPT OF BENEFITS.—An eligible beneficiary shall periodically, as determined by the Secretary—

"(A) recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits; and

"(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

"(7) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(C), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

"(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

"(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such

agreement and who shall provide an eligible beneficiary with—

"(A) information regarding how to access the appeals process established for the program;

"(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

"(C) such other services as the Secretary, by regulation, shall require; and

"(2) ensure that the System and such counselors comply with the requirements of subsection (i).

"(e) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

"(1) accessing and coordinating long-term services and supports in the most integrated setting;

"(2) possible eligibility for other benefits and services;

"(3) development of a service and support plan;

"(4) information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs; and

"(5) such other services as the Secretary, by regulation, may require.

"(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

"(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

"(h) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Disability Determination Service and Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

"(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

"(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

"(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

"(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

"(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and

beneficiaries received services from the entity or another entity.

"(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

"(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

"SEC. 3206. CLASS INDEPENDENCE FUND.

"(a) ESTABLISHMENT OF CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'CLASS Independence Fund'. The Secretary of the Treasury shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and remaining after investment of such amounts under subsection (b), including additional amounts derived as income from such investments. The amounts held in the Fund are appropriated and shall remain available without fiscal year limitation—

"(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

"(2) to pay the administrative expenses related to the Fund and to investment under subsection (b); and

"(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

"(b) INVESTMENT OF FUND BALANCE.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1841(d) of the Social Security Act (42 U.S.C. 1395t).

"(c) OFF-BUDGET STATUS; LOCK-BOX PROTECTION.—

"(1) EXCLUSION OF TRUST FUNDS FROM ALL BUDGETS.—Notwithstanding any other provision of law, the amounts derived from payments into the Fund and amounts paid from the Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

"(A) the budget of the United States Government, as submitted by the President;

"(B) the congressional budget; or

"(C) the Balanced Budget and Emergency Deficit Control Act of 1985.

"(2) LOCK-BOX PROTECTION.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, it shall not be in order in the Senate or the House of Representatives to consider any measure that would authorize the payment or use of amounts in the Fund for any purpose other than a purpose authorized under this title.

"(B) 60-VOTE WAIVER REQUIRED IN THE SENATE.—

"(i) IN GENERAL.—Subparagraph (A) may be waived or suspended in the Senate only by the affirmative vote of 3/5 of the Members, duly chosen and sworn.

"(ii) APPEALS.—

"(I) PROCEDURE.—Appeals in the Senate from the decisions of the Chair relating to clause (i) shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the measure that would authorize the payment or use of amounts in the Fund for a

purpose other than a purpose authorized under this title.

"(II) 60-VOTES REQUIRED.—An affirmative vote of 3/5 of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised in relation to clause (i).

"(C) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This section is enacted by Congress—

"(i) 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 measure described in subparagraph (A), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(ii) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the pro-

cedure 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.

"(d) BOARD OF TRUSTEES.—

"(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the 'Board of Trustees') composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is

first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

"(2) DUTIES.—

"(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

"(i) Hold the CLASS Independence Fund.

"(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

"(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is unduly small.

"(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

"(B) REPORT.—The report provided for in subparagraph (A)(ii) shall—

"(i) include—

"(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

"(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

"(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period be-

ginning with the current fiscal year; and

"(IV) an actuarial opinion by the Chief Actuary of the Social Security Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

"(ii) be printed as a House document of the session of the Congress to which the report is made.

"(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund create expected financial problems that are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to

adjust monthly premiums or impose a temporary moratorium on new enrollments.

"SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

"(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the 'CLASS Independence Advisory Council'.

"(b) MEMBERSHIP.—

"(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employ of the United States—

"(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

"(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who require services and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics,

and other relevant disciplines, as determined by the Secretary.

"(2) TERMS.—

"(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

"(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

"(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

"(c) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

"(1) the development of the CLASS Independence Benefit Plan under section 3203; and

"(2) the determination of monthly premiums under such plan.

"(d) MEETINGS.—

"(1) IN GENERAL.—The CLASS Independence Advisory Council shall meet at the call of the Chair and as frequently as the Secretary deems necessary.

"(2) UPON REQUEST.—The Chair shall call a meeting of the CLASS Independence Advisory Council upon request of at least 4 members of the Council.

"(3) QUORUM.—A majority of the members of the CLASS Independence Advisory Council shall constitute a quorum but a lesser number may hold hearings.

"(e) POWERS.—

"(1) HEARINGS.—The CLASS Independence Advisory Council may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Council considers advisable to carry out its duties.

"(2) INFORMATION FROM FEDERAL AGENCIES.—The CLASS Independence Advisory Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out its duties. Upon request of

the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

"(3) POSTAL SERVICES.—The CLASS Independence Advisory Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(4) GIFTS.—The CLASS Independence Advisory Council may accept, use, and dispose of gifts or donations of services or property.

"(f) PERSONNEL.—

"(1) COMPENSATION OF MEMBERS.—Each member of the CLASS Independence Advisory Council 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 Council.

"(2) TRAVEL EXPENSES.—The members of the CLASS Independence Advisory Council 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 Council.

"(3) STAFF.—

"(A) IN GENERAL.—The Chair of the CLASS Independence Advisory Council 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 Council to perform its duties. The employment of an executive director shall be subject to confirmation by the Council.

"(B) COMPENSATION.—The Chair of the CLASS Independence Advisory Council may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

"(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the CLASS Independence Advisory Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chair of the CLASS Independence Advisory Council 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.

"(g) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

"(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

"SEC. 3208. REGULATIONS; ANNUAL REPORT.

"(a) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

"(b) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

"(1) The total number of enrollees in the program.

"(2) The total number of eligible beneficiaries during the fiscal year.

"(3) The total amount of cash benefits provided during the fiscal year.

"(4) A description of instances of fraud or abuse identified during the fiscal year.

"(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program or to prevent the occurrence of fraud or abuse.

"SEC. 3209. TAX TREATMENT OF PROGRAM.

"The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner

as a qualified long-term care insurance contract for qualified long-term care services.".

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 5006(e)(2)(A) of division B of Public Law 111–5, is amended—

(A) in paragraph (72), by striking "and" at the end;

(B) in paragraph (73)(B), by striking the period and inserting "; and"; and

(C) by inserting after paragraph (73) the following:

"(74) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish.".

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of the Social Security Act

(42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended—

(1) in paragraph (73)(B), by striking "and" at the end;

(2) in paragraph (74), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (74), the following:

"(75) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

"(A) assess the extent to which entities such as providers of home care, home health services, home and community service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established

under title XXXII of the Public Health Service Act, including in rural and underserved areas;

"(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas; and

"(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from relying on family members for the provision of personal care services.".

(c) PERSONAL CARE ATTENDANTS WORKFORCE ADVISORY PANEL.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, the salaries, wages, and benefits of such workers, and access to the services provided by such workers.

(2) MEMBERSHIP.—In appointing members to the Personal Care Attendants Workforce Advisory Panel, the Secretary shall ensure that such members include the following:

(A) Individuals with disabilities of all ages.

(B) Senior individuals.

(C) Representatives of individuals with disabilities.

(D) Representatives of senior individuals.

(E) Representatives of workforce and labor organizations.

(F) Representatives of home and community-based service providers.

(G) Representatives of assisted living providers.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2011.

PART II—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 175. CREDIT FOR COSTS OF EMPLOYERS WHO ELECT TO AUTOMATICALLY ENROLL EMPLOYEES AND WITHHOLD CLASS PREMIUMS FROM WAGES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business credits) is amended by inserting after section 45Q the following:

"SEC. 45R. CREDIT FOR COSTS OF AUTOMATICALLY ENROLLING EMPLOYEES AND WITHHOLDING CLASS PREMIUMS FROM WAGES.

"(a) GENERAL RULE.—For purposes of section 38, the CLASS automatic enrollment and premium withholding credit determined under this section for the taxable year is an amount equal to 25 percent of the total amount paid or incurred by the taxpayer during the taxable year to—

"(1) automatically enroll employees in the CLASS program established under title XXIX of the Public Health Service Act, and

"(2) withhold monthly CLASS premiums on behalf of an employee who is enrolled in that program.

"(b) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under this chapter for any amount taken into account in determining the credit under this section.

"(c) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.".

(b) CREDIT MADE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of the Internal Revenue Code of 1986 (relating to general business credit) is amended by striking "plus" at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting ", plus", and by inserting after paragraph (35) the following new paragraph:

"(36) the CLASS automatic enrollment and premium withholding credit determined under section 45R(a).".

(c) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by in-

serting after the item relating to section 45Q the following new item:

"Sec. 45R. Credit for costs of automatically enrolling employees and withholding CLASS premiums from wages.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses paid or incurred after December 31, 2010, in taxable years ending after such date.

SEC. 176. LONG-TERM CARE INSURANCE INCLUDIBLE IN CAFETERIA PLANS.

(a) IN GENERAL.—Section 125(f) of the Internal Revenue Code of 1986 is amended by striking the last sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

Subtitle F—Affordable Health Care Coverage for Retirees

Subtitle G—Miscellaneous Provisions

SEC. ___1. GENERAL DEFINITIONS.

In this title: [To be supplied].

(1) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services (unless specifically provided otherwise).

SEC. ___2. REGULATIONS.

The Secretary of Health and Human Services shall promulgated regulations to carry out this title.