I

111TH CONGRESS
1ST SESSION

H. R. 956

To expand the number of individuals and families with health insurance coverage, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 10, 2009

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

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A BILL

To expand the number of individuals and families with health insurance coverage, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Coverage, Affordability, Responsibility, and Equity Act of 2009'' or the ''HealthCARE Act of 2009''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—STATE WAIVERS

SEC. 101. STATE WAIVERS.

(a) IN GENERAL.—Notwithstanding any other provision of law, a State may apply to the Secretary of Health and Human Services (in this Act referred to as the ''Secretary'') for waivers of such provisions of law as may be necessary for the State to implement policies that make comprehensive, affordable health coverage available for all State residents, including access to essential benefits with limits on cost-sharing, as provided in the most recent report under section 501(e)(2).

(b) REQUIREMENTS.—In order to ensure that waivers under this section benefit rather than harm health care consumers, a State shall not be eligible for a waiver under this section unless—

(1) the State reasonably expects to achieve a level of enrollment in coverage described in subsection (a) that is at least equal to the level of coverage (taking into account the number of insured individuals, covered benefits, and premium and out-of-pocket costs to the consumer for such coverage) that the State would have achieved if the State had fully implemented the coverage options available under titles III and IV of this Act;

(2) no individual who would have qualified for assistance under the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act, as of either the date of the waiver request or the date of enactment of this Act, will be denied eligibility for such program, have a reduction in benefits under such program, have reduced access to geographically and linguistically appropriate care or essential community providers, or be subject to increased premiums or cost-sharing under the waiver program under this section; and

(3) the State agrees to comply with such standards or guidelines as the Secretary of Health and Human Services may require to ensure that the requirements of paragraphs (1) and (2) are satisfied.

(c) FEDERAL PAYMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall pay a State with a waiver approved under this section an amount each quarter equal to the sum of—

(A) the Federal payments the State and residents of the State (including, but not limited to, through the credit allowed under section 36A of the Internal Revenue Code of 1986 for

health insurance costs) would have received if the State had exercised the coverage options under titles III and IV of this Act with respect to residents of the State who have not attained age 65; and

(B) the amount of any grants authorized by this Act that the State would have received if the State had applied for such grants.

(2) ADDITIONAL PAYMENT FOR MEDICARE BENEFICIARIES UNDER AGE 65.—

(A) IN GENERAL.—In the case of a State that elects to enroll an individual described in subparagraph (B) in coverage described in subsection (a), the amount described in paragraph (1) with respect to a quarter shall be increased by the amount described in subparagraph (C).

(B) INDIVIDUAL DESCRIBED.—An individual is described in this subparagraph if the individual—

(i) has not attained age 65;

(ii) is eligible for coverage under title XVIII of the Social Security Act; and

(iii) voluntarily elects to enroll in coverage described in subsection (a).

(C) AMOUNT DESCRIBED.—The amount described in this subparagraph is the amount equal to the amount that the Federal Government would have incurred with respect to a quarter for providing coverage to an individual described in subparagraph (B) under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(d) IMPLEMENTATION DATE.—No State may submit a request for a waiver under this section before October 1, 2011.

TITLE II—IMPROVING QUALITY AND SAFETY THROUGH PREVENTIVE SERVICES, CARE COORDINATION, AND THE USE OF HEALTH INFORMATION TECHNOLOGY

SEC. 201. ADDITIONAL WAIVER AUTHORITY.

(a) IN GENERAL.—Notwithstanding the requirements to submit a state waiver under title I, the Secretary shall establish a process by which States may apply for a waiver to implement policies that emphasize the use of preventive services, care coordination by a personal physician, and health information technology (in this section referred to as a qualified patient-centered medical home).

(b) DEFINITIONS.—For purposes of this title:

(1) QUALIFIED PATIENT-CENTERED MEDICAL HOME.—The term ''qualified patient-centered medical home'' or ''PC–MH'' means a physician-directed practice that has voluntarily participated in a qualification process to demonstrate it has the capabilities to achieve improvements in the management and coordination of care of eligible beneficiaries, including those with multiple chronic diseases, by incorporating attributes of the care management model.

(2) CARE MANAGEMENT MODEL.—The term ''care management model'' means a model that uses health information and other physician practice innovations to improve the management and coordination of care provided to patients with one or more chronic illnesses. Attributes of the model include the following:

(A) Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

(B) Evidence-based medicine and clinical decision-support tools guide decision making.

(C) Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(D) Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

(E) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(F) Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

(G) Patients and families participate in quality improvement activities at the practice level.

(3) PATIENT CENTERED MEDICAL HOME REIMBURSEMENT METHODOLOGY.—The patient centered medical home reimbursement methodology is a methodology to reimburse physicians in qualified PC–MH practices based on the value of the services

provided by such practices. Such methodology shall include, at a minimum the following:

(A) Recognition of the value of physician and clinical staff work associated with patient care that falls outside the face-to-face visit, such as the time and effort spent on educating family caregivers and arranging appropriate follow-up services with other health care professionals, such as nurse educators.

(B) Services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

(C) Recognition of expenses that the PC–MH practices will incur to acquire and utilize health information technology, such as clinical decision support tools, patient registries and/or electronic medical records.

(D) Reimbursement for separately identifiable email and telephonic consultations, either as separately billable services or as part of a global management fee.

(E) Recognition of the value of physician work associated with remote monitoring of clinical data using technology.

(F) Allowance for separate fee-for-service payments for face-to-face visits.

(G) Recognition of case mix differences in the patient population being treated within the practice.

(H) Recognition and sharing of savings from reduced hospitalizations associated with physician-guided care management in the office setting.

(I) Allowance for additional payments for achieving measurable and continuous quality improvements.

(4) PERSONAL PHYSICIAN.—The term ''personal physician'' means a physician who practices in a qualified PC–MH and whom the practice has determined has the training to provide first contact, continuous and comprehensive care for the whole person, not limited to a specific disease condition or organ system.

(5) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means a beneficiary enrolled under the Medicaid or SCHIP program or other State resident who selects a primary care or principal care physician in a qualified PC–MH as their personal physician.

(6) PATIENT-CENTERED MEDICAL HOME QUALIFICATION.—The PC–MH qualification is a process whereby an interested practice will voluntarily submit information to an objective external private-sector entity that is recognized and deemed by the state or by the Secretary to make the determination as to whether the practice has the attributes of a qualified PC–MH based on standards the Secretary shall establish.

(c) REPORT AND EVALUATION.—States shall submit an annual report to the Secretary that describes initiatives it has taken to encourage the provision of care through a patient-centered medical home as described in this section.

TITLE III—INCREASING HEALTH CARE COVERAGE

Subtitle A—Medicaid and SCHIP

SEC. 301. STATE OPTION TO OFFER MEDICAID COVERAGE BASED ON NEED.

(a) STATE OPTION.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) by striking ''or'' at the end of subclause (XVIII);

(2) by adding ''or'' at the end of subclause (XIX); and

(3) by adding at the end the following:

"(XX) who are not otherwise eligible for medical assistance under this title and whose income does not exceed such income level as the State may establish, expressed as a percentage (not to exceed 100) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;".

(b) INCREASED FMAP.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in the first sentence of subsection (b)—

(A) by striking "and (4)" and inserting "(4)"; and

(B) by inserting before the period the following: ", and (5) in the case of a State that meets the conditions described in paragraph (1) of subsection (y), the Federal medical assistance percentage shall be equal to the need-

based enhanced FMAP described in paragraph (2) of subsection (y)''; and

(2) by adding at the end the following:

''(y)(1) For purposes of clause (5) of the first sentence of subsection (b), the conditions described in this subsection are the following:

''(A) The State provides medical assistance to individuals described in subsection (a)(10)(A)(ii)(XX).

''(B) The State uses streamlined enrollment and outreach measures to all individuals described in subparagraph (A) including—

''(i) the same application and retention procedures (such as 1-page enrollment forms and enrollment by mail) used by the majority of State programs under title XXI during the preceding year; and

''(ii) outreach efforts proportional in scope and reasonably expected effectiveness to those employed by the State during a comparable stage of implementation of the State's program under title XXI.

''(C) The State applies eligibility standards and methodologies under this title with respect to individuals residing in the State who have not attained

age 65 that are not more restrictive (as determined under section 1902(a)(10)(C)(i)(III)) than the standards and methodologies that applied under this title with respect to such individuals as of July 1, 2009.

''(2)(A) For purposes of clause (5) of the first sentence of subsection (b), the need-based enhanced FMAP for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased, subject to subparagraph (B), by such percentage increase as would compensate all States for the additional expenditures that would be incurred by all States if the States were to provide medical assistance to all individuals whose income does not exceed 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved and who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XX).

''(B) In the case of a State that provides medical assistance to individuals described in section 1902(a)(10)(A)(ii)(XX) but limits such assistance to individuals with income at or below a percentage of the income

official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved that is less than 100, the Secretary shall reduce the need-based enhanced FMAP otherwise determined for the State under subparagraph (A) by a proportion based on the national income distribution of all individuals in all States who are (regardless of whether such individuals are enrolled under this title) eligible for medical assistance only on the basis of section 1902(a)(10)(A)(ii)(XX).''.

(c) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(1) by striking ''or'' at the end of clause (xii);

(2) by adding ''or'' at the end of clause (xiii); and

(3) by inserting after clause (xiii) the following:

''(xiv) individuals who are eligible for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XX);''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010, and apply to medical assistance provided on or after that date, without

regard to whether final regulations to carry out such amendments have been promulgated by such date.

SEC. 302. STATE OPTION TO PROVIDE COVERAGE OF CHILDREN UNDER SCHIP IN EXCESS OF THE STATE'S ALLOTMENT.

(a) IN GENERAL.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), as amended by sections 111(a) and 112 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following:

"SEC. 2113. STATE OPTION TO PROVIDE COVERAGE OF CHILDREN IN EXCESS OF THE STATE'S ALLOTMENT.

''(a) STATE OPTION.—In the case of a State that meets the condition described in subsection (b), the following shall apply:

''(1) Notwithstanding section 2105 and without regard to the State's allotment under section 2104, the Secretary shall pay the State an amount for each quarter equal to the enhanced FMAP of expenditures incurred in the quarter that are described in section 2105(a)(1).

''(2) The Secretary shall reduce the State's allotment under section 2104, for the first fiscal year for which the State amendment described in sub-

section (b) applies, and for each fiscal year thereafter, by an amount equal to the amount that the Secretary determines the State would have expended to provide child health assistance to targeted low-income children during that fiscal year if that State had not elected the State option to provide such assistance in accordance with this section.

''(3) Subsections (f) and (g) of section 2104 shall not apply to the State's reduced allotment (after the application of paragraph (2)).

''(b) CONDITION DESCRIBED.—For purposes of subsection (a), the condition described in this subsection is that the State has made an irrevocable election, through a plan amendment, to provide child health assistance to all targeted low-income children residing in the State (without regard to date of application for assistance) and to cover health services listed in the State plan whenever medically necessary.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 2010, and applies to child health assistance provided on or after that date, without regard to whether final regulations to carry out such amendment have been promulgated by such date.

Subtitle B—Refundable Tax Credit for Health Insurance Costs of Low-Income Individuals and Families

SEC. 311. CREDIT FOR HEALTH INSURANCE COSTS OF CERTAIN LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36 the following new section:

"SEC. 36A. HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the applicable percentage of the amount paid by the taxpayer (or on behalf of the taxpayer) for coverage of the taxpayer or qualifying family members under qualified health insurance for eligible coverage months beginning in such taxable year.

"(b) APPLICABLE PERCENTAGE.—For purposes of this section—

"(1) IN GENERAL.—Subject to paragraph (2), the term 'applicable percentage' means the standard Government contribution (determined for full-time

Federal employees enrolling in coverage for which such contribution is not limited by section 8906(b)(1) of title 5, United States Code) for an employee enrolled in a health benefits plan under chapter 89 of title 5, United States Code, for the calendar year in which the taxable year begins, expressed as a percentage of the total premium for such plan.

''(2) INCREASED PERCENTAGE FOR CERTAIN TAXPAYERS.—

''(A) IN GENERAL.—In the case of a taxpayer whose adjusted gross income for the preceding taxable year does not exceed 150 percent of the poverty level, the applicable percentage determined under paragraph (1) shall be increased by such percentage points as the Secretary determines will fully compensate such an individual for the individual's limited purchasing power in comparison to individuals whose adjusted gross income equals the average adjusted gross income for all Federal employees, to the extent that the amount of the resulting increase in the credit amount for all such eligible low-income individuals for the taxable year is not reasonably expected to exceed the 5

percentage point dollar amount for that year, as determined under subparagraph (B).

"(B) DETERMINATION OF 5 PERCENTAGE POINT DOLLAR AMOUNT.—For purposes of subparagraph (A), the 5 percentage point dollar amount for any taxable year is the product of—

"(i) the total number of individuals receiving credits under this section for such year; and

"(ii) the amount equal to 5 percent of the average health insurance premium amount to which such credits are applied.

"(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed to prevent the Secretary from establishing more than 1 level of supplemental assistance that provides greater assistance to individuals with lower income, determined as a percentage of poverty.

"(3) APPLICATION OF FEHBP COVERAGE CATEGORIES TO DETERMINATION OF CREDIT.—The percentages described in paragraphs (1) and (2) shall be applied to a taxpayer consistent with the coverage categories (such as self or family coverage) applied with respect to a health benefits plan under chapter 89 of title 5, United States Code.

''(c) MAXIMUM PREMIUM AMOUNT.—The amount paid for qualified health insurance taken into account under subsection (a) for any taxable year shall not exceed an amount equal to the capped premium established for the applicable State under section 404(c)(10) of the Health Coverage, Affordability, Responsibility, and Equity Act of 2009 for the calendar year in which the such taxable year begins.

''(d) ELIGIBLE COVERAGE MONTH.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible coverage month' means any month if during such month the taxpayer or a qualifying family member—

''(A) is an eligible low-income individual;

''(B) is covered by qualified health insurance, the premium for which is paid by the taxpayer (or on behalf of the taxpayer);

''(C) does not have other specified coverage; and

''(D) is not imprisoned under Federal, State, or local authority.

''(2) JOINT RETURNS.—In the case of a joint return, the requirement of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirement.

''(e) ELIGIBLE LOW-INCOME INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible low-income individual' means an individual—

''(A) who has not attained age 65;

''(B) whose adjusted gross income does not exceed 200 percent of the poverty level;

''(C) who is ineligible for the medicaid program or the State children's health insurance program under title XIX or XXI of the Social Security Act (other than under section 1928 of such Act);

''(D) who has limited access to health insurance coverage through the employer of the individual or a member of the individual's family (either because the employer does not offer such coverage to the individual or because the employee contribution for such coverage would exceed an amount equal to 5 percent of the household income of such individual, as determined in accordance with paragraph (2));

''(E) who applies for a credit under this section not later than 60 days after receiving notice of potential eligibility for such credit,

under procedures established by the Secretary; and

''(F) who resides in a State where the eligibility standards and methodologies applied under the medicaid and State children's health insurance programs with respect to individuals residing in the State who have not attained age 65 are not more restrictive (as determined under section 1902(a)(10)(C)(i)(III) of the Social Security Act) than the standards and methodologies that applied under such programs with respect to such individuals as of July 1, 2009.

''(2) DETERMINATION OF ELIGIBILITY.—

''(A) SCHIP AGENCY.—

''(i) IN GENERAL.—The determination of whether an individual is an eligible low-income individual for purposes of this section shall be made by the State agency with responsibility for determining the eligibility of individuals for assistance under the State children's health insurance program under title XXI of the Social Security Act.

''(ii) APPLICATION OF SCREEN AND ENROLL REQUIREMENTS.—

''(I) IN GENERAL.—The State agency referred to in clause (i) shall ensure that individuals applying for a certificate of eligibility are screened for potential eligibility under the medicaid and State children's health insurance programs and that individuals found through screening to be eligible for assistance under such a program are enrolled for assistance under the appropriate program. To the maximum extent possible pursuant to State options under title XIX of the Social Security Act, and notwithstanding any otherwise applicable provision of, or State plan provision under, such title, screening and enrollment activities described in the previous sentence shall use the procedures employed by the State children's health insurance program operated under title XXI of the Social Security Act, if such procedures differ

from those ordinarily employed by the State program operated under title XIX of such Act.

''(II) NO DELAY OF ISSUANCE OF CERTIFICATE.—The application of the screen and enroll requirements of clause (i) shall not delay the issuance of a certificate of eligibility to an individual for purposes of this section. The State agency referred to in clause (i) shall adopt procedures to ensure that an individual issued a certificate of eligibility under this paragraph who is subsequently determined to be eligible for the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under XXI of such Act shall be enrolled in the appropriate program without an interruption in the individual's health insurance coverage.

''(B) STANDARDS.—

"(i) IN GENERAL.—An individual is an eligible low-income individual for purposes of this section if—

"(I) on the basis of the individual's tax return for the preceding taxable year, the individual meets the requirements of paragraph (1)(B), and the individual otherwise satisfies the requirements of paragraph (1), or

"(II) the individual is determined to satisfy the requirements of paragraph (1) after the application of the same eligibility methodologies as would apply for purposes of determining the eligibility of an individual for assistance under the State children's health insurance program under title XXI of the Social Security Act.

"(ii) APPLICATION OF SCHIP INCOME DETERMINATION METHODOLOGIES.—For purposes of clause (i)(II), determinations of income levels shall be made using the methodologies described in that clause, to the extent such methodologies for

ascertaining household income differ from any otherwise applicable method for determining adjusted gross income or the definition of adjusted gross income.

''(C) CERTIFICATE OF ELIGIBILITY.—

''(i) IN GENERAL.—An individual who is determined to be an eligible low-income individual shall be issued a certificate of eligibility by the State agency referred to in subparagraph (A).

''(ii) CERTIFICATE AMOUNT.—Such certificate shall indicate the applicable percentage of the amount paid for coverage under qualified health insurance that the individual is eligible for under this section (including any supplemental assistance which the individual may be eligible for under subsection (b)(2), unless the individual elects to not receive such supplemental assistance).

''(iii) 12-MONTH PERIOD OF ISSUE.—The certificate of eligibility shall apply for a 12-month period from the date of issue, notwithstanding any changes in household circumstances following the individual's ap-

plication for a credit under this section or supplemental assistance.

''(D) SUPPLEMENTAL ASSISTANCE.—The State agency described in subparagraph (A) shall determine an individual's eligibility for supplemental assistance under subsection (b)(2) based on the methodologies referred to in subparagraph (B)(ii).

''(f) QUALIFYING FAMILY MEMBER.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualifying family member' means the taxpayer's spouse and any dependent of the taxpayer. Such term does not include any individual who is not an eligible low-income individual under subsection (e)(1).

''(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC.—If paragraph (2) of section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (within the meaning of section 152(e)(3)) and not with respect to the noncustodial parent.

''(g) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means any of the following:

''(A) Coverage under an insurance plan participating in a purchasing pool established pursuant to section 403 of the Health Coverage, Affordability, Responsibility, and Equity Act of 2009.

''(B) Coverage under individual health insurance pursuant to section 412 of such Act.

''(C) Coverage, pursuant to section 413 of such Act, under the medicaid program or the State children's health insurance program if 1 or more family members qualifies for coverage under such program.

''(D) Coverage, pursuant to section 414 of such Act, under an employer-sponsored insurance plan, including—

''(i) coverage under a COBRA continuation provision (as defined in section 9832(d)(1));

''(ii) State-based continuation coverage provided under a State law that requires such coverage;

"(iii) coverage voluntarily offered by a former employer of the individual or family member; or

"(iv) coverage under a group health plan that is available through the employment of the individual or a family member.

"(2) EXCEPTION.—The term 'qualified health insurance' shall not include—

"(A) a flexible spending or similar arrangement; and

"(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

"(3) DEFINITIONS.—For purposes of this subsection—

"(A) EMPLOYER-SPONSORED INSURANCE.—

"(i) IN GENERAL.—The term 'employer-sponsored insurance' means any insurance which covers medical care under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer's spouse.

"(ii) TREATMENT OF CAFETERIA PLANS.—For purposes of clause (i), the

cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

''(B) INDIVIDUAL HEALTH INSURANCE.—The term 'individual health insurance' means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

''(h) OTHER SPECIFIED COVERAGE.—For purposes of this section, an individual has other specified coverage for any month if, as of the first day of such month—

''(1) COVERAGE UNDER MEDICARE.—Such individual is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title.

''(2) CERTAIN OTHER COVERAGE.—Such individual—

''(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code; or

''(B) is entitled to receive benefits under chapter 55 of title 10, United States Code.

''(i) FEDERAL POVERTY LEVEL; POVERTY LEVEL; POVERTY.—For purposes of this section, the terms 'Federal poverty level', 'poverty level', and 'poverty' mean the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(j) SPECIAL RULES.—

''(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(2) COORDINATION WITH OTHER DEDUCTIONS AND CREDITS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213. The amount of any credit otherwise

allowed under this section shall be reduced by the amount of any credit allowed under section 35.

''(3) HEALTH SAVINGS ACCOUNT DISTRIBUTIONS.—Amounts distributed from a health savings account (as defined in section 223(d)) or an Archer MSA (as defined in section 220(d)) shall not be taken into account under subsection (a).

''(4) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(5) BOTH SPOUSES ELIGIBLE LOW-INCOME INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

''(A) the taxpayer is married at the close of the taxable year;

''(B) the taxpayer and the taxpayer's spouse are both eligible low-income individuals during the taxable year; and

''(C) the taxpayer files a separate return for the taxable year.

''(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

''(7) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

''(8) TREATMENT OF PAYMENTS.—For purposes of this section:

''(A) PAYMENTS BY SECRETARY.—Any payment made by the Secretary on behalf of any individual under section 7527A (relating to advance payment of credit for health insurance costs of eligible low-income individuals) shall be treated as having been made by the taxpayer (or on behalf of the taxpayer) on the first day of the month for which such payment was made.

''(B) PAYMENTS BY TAXPAYER.—Any payment made by the taxpayer (or on behalf of the taxpayer) for eligible coverage months shall be

treated as having been so made on the first day of the month for which such payment was made.

''(9) REGULATIONS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services, shall administer the credit allowed under this section and shall prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050W, and section 7527A.

''(B) ELIGIBILITY DETERMINATIONS.—Such regulations shall include such standards as the Secretary of Health and Human Services may specify with respect to the requirements for eligibility determinations under subsection (e)(2).

''(C) MEASURES TO COMBAT FRAUD AND ABUSE.—Such regulations shall include appropriate procedures to deter, detect, and penalize fraudulent efforts to obtain a credit under this section by individuals, providers of qualified health insurance, and others.''.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36A,'' after ''36,''.

(2) The table of sections for subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36 the following new item:

''Sec. 36A. Health insurance costs of eligible low-income individuals.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

(d) REIMBURSEMENT FOR ADMINISTRATIVE COSTS INCURRED IN DETERMINING ELIGIBILITY FOR CREDIT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall reimburse States for the reasonable administrative costs incurred in making eligibility determinations in accordance with section 36A(e) of the Internal Revenue Code of 1986 (as added by subsection (a)). Such reimbursement shall not apply to State costs required under the medicaid or State children's health insurance programs.

(2) APPLICATION.—A State desiring reimbursement under this subsection shall submit an application to the Secretary of Health and Human Services in such manner, at such time, and containing such information as the Secretary may require.

(3) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated such sums as may be necessary to carry out this subsection.

SEC. 312. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

"SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

''(a) GENERAL RULE.—Not later than August 1, 2011, the Secretary shall establish a program for making payments on behalf of certified individuals to providers of qualified health insurance (as defined in section 36A(g)) for such individuals.

''(b) LIMITATION ON ADVANCE PAYMENTS DURING ANY TAXABLE YEAR.—The Secretary may make payments under subsection (a) only to the extent that the total amount of such payments made on behalf of any individual during the taxable year is not reasonably expected to exceed the applicable percentage (as defined in section

36A(b)) of the amount paid by the taxpayer (or on behalf of the taxpayer) for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

''(c) CERTIFIED INDIVIDUAL.—For purposes of this section, the term 'certified individual' means any individual for whom a health coverage eligibility certificate is in effect.

''(d) HEALTH COVERAGE ELIGIBILITY CERTIFICATE.—For purposes of this section, the term 'health coverage eligibility certificate' means any written statement that an individual is an eligible low-income individual (as defined in section 36A(e)) if such statement provides such information as the Secretary may require for purposes of this section and is issued by the State agency responsible for administering the State children's health insurance program under title XXI of the Social Security Act.''.

(b) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for

purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT A PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.—The Secretary may disclose to providers of health insurance for any certified individual (as defined in section 7527A(c)) return information with respect to such certified individual only to the extent necessary to carry out the program established by section 7527A (relating to advance payment of credit for health insurance costs of eligible low-income individuals).''.

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (20)'' each place it appears and inserting ''(20), or (21)''.

(3) UNAUTHORIZED INSPECTION OR DISCLOSURE OF RETURNS OR RETURN INFORMATION.—Section 7213(a)(2) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

"SEC. 6050X. RETURNS RELATING TO CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE LOW-INCOME INDIVIDUALS.

"(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for health insurance costs of eligible low-income individuals) with respect to any certified individual (as defined in section 7527A(c)) shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

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

"(1) is in such form as the Secretary may prescribe; and

"(2) contains—

"(A) the name, address, and TIN of each individual referred to in subsection (a);

''(B) the number of months for which amounts were entitled to be received with respect to such individual under section 7527A (relating to advance payment of credit for health insurance costs of eligible low-income individuals);

''(C) the amount entitled to be received for each such month; and

''(D) such other information as the Secretary may prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—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—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person; and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking '', and'' at the end of clause (xxiii) and inserting '', or'', and by adding at the end the following new clause:

''(xxiv) section 6050X (relating to returns relating to credit for health insurance costs of eligible low-income individuals), and''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting '', or'', and by adding after subparagraph (FF) the following new subparagraph:

''(GG) section 6050X (relating to returns relating to credit for health insurance costs of eligible low-income individuals).''.

(d) CLERICAL AMENDMENTS.—

(1) ADVANCE PAYMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 7527 the following new item:

''Sec. 7527A. Advance payment of credit for health insurance costs of eligible low-income individuals.''.

(2) INFORMATION REPORTING.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050W the following new item:

''Sec. 6050X. Returns relating to credit for health insurance costs of eligible low-income individuals.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2012.

TITLE IV—IMPROVING ACCESS TO HEALTH PLANS

SEC. 401. DEFINITIONS.

In this title:

(1) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual with respect to whom a tax credit is allowed under section 36A of the Internal Revenue Code of 1986 (as added by section 311).

(2) EMPLOYER.—The term ''employer'' includes a not-for-profit employer.

(3) PARTICIPATING INSURER.—The term ''participating insurer'' means an entity with a contract under section 405(a).

(4) PRIVATE GROUP HEALTH INSURANCE PLAN.—The term ''private group health insurance

plan'' means a plan offered by a participating insurer that provides health benefits coverage to eligible individuals and that meets the requirements of this title.

(5) PURCHASING POOL OPERATOR.—The term ''purchasing pool operator'' means the entity designated by the State under section 404.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) SMALL EMPLOYER.—The term ''small employer'' means an employer with not less than 2 and not more than 100 employees.

SEC. 402. ESTABLISHMENT OF HEALTH INSURANCE PURCHASING POOLS.

There is established a program under which the Secretary shall ensure that each eligible individual has the opportunity to enroll, through a purchasing pool operator, in a private group health insurance plan offered by a participating insurer under this title.

SEC. 403. PURCHASING POOLS.

(a) ESTABLISHMENT OF PURCHASING POOLS.—Each State participating in the program under this title shall establish a purchasing pool that is available to each eligible individual who resides in the State.

(b) TYPES OF PURCHASING POOLS.—

(1) IN GENERAL.—A purchasing pool established under subsection (a) shall be 1 of the following:

(A) A statewide purchasing pool operated by the State.

(B) A statewide purchasing pool operated on behalf of the State by the Director of the Office of Personnel Management, or the designee of such Director.

(2) OPM OPERATED POOL.—In the case of a statewide purchasing pool described in paragraph (1)(B), the Director of the Office of Personnel Management or the Director's designee, may limit participating insurers in such pool to those described in section 405(e), except that the Director or such designee shall ensure that additional private group health insurance plans participate in such a pool to the extent necessary to meet the requirements of section 404(c)(9).

(c) STATE ELECTION PROCESS.—

(1) IN GENERAL.—Each State participating in the program under this title shall notify the Secretary, not later than January 4, 2011, of the type of purchasing pool that applies to residents of the State.

(2) DEFAULT CHOICE.—If a State participating in the program under this title fails to notify the Secretary of the type of purchasing pool elected by the State by the date described in paragraph (1), the State shall be deemed to have elected the type of purchasing pool described in subsection (b)(1)(B).

(3) CHANGE OF ELECTION.—The Secretary shall establish procedures under which a State participating in the program under this title may change the election of the type of purchasing pool applicable to residents of the State.

SEC. 404. PURCHASING POOL OPERATORS.

(a) DESIGNATION.—Each State shall designate a purchasing pool operator that shall be responsible for operating the purchasing pool established under section 403(a). A purchasing pool operator may be (or, to have 1 or more of its functions performed, may contract with) a private entity that has entered into a contract with the State if such entity meets requirements established by the Secretary for purposes of the program under this title.

(b) OPERATION SIMILAR TO FEHBP.—Each purchasing pool operator shall operate the purchasing pool established under section 403(a) in a manner that is similar to the manner in which the Director of the Office of Personnel Management operates the Federal employees'

health benefits program under chapter 89 of title 5, United States Code, including (but not limited to) the performance of the specific functions described in subsection (c).

(c) SPECIFIC FUNCTIONS DESCRIBED.—The specific functions described in this subsection include the following:

(1) Each purchasing pool operator shall offer one-stop shopping for eligible individuals to enroll for health benefits coverage under private, group health insurance plans offered by participating insurers.

(2) Each purchasing pool operator shall limit participating insurers to those that meet the conditions for participation described in this title.

(3) Each purchasing pool operator shall negotiate (or, in the case of a purchasing pool described in section 403(b)(1)(B), shall negotiate or otherwise determine) bids and terms of coverage with insurers.

(4) Each purchasing pool operator shall provide eligible individuals with comparative information on private group health insurance plans offered by participating insurers.

(5) Each purchasing pool operator shall assist eligible individuals in enrolling with a private group

health insurance plan offered by a participating insurer.

(6) Each purchasing pool operator shall collect private group health insurance plan premium payments for participating insurers and process such premium payments.

(7) Each purchasing pool operator shall reconcile from year to year aggregate premium payments and claims costs of private group health insurance plans consistent with practices under the Federal employees' health benefits program under chapter 89 of title 5, United States Code.

(8) Each purchasing pool operator shall offer customer service to eligible individuals enrolled for health benefits coverage under a private group health insurance plan offered by a participating insurer.

(9) Each purchasing pool operator shall ensure that each eligible individual has the option of enrolling in either of at least 2 benchmark or benchmark-equivalent plans with—

(A) a premium at or below a cap established by the pool operator for purposes of this title; and

(B) coverage of essential services included in the report required under section 501(e)(2), with cost-sharing consistent with such report.

(10) Each purchasing pool operator shall establish a premium cap for purposes of determining the credit limitation under section 36A(c) of the Internal Revenue Code of 1986, as added by section 311(a). The cap required under this paragraph may not be less than the premium charged to Federal employees by the most highly enrolled health plan under the Federal employees' health benefits program under chapter 89 of title 5, United States Code. If the most highly enrolled plan in that program differs for Federal enrollees in the State and all Federal enrollees nationally in such plan, the minimum permitted premium cap shall be the lower of such premiums.

SEC. 405. CONTRACTS WITH PARTICIPATING INSURERS.

(a) IN GENERAL.—Each purchasing pool operator shall negotiate and enter into contracts for the provision of health benefits coverage under the program under this title with entities that meet the conditions of participation described in subsection (b) and other applicable requirements of this Act.

(b) CONSUMER INFORMATION.—In carrying out its duty under section 404(c)(4) to inform eligible individuals

about private group health plans, the purchasing pool operator shall provide information that meets the requirements of section 412(b)(2).

(c) STATE LICENSURE.—

(1) IN GENERAL.—Subject to paragraph (2), a health plan shall not be a participating insurer unless the plan has a State license to provide State residents with the private group coverage health insurance plans that it offers through the pool.

(2) EXCEPTION.—A pool operator may enter into a contract under subsection (a) to cover pool participants through a health plan without a State license described in paragraph (1) if such plan is offered to Federal employees nationwide and, with respect to such employees, is exempt from State health insurance regulation. Nothing in this paragraph shall be construed to permit coverage of pool participants through such a plan except with groups, contracts, and premium rates that are entirely distinct from those used for individuals covered under the Federal employee's health benefits program under chapter 89 of title 5, United States Code.

(d) ADDITIONAL STOP-LOSS COVERAGE AND REINSURANCE.—Purchasing pool operators are authorized to encourage participation in the program under this title,

improve covered benefits, reduce out-of-pocket cost-sharing, limit premiums, or achieve other objectives of this Act by—

(1) funding stop-loss coverage above levels otherwise offered in the purchasing pool; or

(2) providing or subsidizing reinsurance in addition to that provided under section 411.

(e) PARTICIPATION OF FEHBP PLANS.—

(1) IN GENERAL.—Each entity with a contract under section 8902 of title 5, United States Code, shall be a participating insurer unless such entity notifies the Secretary in writing of its intention not to participate in the program under this title prior to such time as is designated by the Secretary so as to allow such decisions to be taken into account with respect to eligible individuals' choice of a private group health insurance plan under such program. Such participation in the program under this title shall include at least the covered benefits and provider networks available through such an entity and shall not involve greater out-of-pocket cost-sharing than the plan offered by such entity pursuant to its contract under section 8902 of title 5, United States Code.

(2) NO EFFECT ON FEHBP COVERAGE.—The Director of Office of Personnel Management shall take such steps as are necessary to ensure that each individual enrolled for health benefits coverage under the program under chapter 89 of title 5, United States Code, is not adversely affected by eligible individuals or others enrolled for coverage under the program under this title. Such steps shall include (but need not be limited to) the establishment of separate risk pools, separate contracts with participating insurers, and separately negotiated premiums.

SEC. 406. OPTIONS FOR HEALTH BENEFITS COVERAGE.

(a) SCOPE OF HEALTH BENEFITS COVERAGE.—The health benefits coverage provided to an eligible individual under a private group health insurance plan offered by a participating insurer shall consist of any of the following:

(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

(A) INCLUSION OF ESSENTIAL SERVICES.—The coverage includes each of the essential services identified by the National Advisory Commission on Expanded Access to Health Care and adopted by Congress under title III.

(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is equal to or greater than the actuarial value of one of the benchmark benefit packages.

(3) ALTERNATIVE COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, offers health benefits coverage equivalent to or greater than a plan described in and offered under section 8903(1) of title 5, United States Code.

(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

(1) FEHBP-EQUIVALENT HEALTH BENEFITS COVERAGE.—The plan described in and offered under chapter 89 of title 5, United States Code with the highest number of enrollees under such section for the year preceding the year in which the private group health insurance plan is proposed to be offered.

(2) PUBLIC PROGRAM-EQUIVALENT HEALTH BENEFITS COVERAGE.—Coverage provided under the State plan approved under the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) (without regard to coverage provided under a waiver of the requirements of either such program).

(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act (42 U.S.C. 33gg–91(b)(3))); and

(B) has the largest insured commercial, nonmedicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State.

(4) STATE EMPLOYEE COVERAGE.—The health insurance plan that is offered to State employees and has the largest enrollment of covered lives of any such plan.

(5) APPLICATION OF BENCHMARK STANDARDS.—A private group health plan offers bench-

mark benefits if, with respect to a benchmark plan described in paragraph (1), (2), (3), or (4), the private group health plan covers all items and services offered by the benchmark plan, with out-of-pocket cost-sharing for such items and services that is not greater than under the benchmark plan. Nothing in this title shall be construed to forbid a private group health plan from offering additional items and services not covered by such a benchmark plan or reducing out-of-pocket cost-sharing below levels applicable under such plan.

SEC. 407. ENROLLMENT PROCESS FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—The Secretary shall establish a process through which an eligible individual—

(1) may make an annual election to enroll in any private group health insurance plan offered by a participating insurer that has been awarded a contract under section 405(a) and serves the geographic area in which the individual resides, provided that such insurer's geographic area of service and guaranteed issuance under this section is conterminous with, or includes all of, a geographic area served pursuant to an entity's contact under section 8902 of title 5, United States Code; and

(2) may make an annual election to change the election under this clause.

(b) RULES.—In establishing the process under subsection (a), the Secretary shall use rules similar to the rules for enrollment, disenrollment, and termination of enrollment under the Federal employees health benefits program under chapter 89 of title 5, United States Code, including the application of the guaranteed issuance provision described in subsection (c).

(c) GUARANTEED ISSUANCE.—An eligible individual who is eligible to enroll for health benefits coverage under a private group health insurance plan that has been awarded a contract under section 405(a) at a time during which elections are accepted under this title with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1))) or any other factor.

SEC. 408. PLAN PREMIUMS.

(a) IN GENERAL.—Each purchasing pool operator shall negotiate (or, in the case of a purchasing pool operated pursuant to section 403(b)(1)(B), shall otherwise determine) a premium for each private group health insurance plan offered by a participating insurer.

(b) PERMITTED PROFIT MARGINS.—

(1) IN GENERAL.—Each premium negotiated under subsection (a) may not permit a profit margin that exceeds the applicable percentage (as defined in paragraph (2)).

(2) APPLICABLE PERCENTAGE DEFINED.—In this subsection, the term ''applicable percentage'' means—

(A) for the first 3 years that a purchasing pool is operated, 2 percent;

(B) for any subsequent year, the percentage determined by the purchasing pool operator, which may not be—

(i) less than the profit margin permitted under the Federal employees health benefits program under chapter 89 of title 5, United States Code; or

(ii) more than a multiple, established by the Secretary for purposes of this subsection, of profit margins permitted under such program.

SEC. 409. ENROLLEE PREMIUM SHARE.

(a) IN GENERAL.—A participating insurer offering a private group health insurance plan that has been awarded a contract under section 405(a) in which the eligible individual is enrolled may not deny, limit, or condition the

coverage (including out-of-pocket cost-sharing) or provision of health benefits coverage or vary or increase the enrollee premium share under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)) or any other factor.

(b) RISK-ADJUSTED PLAN PAYMENTS AND PREMIUMS CHARGED TO ENROLLEES.—

(1) IN GENERAL.—For each private group health insurance plan operated by a participating insurer, the pool operator shall adjust premium payments to compensate for the difference in health risk factors between plan enrollees and State residents as a whole (including residents who are not eligible individuals). Such adjustments shall employ risk-adjustment mechanisms promulgated by the Secretary.

(2) ADDITIONAL ADJUSTMENTS.—The pool operator shall also provide additional adjustments to premium payments that compensate participating insurers for the cost of keeping out-of-pocket cost-sharing amounts consistent with section 404(c)(9)(B).

(3) ENROLLEE PREMIUM COSTS.—The adjustments described in this subsection shall not affect enrollee premium shares, which shall be based on the

premium that would be charged for enrollees with health risk factors for State residents as a whole (as described in paragraph (1)), without taking into account cost-sharing adjustments under section 404(c)(9)(B).

(c) AMOUNT OF PREMIUM.—The amount of the enrollee premium share shall be equal to premium amounts (if any) above the applicable cap set pursuant to section 404(c)(10), plus 100 percent of the remainder minus the applicable percentage (as defined in section 36A(b) of the Internal Revenue Code of 1986, as added by section 311).

SEC. 410. PAYMENTS TO PURCHASING POOL OPERATORS AND PAYMENTS TO PARTICIPATING INSURERS.

The Secretary shall establish procedures for making payments to each purchasing pool operator as follows:

(1) RISK-ADJUSTMENT PAYMENT.—The Secretary shall pay each purchasing pool operator for the net costs of risk-adjusted payments to plans under section 409(b), to the extent the sum of upward adjustments exceeds the sum of downward adjustments for the pool operator.

(2) STOP-LOSS AND REINSURANCE PAYMENTS.—

(A) IN GENERAL.—The Secretary shall pay each purchasing pool operator for the applicable percentage (as defined in subparagraph (B)) of—

(i) the costs of any stop-loss coverage funded by the purchasing pool operator under section 405(d)(1); and

(ii) any reinsurance provided in accordance with section 405(d)(2).

(B) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term ''applicable percentage'' means—

(i) for the first 3 years that a purchasing pool is operated, 100 percent;

(ii) for the next 2 years that such purchasing pool is operated, 50 percent; and

(iii) for any subsequent year, 0 percent.

(3) PAYMENTS NECESSARY TO KEEP COST-SHARING WITHIN APPLICABLE LIMITS.—The Secretary shall make payments to purchasing pool operators to reimburse purchasing pool operators for the amount paid by such operators to participating insurers necessary to keep out-of-pocket cost-sharing

for individuals with limited ability to pay within applicable limits.

(4) PAYMENT FOR ADMINISTRATIVE COSTS.—The Secretary shall make payments to each purchasing pool operator for necessary pool administrative expenses.

(5) PAYMENTS TO OPM.—In the case of a purchasing pool described in section 403(b)(1)(B), payments under this section shall be made to the Director of the Office of Personnel Management.

SEC. 411. STATE-BASED REINSURANCE PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall establish standards for State-based reinsurance programs for eligible individuals to guard against adverse selection and to improve the functioning of the individual health insurance market.

(b) GRANTS FOR STATEWIDE REINSURANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary may award grants to States for the reasonable costs incurred in providing reinsurance under this section, consistent with standards developed by the Secretary, for coverage offered in the individual health insurance market and through State-based purchasing pools described in section 403.

(2) LIMITATION.—Such grants may not pay for reinsurance extending beyond individuals in the top 3 percent of the national health care spending distribution, as determined by the Secretary.

(3) APPLICATION.—A State desiring a grant under this section shall submit an application to the Secretary in such manner, at such time, and containing such information as the Secretary may require.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary for making grants under this section.

SEC. 412. COVERAGE UNDER INDIVIDUAL HEALTH INSURANCE.

(a) IN GENERAL.—Eligible individuals may use credits allowed under the Internal Revenue Code of 1986 (including supplemental assistance provided under such Code) for the purchase of health insurance coverage to enroll in State-licensed individual health insurance meeting the conditions of participation described in subsection (b).

(b) CONDITIONS OF PARTICIPATION.—The Secretary shall promulgate regulations that establish the terms and conditions under which an entity may participate in the program under this section and that include the following:

(1) PLAN MARKETING.—Conditions of participation for plans in the individual market (as developed by the Secretary) that—

(A) ensure that consumers receive the consumer information described in paragraph (2) before selecting a plan; and

(B) detect, deter, and penalize marketing fraud by entities offering or purporting to offer individual insurance.

(2) CONSUMER INFORMATION.—Requirements for each entity offering individual insurance to provide eligible individuals with information in a uniform and easily comprehensible manner that allows for informed comparisons by eligible individuals and that includes information regarding the health benefits coverage, costs, provider networks, quality, the amount and proportion of health insurance premium payments that go directly to patient care, and the plan's coverage rules (including amount, duration, and scope limits) and out-of-pocket cost-sharing (both inside and outside plan networks) for each essential service recommended by the National Advisory Commission on Expanded Access to Health Care and adopted by Congress under title III (which shall be prominently identified as an essential serv-

ice, including by reference to the Commission recommendation denoting the service as essential). To the maximum extent feasible, such requirements shall specify that the content and presentation of the information shall be provided in the same manner as similar information is presented to enrollees in the Federal employees health benefits program under chapter 89 of title 5, United States Code.

(3) OTHER CONDITIONS, INCLUDING THE ELIMINATION OF BARRIERS TO AFFORDABLE COVERAGE.—

(A) IN GENERAL.—Requirements for each entity offering individual insurance to abide by conditions of participation that the Secretary believes are reasonable and appropriate measures to address barriers to affordable health insurance coverage.

(B) SPECIFIC CONDITIONS.—The requirements developed by the Secretary under subparagraph (A) shall include (but need not be limited to)—

(i) guaranteed renewability, without premium increases based on changed individual risk; and

(ii) limits on risk rating.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to authorize the Secretary to impose any requirements on individual insurance, except with respect to eligible individuals purchasing individual insurance using advance payment of a tax credit provided under section 36A of the Internal Revenue Code of 1986.

SEC. 413. USE OF PREMIUM SUBSIDIES TO UNIFY FAMILY COVERAGE WITH MEMBERS ENROLLED IN MEDICAID AND SCHIP.

Notwithstanding any other provision of law, the Secretary shall establish procedures under which, in the case of a family with 1 or more members enrolled in with a managed care entity under the State medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act (42 U.S.C. 1396 et seq., 1397aa et seq.) and 1 or more members who are an eligible individual under this title, the family shall have the option to enroll all family members with the managed care entity under either or both such State programs. The procedures established by the Secretary shall provide that premiums charged to eligible individuals for enrollment with such an entity shall be based on the capitated payments established for adults or children, excluding adults and children who are known

to be pregnant, blind, disabled, or (in the case of adults) elderly, under the applicable State program (except that, in the case of an eligible individual known to be pregnant, premiums shall reflect capitated payments established under such State program for individuals known to be pregnant) plus reasonable administrative costs.

SEC. 414. COVERAGE THROUGH EMPLOYER-SPONSORED HEALTH INSURANCE.

(a) IN GENERAL.—Eligible individuals may use credits allowed under the Internal Revenue Code of 1986 and supplemental assistance to enroll in coverage offered by eligible employers.

(b) ELIGIBLE EMPLOYERS.—For purposes of this section, the term ''eligible employers'' includes the following:

(1) The current employer of the eligible individual or a member of such individual's family.

(2) A former employer required to offer coverage of the eligible individual under a COBRA continuation provision (as defined in section 9832(d)(1) of the Internal Revenue Code) or a State law requiring continuation coverage.

(3) A former employer voluntarily offering coverage of the eligible individual.

(c) APPLICATION OF DISREGARD OF PREEXISTING CONDITIONS EXCLUSIONS.—Notwithstanding any other provision of law, in the case of an individual who experiences a qualifying event (as defined in section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163)) and who, not later than 6 months after such event, is determined to be an eligible individual under this title, the same rules with respect to preexisting conditions as apply to a nonelecting TAA-eligible individual under section 605(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with respect to such individual, regardless of which type of qualified coverage the individual purchases.

(d) EXTENSION OF COBRA ELECTION PERIOD.—Notwithstanding any other provision of law, in the case of an individual who experiences a qualifying event (as defined in section 603 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1163)) and who, not later than 6 months after such event, is determined to be an eligible individual under this title, the same rules with respect to the temporary extension of a COBRA election period as apply to a nonelecting TAA-eligible individual under section 605(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1165(b)) shall apply with respect to such individual.

(e) CURRENT EMPLOYER COVERAGE.—If an eligible individual uses the credits allowed under the Internal Revenue Code of 1986 and supplemental assistance to purchase coverage from an employer described in subsection (b), such credits and assistance shall apply as a percentage, not of the total premium amount for the eligible individual, but of the employee's or former employee's share of premium payments.

SEC. 415. PARTICIPATION BY SMALL EMPLOYERS.

(a) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish procedures under which, during annual open enrollment periods, a small employer shall have the option of purchasing group coverage for employees and dependents of employees, including individuals who are not otherwise eligible individuals under this title, through a purchasing pool established under section 403(a).

(b) CONDITIONS OF PARTICIPATION.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the same requirements that apply with respect to participating insurers covering eligible low-income individuals under section 403 shall apply with respect to coverage offered by such insurers through a small employer.

(2) RISK ADJUSTMENT.—

(A) INCREASED PAYMENTS.—If employees of a small employer who are not otherwise eligible individuals under this title enroll in a private group health insurance plan under this title and have a collective risk level that exceeds the statewide average (as determined pursuant to risk adjustment mechanisms developed by the Secretary consistent with section 409(b)(1)), the Secretary (through a pool operator) shall provide participating insurers with such small employer enrollment bonus payments as are necessary to compensate the insurers for such increased risk. The premium charged to enrollees under this section shall be the same premium that is the basis of premium charges to enrollees who are eligible low-income individuals.

(B) REDUCED PAYMENTS.—A pool operator shall reduce payments to any plan with a risk level that falls below the statewide average (as so determined).

(3) ADMINISTRATIVE GUIDELINES.—The Secretary shall develop guidelines for pool operators to use in serving small employers, which shall be modeled after existing, successful, longstanding small

business purchasing cooperatives, and shall include administratively simple methods for small employers and licensed insurance brokers to participate in the program established under this title.

(c) INFORMATION CAMPAIGN.—

(1) IN GENERAL.—The pool operator for a State shall establish and conduct, directly or through 1 or more public or private entities (which may include licensed insurance brokers), a health insurance information program to inform small employers about health coverage for employees.

(2) REQUIREMENTS.—The program established under paragraph (1) shall educate small employers with respect to matters that include (but are not limited to) the following:

(A) The benefits of providing health insurance to employees, including tax benefits to both the employer and employees, increased productivity, and decreased employee turnover.

(B) The rights of small employers under Federal and State health insurance reform laws.

(C) Options for purchasing coverage, including (but not limited to) through the State's

purchasing pool operated pursuant to section 403.

(d) GRANTS TO HELP STATE-BASED POOLS PROMOTE SMALL BUSINESS COVERAGE.—

(1) IN GENERAL.—The Secretary may award grants to a pool operator for the following:

(A) The net costs of risk-adjusted payments under paragraph (b)(2), to the extent the sum of upward adjustments exceeds the sum of downward adjustments for the pool operator.

(B) The reasonable cost of the information campaign under subsection (c).

(C) The pool operator's reasonable administrative costs to implement this section.

(2) LIMITATION.—This section shall not apply to a State's pool unless sufficient grant funds have been received under this subsection to implement this section on a fiscally sound basis and such receipt is certified by the pool operator.

(3) APPLICATION.—A pool operator desiring a grant under this section shall submit an application to the Secretary in such manner, at such time, and containing such information as the Secretary may require.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary for making grants under this subsection.

SEC. 416. REPORT.

Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report containing recommendations for such legislative and administrative changes as the Secretary determines are appropriate to permit affinity groups related for reasons other than a common employer to participate in purchasing pools established under section 403.

SEC. 417. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated, such sums as may be necessary to carry out this title for fiscal year 2012 and each fiscal year thereafter.

(b) RULE OF CONSTRUCTION.—Amounts appropriated in accordance with subsection (a) shall be in addition to other amounts appropriated directly under this title and nothing in subsection (a) shall be construed to relieve the Secretary of mandatory payment obligations required under this title.

TITLE V—NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE

SEC. 501. NATIONAL ADVISORY COMMISSION ON EXPANDED ACCESS TO HEALTH CARE.

(a) ESTABLISHMENT.—Not later than October 1, 2009, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), shall establish an entity to be known as the National Advisory Commission on Expanded Access to Health Care (referred to in this section as the ''Commission'').

(b) APPOINTMENT OF MEMBERS.—

(1) IN GENERAL.—Not later than 45 days after the date of enactment of this Act, the House and Senate majority and minority leaders shall each appoint 4 members of the Commission and the Secretary shall appoint 1 member.

(2) CRITERIA.—Members of the Commission shall include representatives of the following:

(A) Consumers of health insurance.

(B) Health care professionals.

(C) State officials.

(D) Economists.

(E) Health care providers.

(F) Experts on health insurance.

(G) Experts on expanding health care to individuals who are uninsured.

(3) CHAIRPERSON.—At the first meeting of the Commission, the Commission shall select a Chairperson from among its members.

(c) MEETINGS.—

(1) IN GENERAL.—After the initial meeting of the Commission which shall be called by the Secretary, the Commission shall meet at the call of the Chairperson.

(2) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(3) SUPERMAJORITY VOTING REQUIREMENT.—To approve a report required under paragraph (2) or (3) of subsection (e), at least 60 percent of the membership of the Commission must vote in favor of such a report.

(d) DUTIES.—The Commission shall—

(1) assess the effectiveness of programs designed to expand health care coverage or make health care coverage affordable to the otherwise uninsured individuals through identifying the accomplishments and needed improvements of each program;

(2) make recommendations about benefits and cost-sharing to be included in health care coverage for various groups, taking into account—

(A) the special health care needs of children and individuals with disabilities;

(B) the different ability of various populations to pay out-of-pocket costs for services;

(C) incentives for efficiency and cost-control; and

(D) preventative care, disease management services, and other factors;

(3) recommend mechanisms to discourage individuals and employers from voluntarily opting out of health insurance coverage;

(4) recommend mechanisms to expand health care coverage to uninsured individuals with incomes above 200 percent of the official income poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(5) recommend automatic enrollment and retention procedures and other measures to increase health care coverage among those eligible for assistance;

(6) review the roles, responsibilities, and relationship between Federal and State agencies with respect to health care coverage and recommend improvements; and

(7) analyze the size, effectiveness, and efficiency of current tax and other subsidies for health care coverage and recommend improvements.

(e) REPORTS.—

(1) ANNUAL REPORT.—The Commission shall submit annual reports to the President and Congress addressing the matters identified in subsection (d).

(2) BIENNIAL REPORT.—

(A) IN GENERAL.—The Commission shall submit biennial reports to the President and Congress, which shall contain—

(i) recommendations concerning essential benefits and maximum out-of-pocket cost-sharing (for the general population and for individuals with limited ability to pay, which shall not exceed the out-of-pocket cost-sharing permitted under section 2103(e) of the Social Security Act (42 U.S.C. 1397cc(e))) for the coverage options described in title IV; and

(ii) proposed legislative language to implement such recommendations.

(B) CONGRESSIONAL ACTION.—The legislative language proposed under subparagraph (A)(ii) shall proceed to immediate consideration on the floor of the House of Representatives and the Senate and shall be approved or rejected, without amendment, using procedures employed for recommendations of military base closing commissions.

(3) COMMISSION REPORT.—No later than January 15, 2013, the Commission shall submit a report to the President and Congress, which shall include—

(A) recommendations on policies to provide health care coverage to uninsured individuals with incomes above 200 percent of the official income poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;

(B) recommendations on changes to policies enacted under this Act; and

(C) proposed legislative language to implement such recommendations.

(f) ADMINISTRATION.—

(1) POWERS.—

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

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

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

(D) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(2) COMPENSATION.—While serving on the business of the Commission (including travel time),

a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(3) STAFF.—

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

(B) STAFF COMPENSATION.—The Chairperson of the Commission 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.

(C) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

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

(g) TERMINATION.—Except with respect to activities in connection with the ongoing biennial report required under subsection (e)(2), the Commission shall terminate

90 days after the date on which the Commission submits the report required under subsection (e)(3).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for fiscal year 2010 and each fiscal year thereafter.

SEC. 502. CONGRESSIONAL ACTION.

(a) BILL INTRODUCTION.—

(1) IN GENERAL.—Any legislative language included in the report required under section 501(e)(3) may be introduced as a bill by request in the following manner:

(A) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the majority leader and the minority leader not later than 10 days after receipt of the legislative language.

(B) SENATE.—In the Senate, by the majority leader and the minority leader not later than 10 days after receipt of the legislative language.

(2) ALTERNATIVE BY ADMINISTRATION.—The President may submit legislative language based on the recommendations of the Commission and such legislative language may be introduced in the manner described in paragraph (1).

(b) COMMITTEE CONSIDERATION.—

(1) IN GENERAL.—Any legislative language submitted pursuant to paragraph (1) or (2) of subsection (a) (in this section referred to as ''implementing legislation'') shall be referred to the appropriate committees of the House of Representatives and the Senate.

(2) REPORTING.—

(A) COMMITTEE ACTION.—If, not later than 150 days after the date on which the implementing legislation is referred to a committee under paragraph (1), the committee has reported the implementing legislation or has reported an original bill whose subject is related to reforming the health care system, or to providing access to affordable health care coverage for Americans, the regular rules of the applicable House of Congress shall apply to such legislation.

(B) DISCHARGE FROM COMMITTEES.—

(i) SENATE.—

(I) IN GENERAL.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported by a committee of the

Senate within 180 days after the date on which such legislation was referred to committee under paragraph (1), it shall be in order for any Senator to move to discharge the committee from further consideration of such implementing legislation.

(II) SEQUENTIAL REFERRALS.—Should a sequential referral of the implementing legislation be made, the additional committee has 30 days for consideration of implementing legislation before the discharge motion described in subclause (I) would be in order.

(III) PROCEDURE.—The motion described in subclause (I) shall not be in order after the implementing legislation has been placed on the calendar. While the motion described in subclause (I) is pending, no other motions related to the motion described in subclause (I) shall be in order. Debate on a motion to discharge shall be limited to not more than 10 hours,

equally divided and controlled by the majority leader and the minority leader, or their designees. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed or disagreed to.

(IV) EXCEPTION.—If implementing language is submitted on a date later than May 1 of the second session of a Congress, the committee shall have 90 days to consider the implementing legislation before a motion to discharge under this clause would be in order.

(ii) HOUSE OF REPRESENTATIVES.—If the implementing legislation or an original bill described in subparagraph (A) has not been reported out of a committee of the House of Representatives within 180 days after the date on which such legislation was referred to committee under paragraph (1), then on any day on which the call of the calendar for motions to discharge committees is in order, any member

of the House of Representatives may move that the committee be discharged from consideration of the implementing legislation, and this motion shall be considered under the same terms and conditions, and if adopted the House of Representatives shall follow the procedure described in subsection (c)(1).

(c) FLOOR CONSIDERATION.—

(1) MOTION TO PROCEED.—If a motion to discharge made pursuant to subsection (b)(2)(B)(i) or (b)(2)(B)(ii) is adopted, then, not earlier than 5 legislative days after the date on which the motion to discharge is adopted, a motion may be made to proceed to the bill.

(2) FAILURE OF MOTION.—If the motion to discharge made pursuant to subsection (b)(2)(B)(i) or (b)(2)(B)(ii) fails, such motion may be made not more than 2 additional times, but in no case more frequently than within 30 days of the previous motion. Debate on each of such motions shall be limited to 5 hours, equally divided.

(3) APPLICABLE RULES.—Once the Senate is debating the implementing legislation the regular rules of the Senate shall apply.

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