

**AMENDMENT TO THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 3200
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(AINS-EC__001)

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

1 (3) EQUAL TREATMENT OF CERTAIN EMPLOYED
2 INDIVIDUALS.—

3 (A) IN GENERAL.—For purposes of apply-
4 ing this section with respect to an individual
5 who is an employee of an employer that has an
6 annual payroll (for the preceding calendar year)
7 which does not exceed \$750,000 and that
8 makes the contribution which would be required
9 under section 313(a) if the table specified in
10 subparagraph (B) were substituted for the table
11 specified in section 313(b)(1) (and if, in apply-
12 ing section 313(b)(2), \$750,000 were sub-
13 stituted for \$400,000), such individual shall be

1 treated in the same manner as an employee of
2 an employer that makes the contribution de-
3 scribed in section 313(a) (without regard to this
4 paragraph).

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

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

【Negotiated payment rates under public option:】 In
section 223—

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

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

7 (a) **NEGOTIATION OF PAYMENT RATES.**—

8 (1) **IN GENERAL.**—The Secretary shall nego-
9 tiate payment rates for the public health insurance
10 option for services and health care providers con-
11 sistent with this section and section 224.

12 (2) **MANNER OF NEGOTIATION.**—The Secretary
13 shall negotiate such rates in a manner that results
14 in payment rates that are not lower, in the aggre-
15 gate, than rates under title XVIII of the Social Se-

1 security Act, and not higher, in the aggregate, than
2 the average rates paid by other QHBP offering enti-
3 ties for services and health care providers.

4 (3) INNOVATIVE PAYMENT METHODS.—Nothing
5 in this subsection shall be construed as preventing
6 the use of innovative payment methods such as those
7 described in section 224 in connection with the nego-
8 tiation of payment rates under this subsection.

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

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

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

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

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

9 (1) IN GENERAL.—For purposes of this sub-
10 title, subject to paragraph (3), the table specified in
11 this subsection is as follows:

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

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

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

【Medicaid matching:】 Amend paragraph (2) of sec-
 tion 1701(a) to read as follows:

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

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

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

3 “(y) ADDITIONAL EXPENDITURES SUBJECT TO IN-
4 CREASED FMAP.—For purposes of section 1905(b)(5),
5 the amounts described in this subsection are the following:

6 “(1) Amounts expended for medical assistance
7 for individuals described in subclause (VIII) of sec-
8 tion 1902(a)(10)(A)(i).”

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

In the heading of section 1701(e), strike “100%”
and insert “INCREASED”.

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

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

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

10 (a) GAO STUDY ON FMAP.—

11 (1) STUDY.—The Comptroller General of the
12 United States shall conduct a study regarding fed-
13 eral payments made to the State Medicaid programs
14 under title XIX of the Social Security Act for the
15 purposes of making recommendations to Congress.

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

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

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

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

19 (1) STUDY.—The Comptroller General of the
20 United States shall conduct a study of the adminis-
21 tration of the Medicaid program by the Department
22 of Health and Human Services, State Medicaid
23 agencies, and local government agencies. The report
24 shall address the following issues:

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

5 (B) The administrative functions on which
6 federal Medicaid funds expended and the
7 amounts of such expenditures (whether spent
8 directly or by contract).

9 (2) REPORT.—Not later than February 15,
10 2011, the Comptroller General shall submit to the
11 appropriate committees of Congress a report on the
12 study conducted under paragraph (1).

【Level Playing Field for Public Option:】 In section 112, insert “and shall apply to the public health insurance option” after “or otherwise,”.

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

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

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

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

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

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

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

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

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

1 **SEC. 227. APPLICATION OF HIPAA INSURANCE REQUIRE-**
2 **MENTS.**

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

8 **SEC. 228. APPLICATION OF HEALTH INFORMATION PRI-**
9 **VACY, SECURITY, AND ELECTRONIC TRANS-**
10 **ACTION REQUIREMENTS.**

11 Part C of title XI of the Social Security Act, relating
12 to standards for protections against the wrongful disclo-
13 sure of individually identifiable health information, health
14 information security, and the electronic exchange of health
15 care information, shall apply to the public health insur-
16 ance option in the same manner as such part applies to
17 other health plans (as defined in section 1171(5) of such
18 Act).

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

19 (g) **ROLE FOR ENROLLMENT AGENTS AND BRO-**
20 **KERS.**—Nothing in this division shall be construed to af-
21 fect the role of enrollment agents and brokers under State
22 law, including with regard to the enrollment of individuals

1 and employers in qualified health benefits plans including
2 the public health insurance option.

【Presumptive State operation of certain Ex-
changes:】 In section 208(b), designate the current text
as a paragraph (1), with the heading “IN GENERAL.—”
and appropriate redesignations of subordinate provisions
and add at the end the following new paragraph:

3 (2) PRESUMPTION FOR CERTAIN STATE-OPER-
4 ATED EXCHANGES.—

5 (A) IN GENERAL.—In the case of a State
6 operating an Exchange prior to January 1,
7 2010 that seeks to operate the State-based
8 Health Insurance Exchange under this section,
9 the Commissioner shall presume that such Ex-
10 change meets the standards under this section
11 unless the Commissioner determines, after com-
12 pletion of the process established under sub-
13 paragraph (B), that the Exchange does not
14 comply with such standards.

15 (B) PROCESS.—The Commissioner shall
16 establish a process to work with a State de-
17 scribed in subparagraph (A) to provide assist-
18 ance necessary to assure that the State’s Ex-
19 change comes into compliance with the stand-
20 ards for approval under this section.

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

1 (b) ESTABLISHMENT OF A PROVIDER NETWORK.—

2 (1) IN GENERAL.—Health care providers participating (including physicians and hospitals) in
3 Medicare are participating providers in the public
4 health insurance option unless they opt out in a
5 process established by the Secretary consistent with
6 this subsection.
7

8 (2) REQUIREMENTS FOR OPT-OUT PROCESS.—

9 Under the process established under paragraph
10 (1)—

11 (A) providers described in such subparagraph shall be provided at least a 1-year period
12 prior to the first day of Y1 to opt out of participating in the public health insurance option;
13

14 (B) no provider shall be subject to a penalty for not participating in the public health
15 insurance option;
16

17 (C) the Secretary shall include information
18 on how providers participating in Medicare who
19 chose to opt out of participating in the public
20 health insurance option may opt back in; and
21

22 (D) there shall be an annual enrollment
23 period in which providers may decide whether

1 to participate in the public health insurance op-
2 tion.

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

Amend section 225(c) to read as follows:

7 (c) PAYMENT TERMS FOR PROVIDERS.—The Sec-
8 retary shall establish terms and conditions for the partici-
9 pation (on an annual or other basis specified by the Sec-
10 retary) of physicians and other health care providers
11 under the public health insurance option, for which pay-
12 ment may be made for services furnished during the year.

【Cooperatives:】 In title II of division A, add at the
end the following new subtitle:

13 **Subtitle D—Health Insurance Co-**
14 **operatives**

15 **SEC. 251. ESTABLISHMENT.**

16 Not later than 6 months after the date of the enact-
17 ment of this Act, the Commissioner, in consultation with
18 the Secretary of the Treasury, shall establish a Consumer
19 Operated and Oriented Plan program (in this subtitle re-
20 ferred to as the “CO-OP program”) under which the
21 Commissioner may make grants and loans for the estab-

1 lishment and initial operation of not-for-profit, member-
2 run health insurance cooperatives (in this subtitle individ-
3 ually referred to as a “cooperative”) that provide insur-
4 ance through the Health Insurance Exchange or a State-
5 based Health Insurance Exchange under section 208.
6 Nothing in this subtitle shall be construed as requiring
7 a State to establish such a cooperative.

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

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

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

15 (2) grants to cooperatives to assist such co-
16 operatives in meeting State solvency requirements in
17 the States in which such cooperative offers or issues
18 insurance coverage.

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

22 (1) The cooperative is structured as a not-for-
23 profit, member organization under the law of each
24 State in which such cooperative offers, intends to
25 offer, or issues insurance coverage, with the mem-

1 bership of the cooperative being made up entirely of
2 beneficiaries of the insurance coverage offered by
3 such cooperative.

4 (2) The cooperative did not offer insurance on
5 or before July 16, 2009, and the cooperative is not
6 an affiliate or successor to an insurance company of-
7 fering insurance on or before such date.

8 (3) The governing documents of the coopera-
9 tives incorporate ethical and conflict of interest
10 standards designed to protect against insurance in-
11 dustry involvement and interference in the govern-
12 ance of the cooperative.

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

15 (5) Substantially all of the activities of the co-
16 operative consist of the issuance of qualified health
17 benefit plans through the Health Insurance Ex-
18 change or a State-based health insurance exchange.

19 (6) The cooperative is licenced to offer insur-
20 ance in each State in which it offers insurance.

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

23 (8) As provided in guidance issued by the Sec-
24 retary of Health and Human Services, the coopera-
25 tive operates with a strong consumer focus, includ-

1 ing timeliness, responsiveness, and accountability to
2 members.

3 (9) Any profits made by the cooperative are
4 used to lower premiums, improve benefits, or to oth-
5 erwise improve the quality of health care delivered to
6 members.

7 (c) PRIORITY.—The Commissioner, in making grants
8 and loans under this section, shall give priority to coopera-
9 tives that—

10 (1) operate on a Statewide basis;

11 (2) use an integrated delivery system; or

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

14 (d) RULES OF CONSTRUCTION.—Nothing in this sub-
15 title shall be construed to prevent a cooperative established
16 in one State from integrating with a cooperative estab-
17 lished in another State the administration, issuance of cov-
18 erage, or other activities related to acting as a QHBP of-
19 fering entity. Nothing in this subtitle shall be construed
20 as preventing State governments from taking actions to
21 permit such integration.

22 (e) REPAYMENT FOR VIOLATIONS OF TERMS OF
23 PROGRAM.—If a cooperative violates the terms of the CO-
24 OP program and fails to correct the violation within a rea-
25 sonable period of time, as determined by the Commis-

1 sioner, the cooperative shall repay the total amount of any
2 loan or grant received by such cooperative under this sec-
3 tion, plus interest (at a rate determined by the Secretary).

4 (f) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated \$5,000,000,000 for the
6 period of fiscal years 2010 through 2014 to provide for
7 grants and loans under this section.

8 **SEC. 253. DEFINITIONS.**

9 For purposes of this subtitle:

10 (1) STATE.—The term “State” means each of
11 the 50 States and the District of Columbia.

12 (2) MEMBER.—The term “member”, with re-
13 spect to a cooperative, means an individual who,
14 after the cooperative offers health insurance cov-
15 erage, is enrolled in such coverage.

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

In section 100(c)(11), insert “and cooperatives
under subtitle D of title II” after “the public health in-
surance option”.

In section 100(c)(19)(B), insert “, including a coop-
erative under subtitle D of title II” after “offering the
coverage”.

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

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

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

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

1 **SEC. 1906. ESTABLISHMENT OF CENTER FOR MEDICARE**
2 **AND MEDICAID PAYMENT INNOVATION WITH-**
3 **IN CMS.**

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

1 side clinical and analytical experts with expertise in
2 medicine and health care management. The CMPI
3 shall use open door forums or other mechanisms to
4 seek input from interested parties.

5 “(b) TESTING OF MODELS (PHASE I).—

6 “(1) IN GENERAL.—The CMPI shall test pay-
7 ment models in accordance with selection criteria
8 under paragraph (2) to determine the effect of ap-
9 plying such models under title XVIII, title XIX, or
10 both titles on program expenditures under such ti-
11 tles and the quality of care received by individuals
12 receiving benefits under such titles.

13 “(2) SELECTION OF MODELS TO BE TESTED.—

14 “(A) IN GENERAL.—The Secretary shall
15 give preference to testing models for which, as
16 determined by the professional staff at the Cen-
17 ters for Medicare & Medicaid Services and
18 using such input from outside the Centers as
19 the Secretary determines appropriate, there is
20 evidence that the model addresses a defined
21 population for which there are deficits in care
22 leading to poor clinical outcomes or potentially
23 avoidable expenditures. The Secretary shall
24 focus on models expected to reduce program
25 costs under title XVIII, title XIX, or both titles

1 while preserving or enhancing the quality of
2 care received by individuals receiving benefits
3 under such titles.

4 “(B) APPLICATION TO OTHER DEM-
5 ONSTRATIONS.—The Secretary shall operate the
6 demonstration programs under sections 1222
7 and 1236 of the America’s Affordable Health
8 Choices Act of 2009 through the CMPI in ac-
9 cordance with the rules applicable under this
10 section, including those relating to evaluations,
11 terminations, and expansions.

12 “(3) BUDGET NEUTRALITY.—

13 “(A) INITIAL PERIOD.—The Secretary
14 shall not require as a condition for testing a
15 model under paragraph (1) that the design of
16 the model ensure that the model is budget neu-
17 tral initially with respect to expenditures under
18 titles XVIII and XIX.

19 “(B) TERMINATION.—The Secretary shall
20 terminate or modify the design and implemen-
21 tation of a model unless the Secretary deter-
22 mines (and the Chief Actuary of the Centers for
23 Medicare & Medicaid Services, with respect to
24 spending under such titles, certifies), after test-
25 ing has begun, that the model is expected to—

1 “(i) improve the quality of patient
2 care (as determined by the Administrator
3 of the Centers for Medicare & Medicaid
4 Services) without increasing spending
5 under such titles;

6 “(ii) reduce spending under such titles
7 without reducing the quality of patient
8 care; or

9 “(iii) do both.

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

13 “(4) EVALUATION.—The Secretary shall con-
14 duct an evaluation of each model tested under this
15 subsection. Such evaluation shall include an analysis
16 of—

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

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

22 The Secretary shall make the results of each evalua-
23 tion under this paragraph available to the public in
24 a timely fashion.

1 “(c) EXPANSION OF MODELS (PHASE II).—The Sec-
2 retary may expand the duration and the scope of a model
3 that is being tested under subsection (b) (including imple-
4 mentation on a nationwide basis), to the extent deter-
5 mined appropriate by the Secretary, if—

6 “(1) the Secretary determines that such expan-
7 sion is expected—

8 “(A) to improve the quality of patient care
9 without increasing spending under titles XVIII
10 and XIX;

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

13 “(C) to do both; and

14 “(2) the Chief Actuary of the Centers for Medi-
15 care & Medicaid Services certifies that such expan-
16 sion would reduce (or not result in any increase in)
17 net program spending under such titles.

18 “(d) IMPLEMENTATION.—

19 “(1) WAIVER AUTHORITY.—The Secretary may
20 waive such requirements of title XVIII and of sec-
21 tions 1902(a)(1), 1902(a)(13), and
22 1903(m)(2)(A)(iii) as may be necessary solely for
23 purposes of carrying out this section with respect to
24 testing models described in subsection (b).

1 “(2) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of—

4 “(A) the selection of models for testing or
5 expansion under this section;

6 “(B) the elements, parameters, scope, and
7 duration of such models for testing or dissemi-
8 nation;

9 “(C) the termination or modification of the
10 design and implementation of a model under
11 subsection (b)(3)(B); and

12 “(D) determinations about expansion of
13 the duration and scope of a model under sub-
14 section (e) including the determination that a
15 model is not expected to meet criteria described
16 in paragraphs (1) or (2) of such subsection.

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

21 “(4) FUNDING FOR TESTING ITEMS AND SERV-
22 ICES AND ADMINISTRATIVE COSTS.—There shall be
23 available from the Federal Supplementary Medical
24 Insurance Trust Fund for payments for designing,
25 conducting, and evaluating payment models, as well

1 as for additional benefits for items and services
2 under models tested under subsection (b) not other-
3 wise covered under this title and the evaluation of
4 such models, \$350,000,000 for fiscal year 2010 and,
5 for a subsequent fiscal year, the amount determined
6 under this sentence for the preceding fiscal year in-
7 creased by the annual percentage rate of increase in
8 total expenditures under this title for the previous
9 fiscal year. There are also appropriated, from any
10 amounts in the Treasury not otherwise appropriated,
11 \$25,000,000 for each fiscal year (beginning with fis-
12 cal year 2010) for administrative costs of admin-
13 istering this section with respect to the Medicaid
14 program under title XIX of the Social Security Act.
15 “(e) REPORT TO CONGRESS.—Beginning in 2012,
16 and not less than once every other year thereafter, the
17 Secretary shall submit to Congress a report on activities
18 under this section. Each such report shall describe the
19 payment models tested under subsection (b), any models
20 chosen for expansion under subsection (c), and the results
21 from evaluations under subsection (b)(4). In addition,
22 each such report shall provide such recommendations as
23 the Secretary believes are appropriate for legislative action
24 to facilitate the development and expansion of successful
25 payment models.”

1 (b) MEDICAID CONFORMING AMENDMENT.—Section
2 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
3 as amended by sections 1631(b), 1703, 1753, 1757, and
4 1759, is amended—

5 (1) in paragraph (77), by striking “and” at the
6 end;

7 (2) in paragraph (78), by striking the period at
8 the end and inserting “; and”; and

9 (3) by inserting after paragraph (78) the fol-
10 lowing new paragraph:

11 “(79) provide for implementation of the pay-
12 ment models specified by the Secretary under section
13 1115A(c) for implementation on a nationwide basis
14 unless the State demonstrates to the satisfaction of
15 the Secretary that implementation would not be ad-
16 ministratively feasible or appropriate to the health
17 care delivery system of the State.”.

【end-of-life planning】 Add at the end of subtitle D
of title I of division A the following:

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

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

20 (1) shall provide for the dissemination of infor-
21 mation related to end-of-life planning to individuals
22 seeking enrollment in Exchange-participating health
23 benefits plans offered through the Exchange;

1 (2) shall present such individuals with—

2 (A) the option to establish advanced direc-
3 tives and physician's orders for life sustaining
4 treatment according to the laws of the State in
5 which the individual resides; and

6 (B) information related to other planning
7 tools; and

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

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

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

16 (1) to require an individual to complete an ad-
17 vanced directive or a physician's order for life sus-
18 taining treatment or other end-of-life planning docu-
19 ment;

20 (2) to require an individual to consent to re-
21 strictions on the amount, duration, or scope of med-
22 ical benefits otherwise covered under a qualified
23 health benefits plan; or

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

1 (c) ADVANCED DIRECTIVE DEFINED.—In this sec-
2 tion, the term “advanced directive” includes a living will,
3 a comfort care order, or a durable power of attorney for
4 health care.

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

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

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

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

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

20 (C) provide palliative or hospice care or
21 use an item, good, benefit, or service furnished
22 for the purpose of alleviating pain or discom-
23 fort, even if such use may increase the risk of
24 death, so long as such item, good, benefit, or
25 service is not also furnished for the purpose of

1 causing, or the purpose of assisting in causing,
2 death, for any reason.

3 (3) EXEMPTION.—The requirements of sub-
4 section (a) shall not apply to any State that as of
5 August 1, 2009, requires the inclusion of informa-
6 tion prohibited in such paragraph in advanced direc-
7 tives or other planning tools.

【Public option enrollment voluntary; sense of Com-
mittee on Congressional option:】 At the end of subtitle
B of title II of division A, add the following:

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

10 Nothing in this division shall be construed as requir-
11 ing anyone to enroll in the public health insurance option.
12 Enrollment in such option is voluntary.