H.R. 1549: Helping Sick Americans Now Act

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Overview

In March 2010, the 111th Congress passed health reform legislation, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA; P.L. 111-152) and other laws. Among other provisions, ACA increases access to health insurance, expands private health insurance requirements regarding coverage and benefits, and requires the creation of health insurance exchanges to provide individuals and small employers with access to insurance.[1] Many of ACA's insurance market reforms are already in effect. Remaining reforms become effective on January 1, 2014. At that time, coverage will be available on a guaranteed issue basis, pre-existing condition exclusions will be prohibited,[2] and states or the federal government will be required to establish exchanges (structured marketplaces for the sale and purchase of health insurance)[3].

In order to help individuals with pre-existing conditions obtain health insurance coverage until 2014, ACA established a temporary high-risk pool (HRP) program. Individuals who have been uninsured for at least six months, have been denied coverage because of a pre-existing condition, and are U.S. citizens (or legally residing in the United States) are eligible for coverage under the ACA HRP, known as the Pre-Existing Condition Insurance Plan (PCIP). States may run their own programs or have the Department of Health and Human Services (HHS) do so. ACA provided a $5 billion appropriation to pay claims and administrative costs in excess of premiums. Although national enrollment in PCIP has been lower than expected, costs per participant have exceeded initial estimates. In February 2013, the Centers for Medicare & Medicaid Services (CMS) advised PCIP contractors to suspend program enrollment, in order that CMS would have the funds needed to cover the costs of those already enrolled through the program's end on January 1, 2014.[4]

ACA also authorizes a number of public health activities aimed, for example, at preventing common chronic diseases such as heart disease and cancer; addressing racial, ethnic, and gender disparities in health; expanding the numbers of primary care providers; and other purposes.[5] In addition, ACA appropriates billions of dollars to support new or existing grant programs and other activities, such as PCIP.[6] ACA also established the Prevention and Public Health Fund (PPHF) and provided it with a permanent annual appropriation. PPHF funds are to be transferred by the HHS Secretary "for prevention, wellness, and public health activities.... "[7] The PPHF receives an appropriation of $1 billion per fiscal year from FY2013 through FY2017, after which

[1] CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by (na me redacted).

[2] CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

[3] CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

[4] CMS, memorandum from Richard Popper, Director, Insurance Programs Group, to PCIP Contractors, "Announcement of PCIP Program Enrollment Suspension and Benefit Adjustment Analysis," February 15, 2013. See also https://www.pcip.gov/.

[5] CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by (name redacted) and (name redacted).

[6] CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

[7] ACA Section 4002.

annual appropriations increase incrementally, becoming $2 billion per fiscal year for FY2022 and thereafter. PPHF amounts for FY2013 through FY2021 are subject to sequestration under the Budget Control Act (BCA, P.L. 112-25).[8]

On April 17, 2013, the House Committee on Energy and Commerce reported H.R. 1549, the Helping Sick Americans Now Act. H.R. 1549 would (1) replenish the PCIP account with more than $3 billion transferred from the PPHF, (2) re-open PCIP enrollment, and (3) eliminate the PCIP eligibility requirement of a six-month uninsured period. As discussed in this report, the bill's proposed PPHF transfer appears sufficient to sustain PCIP through its sunset date. However, the loss of PPHF funds for several fiscal years could likely reduce total spending in a number of HHS accounts, particularly at the Centers for Disease Control and Prevention (CDC), to, or below, pre-ACA program levels. (See the later section of this report, "Annual Appropriations".)

This report describes provisions in H.R. 1549, and provides overviews of PCIP and the PPHF. **Appendix A** presents current law (ACA as amended) authorizing and appropriating PCIP **Appendix B** presents current law (ACA as amended) authorizing and appropriating the PPHF.

H.R. 1549, Summary of Provisions

H.R. 1549, the Helping Sick Americans Now Act, Section 2, would provide funding for continued PCIP enrollment by transferring to PCIP all available PPHF funds through FY2016. (See bill language in the text box below.) These funds would include FY2013 funds that were unobligated as of enactment, and all funds appropriated for FY2014 through FY2016. The Congressional Budget Office (CBO) estimates the total amount available for transfer at $3.6 billion, after sequestration, assuming enactment of H.R. 1549 in the spring of 2013.[9] (See also **Table 1**.)

Section 3 of the bill would eliminate the requirement that eligible individuals be uninsured for at least six months prior to PCIP enrollment. Section 4 would reopen PCIP enrollment, effective upon enactment, in accordance with existing program regulations, unless such regulations conflict with changes made by the bill, such as eliminating the requirement to be uninsured for six months.

PCIP authority sunsets on January 1, 2014. (See text of current law in **Appendix A**.) H.R. 1549 states that transferred PPHF funds would remain available for obligation through December 31, 2013. H.R. 1549 does not explicitly address the disposition of any transferred PPHF funds that remained unobligated as of January 1, 2014. The bill would not return these funds to the PPHF. CBO appears to assume that such funds would be returned to the Treasury, estimating that only $2.8 billion of the transferred amount would be spent under PCIP, resulting in an $840 million net reduction in direct spending.[10]

[8] CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by (name redacted).

[9] Congressional Budget Office, "H.R. 1549: Helping Sick Americans Now Act," cost estimate, April 19, 2013.

[10] Ibid. These estimates assume enactment of H.R. 1549 in the spring of 2013.

Text of H.R. 1549, as Reported in the House

SEC. 1. SHORT TITLE.

This Act may be cited as the "Helping Sick Americans Now Act".

SEC. 2. PRIORITIZING FUNDING FOR SICK AMERICANS.

Section 4002(c) of P.L. 111-148 (42 U.S.C. 300u-11(c)) is amended by adding at the end the following: "Notwithstanding any other provision of this section, the Secretary shall transfer amounts that are in the Fund that are attributable to fiscal year 2013 that are not otherwise obligated as of the date of the enactment of this sentence and funds that would otherwise be made available to the Fund for fiscal year 2014, fiscal year 2015, and fiscal year 2016 to the account within the Department of Health and Human Services that provides for funding to carry out the temporary high risk health insurance pool program under section 1101 and such funds shall become available for obligation under such section on such date of enactment and remain so available through December 31, 2013.".

SEC. 3. IMMEDIATE ACCESS TO HEALTH CARE FOR SICK AMERICANS.

(a) In General- Section 1101(d) of P.L. 111-148 (42 U.S.C. 18001(d)) is amended—

(1) in paragraph (1), by adding at the end "and";

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) Effective Date- The amendments made by subsection (a) shall apply with respect to individuals applying for coverage through the high risk insurance pool program on or after the date of the enactment of this Act.

SEC. 4. ENSURING AN ORDERLY REOPENING OF THE PROGRAM FOR SICK AMERICANS.

Section 1101(b) of P.L. 111-148 (42 U.S.C. 18001(b)) is amended by adding at the end the following new paragraph:

"(4) ORDERLY REOPENING OF PROGRAM- The Secretary shall administer this section in accordance with the regulations under part 152 of title 45, Code of Federal Regulations, as in effect as of April 16, 2013, except as is necessary to reflect the amendments made by the Helping Sick Americans Now Act.".

The Pre-Existing Condition Insurance Plan (PCIP) Program

High-risk pools (HRPs) are intended for individuals who cannot obtain or afford health insurance in the private market, primarily because of pre-existing health conditions. States began establishing HRPs in the 1970s, and in 2011, 34 states had state-established HRPs, and approximately 225,000 individuals were enrolled across the states.[11]

In addition to state-established HRPs, ACA requires the HHS Secretary to establish a temporary federal HRP program.[12] The temporary HRP program, known as the Pre-Existing Condition Insurance Plan (PCIP), is intended to provide transitional coverage for uninsured individuals with pre-existing conditions until January 1, 2014, when private health plans will be prohibited from excluding coverage for pre-existing conditions and will be required to make insurance available to every applicant who applies for coverage. Individuals who have been uninsured for at least six

[11] Enrollment data current as of December 31, 2011; available at http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7.

[12] ACA Section 1101. See text of current law in **Appendix A**.

months, have been denied coverage because of a pre-existing condition, and are U.S. citizens (or legally residing in the United States) are eligible for coverage under a PCIP. Coverage offered in a PCIP must meet certain standards related to the amount enrollees pay toward premiums and cost-sharing requirements. ACA appropriated $5 billion of federal funds to subsidize the program's claims and administrative costs.

States can run the PCIP program or elect to have HHS operate the program in their states. HHS administers the PCIPs in 23 states and the District of Columbia, and 27 states administer their own PCIPs. As of February 28, 2013, approximately 110,888 individuals were enrolled in PCIPs across the states.[13] As of February 16, 2013, the federal government suspended acceptance of new enrollment applications for the PCIPs run by HHS, due to concern regarding available funding for existing PCIP enrollees.[14] Similarly, the federal government required state-administered PCIPs to also suspend acceptance of new enrollment applications, as of March 2, 2013.[15] Both HHS-administered and state-administered PCIPs will continue to cover individuals enrolled prior to the suspension dates, until the program terminates in 2014.

The Prevention and Public Health Fund (PPHF)

Authority and Spending

ACA Section 4002 authorizes and appropriates the PPHF with the stated purpose "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The HHS Secretary is required to transfer amounts in the PPHF fund: "... to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs…."[16]

ACA appropriated increasing amounts to the PPHF for FY2010 through FY2014, and an amount of $2 billion per fiscal year in perpetuity thereafter. In February 2012, in the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96, Section 3205), Congress amended the PPHF authority, decreasing the appropriated amounts from FY2013 through FY2021 as part of a package of offsets to partly cover the costs of the law. These costs included, among other things, the costs of extending certain unemployment and health programs. Original appropriations to the PPHF in ACA and current-law amounts are presented in **Table 1**, below. Note that amounts from FY2013 through FY2021 are subject to sequestration.

[13] According to data published by CMS at https://data.cms.gov/Health/Monthly-Pre-Existing-Condition-Insurance-Plan-Enro/dpuq-z7nj.

[14] ACA Section 1101(g)(2) provides authority to the HHS Secretary to make adjustments to the program if she estimates a funding shortfall. See **Appendix A**.

[15] For more information about the suspensions, see https://www.pcip.gov/.

[16] See **Appendix B** for the language in current law authorizing and appropriating the PPHF.

Table 1. PPHF Appropriations Under ACA and Current Law

Dollars in millions

Fiscal Year	Total Appropriation	
	ACA (P.L. 111-148)	Current Law[a]
2010	500	500
2011	750	750
2012	1,000	1,000
2013	1,250	949[b]
2014	1,500	1,000[c]
2015	2,000	1,000[c]
2016	2,000	1,000[c]
2017	2,000	1,000[c]
2018	2,000	1,250[c]
2019	2,000	1,250[c]
2020	2,000	1,500[c]
2021	2,000	1,500[c]
2022 and each subsequent FY	2,000	2,000

Source: Prepared by Congressional Research Service.

a. ACA, as amended by P.L. 112-96, the Middle Class Tax Relief and Job Creation Act of 2012, Sec. 3205.

b. Reflects reduction to $1 billion under P.L. 112-96, and cancellation of 5.1% ($51 million) of FY2013 budgetary resources under Budget Control Act (BCA) sequestration for nonexempt nondefense mandatory programs, as of March 1, 2013. For background on BCA sequestration, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by (name redacted).

c. Amounts through FY2021 are subject to BCA sequestration in amounts to be determined by the White House Office of Management and Budget (OMB). The Congressional Budget Office (CBO) estimates that $70 million (i.e., 7.0%) will be cancelled in each of fiscal years 2014 through 2016. CBO, "H.R. 1549, Helping Sick Americans Now Act, as ordered reported by the House Committee on Energy and Commerce on April 17, 2013," cost estimate, April 19, 2013.

PPHF funds are available to the Secretary on October 1 of each year, when each new fiscal year begins. As a result, the Administration's annual budget proposals for the PPHF reflect not the Administration's request for the funds, but rather its intended distribution and use of the funds. The distribution of PPHF funds to various HHS agencies for FY2010 through the FY2014 President's budget proposal is presented in **Table 2** below.

Table 2. PPHF Transfers to HHS Agencies, FY2010-FY2014

(Dollars in Millions)

Agency	FY2010	FY2011	FY2012	FY2013[a]	FY2014 Proposal[b]	Agency Total, FY10-FY14	Agency Total (%)
AHRQ	5.5	12.0	12.0	6.5	0.0	**36.0**	0.9
AoA/ACL	0.0	0.0	20.0	9.2	24.7	**53.9**	1.3
CDC	191.8	610.9	809.0	462.9	755.1	**2,829.7**	67.4
CMS	0.0	0.0	0.0	453.8[c]	0.0	**453.8**[c]	10.8
HRSA	270.7	20.0	37.0	1.8	57.4	**386.9**	9.2
OS	12.0	19.1	30.0	0.0	104.8	**166.0**	4.0
SAMHSA	20.0	88.0	92.0	14.7	58.0	**272.7**	6.5
TOTAL	**500.0**	**750.0**	**1,000.0**	**949.0**	**1,000.0**	**4,199.0**	**100.0**

Sources: Prepared by Congressional Research Service based on HHS agency congressional budget justifications for FY2012 through FY2014, http://www.hhs.gov/budget/; and HHS, "Prevention and Public Health Fund," funding distribution tables, http://www.hhs.gov/open/recordsandreports/prevention/index.html.

Note: Individual amounts may not add to totals due to rounding. Acronyms are as follows: AHRQ is the Agency for Healthcare Research and Quality, AoA is the Administration on Aging, ACL is the Administration for Community Living, CDC is the Centers for Disease Control and Prevention, CMS is the Centers for Medicare & Medicaid Services, HRSA is the Health Resources and Services Administration, OS is the Office of the HHS Secretary, and SAMHSA is the Substance Abuse and Mental Health Services Administration.

a. Amounts reflect cancellation of $51 million in budgetary resources under FY2013 sequestration.

b. Distribution proposed by the Administration. This is not a budget request, as PPHF funds have already been appropriated. Amounts do not reflect FY2014 sequestration that is required under current law.

c. According to HHS, funds are for "Health Insurance Enrollment Support" for implementation of insurance exchanges under ACA, "[t]o invest in health insurance enrollment support specifically through activities that will assist with eligibility determinations which are in need of intervention and activities to make people aware of insurance options and enrollment assistance available to them." HHS, "Prevention and Public Health Fund," FY2013 funding distribution table, http://www.hhs.gov/open/recordsandreports/prevention/index.html.

Scope of PPHF-Funded Activities

The terms "prevention," "wellness," and "public health activities," which describe allowable PPHF-funded activities, are not defined in the Public Health Service Act (PHSA), ACA, or elsewhere in federal law. ACA was not accompanied by committee reports in either chamber. Finally, HHS has not published regulations, guidance, or other information to clarify the department's views about the types of activities that are within scope for PPHF funding.[17]

HHS recently published an annual report to Congress on PPHF spending for FY2012, as required by law.[18] The report notes spending (typically through grants or contracts) on the following types

[17] For more information about federal prevention activities and how they may be defined, see Government Accountability Office, *Available Information on Federal Spending, Cost Savings, and International Comparisons Has Limitations*, GAO-13-49, December 6, 2012, http://gao.gov/products/GAO-13-49.

[18] HHS, "The Affordable Care Act and the Prevention and Public Health Fund: Report to Congress for FY2012," (continued...)

of activities, among others: (1) *community prevention activities* to improve health and reduce chronic disease risk factors, to reduce tobacco use, and to improve fitness and reduce obesity; (2) *clinical prevention activities* to improve access to important preventive services and definitive care for a variety of health needs; (3) *behavioral health* screening and integration with primary care; (4) *public health infrastructure*, workforce, and training; and (5) *public health research* and data collection.

As seen in **Table 2**, more than two-thirds of PPHF funds have been distributed to the Centers for Disease Control and Prevention (CDC), which states its mission as "[c]ollaborating to create the expertise, information, and tools that people and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats."[19]

Members of Congress hold a variety of views about the PPHF.[20] The Fund's proponents often support an expanded view of the role of public health in addressing so-called social or non-medical determinants of health, such as behavior, socioeconomic status, and the environment.[21] They see the PPHF as a means to enable communities to expand their public health efforts in order to control the chronic disease burdens that affect them. Others have objected to this approach; some criticize the use of the PPHF for public works projects such as playgrounds and bike lanes, while others charge that a federal role in behavior modification is inappropriate and intrusive. Some feel that the PPHF is an unwarranted expenditure of funds in tight fiscal times. Some have objected to the amount of discretion afforded the Secretary in allocating the funds. Some Members of Congress oppose ACA in its entirety.

In April 2013, HHS presented its long-delayed distribution plan for the FY2013 PPHF funds. The department intends to transfer $454 million—almost half of the $949 million available for FY2013—to the Centers for Medicare & Medicaid Services (CMS) to help pay for ongoing ACA implementation activities, including the establishment of the federally facilitated exchanges, as well as consumer education and outreach.[22] Congress did not provide CMS with any FY2013 discretionary funding for ACA implementation. The plan to transfer PPHF funds to CMS was criticized by supporters of the Fund.[23] As shown in **Table 2**, each HHS agency that received a PPHF fund transfer in FY2012 would receive substantially less from the PPHF for FY2013, largely as a result of the transfer to CMS. If H.R. 1549 were enacted, the date of enactment would affect the total amount of FY2013 PPHF funds available for transfer. HHS began obligating

(...continued)

undated, http://www.hhs.gov/open/recordsandreports/prevention/fy2012_aca_rpt_to_congress.pdf.

[19] CDC, Vision, Mission, Core Values, and Pledge, http://www.cdc.gov/about/organization/mission.htm.

[20] Unless otherwise noted, information in this paragraph is drawn from: Michael Kranish, "In Health Bill, Billions for Parks, Paths," *The Boston Globe*, July 9, 2009; John Reichard, "Whither the Overhaul Law's Prevention Fund?," *CQ HealthBeat News*, January 6, 2011; and Jennifer Haberkorn, "The Prevention and Public Health Fund," *Health Affairs*, Health Policy Brief, February 23, 2012. In the 112th Congress, the House passed H.R. 1217, a bill to repeal the PPHF. A similar bill, H.R. 1099, has been introduced in the House in the 113th Congress. Comparable bills have not advanced in the Senate.

[21] For more information, see Michele J. Orza, *High Hopes: Public Health Approaches to Reducing the Need for Health Care*, National Health Policy Forum, September 27, 2010, http://www.nhpf.org/library/details.cfm/2833.

[22] Rachana Dixit, "HHS Sets Aside $454 Million In Prevention Funds For Insurance Enrollment Support, *InsideHealthPolicy,* April 16, 2013.

[23] John Reichard, "HHS Draws $304 Million from Prevention Fund to Enroll Uninsured," *CQ HealthBeat News*, April 12, 2013.

FY2013 PPHF funds in April 2013. The later an enactment date, the more FY2013 PPHF funds would have been obligated and unavailable for transfer.[24]

Annual Appropriations

In some cases, the Secretary has used, or proposed to use, PPHF funds in addition to funds from annual discretionary appropriations. For example, for FY2013, the Administration proposed using the PPHF to fund almost the entire budget of the CDC Center on Birth Defects and Development Disabilities.[25] If PPHF funds were to become unavailable, appropriators would be required to provide additional regular appropriations in order to sustain programmatic activities.[26]

This trend is perhaps most evident for the CDC Chronic Disease Prevention and Health Promotion account, which has received sizeable PPHF distributions since these funds first became available for FY2010. For FY2009, before the PPHF, this account was appropriated at $984 million. Over the next several fiscal years, the account received a smaller discretionary appropriation and an increasing PPHF transfer amount. For example, for FY2012, the account received an $800 million discretionary appropriation and an additional $411 million from the PPHF, providing a $1.21 billion program level (i.e., total available funding). For FY2014, the Administration requests $620 million in discretionary appropriations, and plans to add to this a $416 million PPHF transfer, for a $1.04 billion program level. However, if CDC were to receive the requested discretionary appropriation for FY2014 but the additional PPHF funds were unavailable, the program level would be decreased by 37% (from $984 million to $620 million) compared to FY2009.[27]

[24] Congressional Budget Office, "H.R. 1549: Helping Sick Americans Now Act," cost estimate, April 19, 2013.

[25] CDC, *Justification of Estimates for Congressional Committees*, FY2013, February, 2012, p. 153, http://www.cdc.gov/fmo.

[26] John Reichard, "Advocates: CDC, Other Agencies Face Big Cuts Fast if Prevention Fund Ends," *CQ HealthBeat*, June 18, 2012.

[27] CDC, *Justification of Estimates for Congressional Committees*, FY2014, April, 2013, pp. 135 and 138 (funding history), http://www.cdc.gov/fmo.

Appendix A. PCIP Authority

[ACA Sec. 1101; 42 U.S.C. 18001(d)]

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) IN GENERAL.–Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) ADMINISTRATION.–

(1) IN GENERAL.–The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.–To be eligible for a contract under paragraph (1), an entity shall–

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) MAINTENANCE OF EFFORT.–To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.–

(1) IN GENERAL.–Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) REQUIREMENTS.–A qualified high risk pool meets the requirements of this paragraph if such pool–

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage–

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except

that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall–

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

(ii) vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) ELIGIBLE INDIVIDUAL.–An individual shall be deemed to be an eligible individual for purposes of this section if such individual–

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and

(3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.–

(1) IN GENERAL.–The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

(2) SANCTIONS.–An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan–

(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or

(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)– (I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or (II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.

(3) CONSTRUCTION.–Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) OVERSIGHT.– The Secretary shall establish–

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(g) FUNDING; TERMINATION OF AUTHORITY.–

(1) IN GENERAL.–There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.–If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) TERMINATION OF AUTHORITY.–

(A) IN GENERAL.–Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) TRANSITION TO EXCHANGE.–The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) LIMITATIONS.–The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) RELATION TO STATE LAWS.–The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

Appendix B. PPHF Authority

[ACA Sec. 4002, as amended; 42 U.S.C. §300u-11]

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND

(a) Purpose. It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the "Fund"), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) Funding. There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated–

(1) for fiscal year 2010, $500,000,000;

(2) for each of fiscal years 2012 through 2017, $1,000,000,000;

(3) for each of fiscal years 2018 and 2019, $1,250,000,000;

(4) for each of fiscal years 2020 and 2021, $1,500,000,000; and

(5) for fiscal year 2022, and each fiscal year thereafter, $2,000,000,000.

(c) Use of Fund. The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.

(d) Transfer authority. The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

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