Exhibit 25

Calendar No. 184

111TH CONGRESS *1st Session* | SENATE | REPORT 111–89

AMERICA'S HEALTHY FUTURE ACT OF 2009

R E P O R T

[TO ACCOMPANY S. 1796]

ON

PROVIDING AFFORDABLE, QUALITY HEALTH CARE FOR ALL AMERICANS AND REDUCING THE GROWTH IN HEALTH CARE SPENDING, AND FOR OTHER PURPOSES

together with

ADDITIONAL AND MINORITY VIEWS

COMMITTEE ON FINANCE
UNITED STATES SENATE

OCTOBER 19, 2009.—Ordered to be printed

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Mr. BAUCUS, from the Committee on Finance, submitted the following

R E P O R T

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ADDITIONAL AND MINORITY VIEWS

[To accompany S. 1796]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having considered an original bill, S. 1796, to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, reports favorably thereon and recommends that the bill do pass.

I. BACKGROUND AND NEED FOR LEGISLATION

The U.S. health system is in crisis. In 2008, over 46 million Americans were uninsured and millions more have lost their health coverage as a result of the recent economic downturn. Another 25 million people are underinsured, with coverage that is insufficient to protect against the cost of a major illness. The rising cost of health care outpaces wages by a factor of five to one, placing an ever greater strain on family, business, and government budgets.

Improving the health system is one of the most important challenges we face as a nation, and the inability to achieve comprehensive health reform will undermine any efforts to secure a full and lasting economic recovery. Health reform is an essential part of restoring America's overall economy and maintaining our global competitiveness.

Health care reform is also necessary to protect the finances of working families. Between 2000 and 2009, average family premiums for employer-sponsored health coverage increased by 93 percent—increasing from $6,772 to $13,073—while wages increased by only 19 percent in the same period. Rising health care costs and mounting medical debt account for half of all filed bankruptcies—affecting two million people a year.

Countless studies have shown that those without health coverage generally experience worse health outcomes and poorer health compared to those who are insured. The uninsured are less likely to receive preventive care or even care for traumatic injuries, heart attacks, and chronic diseases. As a result, 23 percent forgo necessary care every year due to cost, while 22,000 uninsured adults die prematurely each year as a result of lacking access to care.

A majority of the uninsured has low or moderate incomes—with two-thirds in families with an annual income less than twice the Federal poverty level (FPL). Eight in ten of the uninsured are in working families in which workers are either not offered coverage by their employer or they do not qualify for employer-offered coverage.

Hospitals and clinics provide an estimated $56 billion annually in uncompensated care to people without health insurance, and those with health coverage pay the bill through higher health care costs and increased premiums. This so-called "hidden health tax" cost the average family over $1,000 in high premiums last year. An estimated ten percent of health care premiums in California are attributable to cost shifting due to the uninsured.

Rising health costs have taken a toll on U.S. businesses as well. An estimated 159 million Americans receive health benefits through an employer, with the average cost of this coverage reaching $4,824 for single coverage and $13,375 for family coverage in 2009. Over the last decade, employer-sponsored coverage has increased by 131 percent, forcing employers—particularly small employers—to make difficult choices among painful options to offset increasing health costs. These choices include raising workers' premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

Federal and state governments have also struggled with health care costs. The Congressional Budget Office has noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance." The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care—a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP, or $4.3 trillion annually. Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years. Over the same period, the GDP will grow by just 64 percent.

Despite high levels of spending on health care, a recent study by the Institute of Medicine concludes that the current health system is not making progress toward improving quality or containing costs for patients or providers. Research documenting poor quality of care received by patients in the U.S. is shocking. A 2003 RAND

Corporation study found that adults received recommended care for many illnesses only 55 percent of the time. Needed care for diabetes was delivered only 45 percent of the time and for pneumonia 39 percent of the time. Patients with breast cancer fared better, but still did not receive recommended care one-quarter of the time.

Compared to other industrialized countries, our quality of care does not reflect the level of our investment. The U.S. ranks last out of 19 industrialized countries in unnecessary deaths and 29th out of 37 countries for infant mortality—tied with Slovakia and Poland, and below Cuba and Hungary. Our rate of infant mortality is double that of France and Germany.

In short, Americans are not getting their money's worth when patients receive services of little or no value—such as hospitalizations that could have been prevented with appropriate outpatient treatment, duplicate tests, or ineffective tests and treatments. Yet the current system does little to steer providers toward the right choices. Even though more care does not necessarily mean better care, Medicare and most other insurers continue to pay for more visits, tests, imaging services, and procedures, regardless of whether the treatment is effective or necessary, and pay even more when treatment results in subsequent injury or illness.

Providers are not consistently encouraged to coordinate patients' care or to supply preventive and primary care services, even though such actions can improve quality of care and reduce costs. Rewarding providers that furnish better quality care, coordinate care, and use resources more judiciously could reduce costs and, most importantly, better meet the health care needs of millions more American patients.

Each of the key challenges facing our health care system—lack of access to care, the cost of care, and the need for better-quality care—must be addressed together in a comprehensive approach. Covering millions of uninsured through a broken health system is fiscally unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will not alleviate the burden of uncompensated care and cost shifting. The time for incremental improvements has passed; health care reform must be comprehensive in scope.

It is in this context that the Finance Committee developed the legislative proposal that would become the "America's Healthy Future Act." The legislation approved by the Finance Committee addresses the challenges facing our health care system by expanding health coverage to 29 million Americans, improving quality of care and transforming the health care delivery system, and reducing Federal health spending and the Federal deficit over the ten year budget window and in the long run.

As a general principle, the bill allows those who like their health insurance to keep what they have today. For the millions of Americans who don't have employer-sponsored coverage, cannot afford to purchase coverage on their own, or who are denied coverage by health insurance companies due to a pre-existing condition, the Chairman's Mark reforms the individual and small-group markets, making health coverage affordable and accessible. These market reforms would require insurance companies to issue coverage to all individuals regardless of health status, prohibit insurers from lim-

iting coverage based on pre-existing conditions and allow only limited variation in premium rates.

The Mark would make purchasing health insurance coverage easier and more understandable by creating state-based web portals, or "exchanges" that would direct consumers to all available health plan options. The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges—like the individual market exchanges—would be web portals that make comparing and purchasing health care coverage easier for small businesses.

The Mark standardizes benefits to force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and ensures that every policy offered in the individual and small group market provides meaningful coverage for essential services. Those age 25 or under will also have access to an affordable young invincible plan that would provide catastrophic coverage and first dollar coverage for prevention. Plans would not be allowed to set lifetime or annual coverage limits.

The Chairman's Mark would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults with incomes at or below $30,000 a year for a family of four ($14,400 for an individual), beginning in 2014. Individuals between 100 percent of FPL and 133 percent of FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a health insurance exchange. The federal government would provide significant additional funding to states to cover the cost of providing services to newly eligible Medicaid beneficiaries.

To ensure that health coverage is affordable, the Mark would provide an advanceable, refundable tax credit for low and middle-income individuals (between 100–400 percent of FPL) to help offset the cost of private health insurance premiums. Undocumented immigrants are prohibited from benefiting from the credit. A cost-sharing subsidy would be provided to limit the amount of out-of-pocket costs that individuals and families between 100–200 percent of FPL have to pay. The cost-sharing subsidy would be designed to buyout any difference in cost sharing between the insurance purchased and a higher actuarial value plan.

A tax credit would also be available to small businesses. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution. Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchange can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of $20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over $20,000, with a complete phase-out at 25 employees or average taxable wages of $40,000. Non-profit organizations with 25 or fewer employees would also be eligible to receive tax credits if they meet the same requirements. These organizations would be eligible for a 25 per-

cent credit from 2011–2013 and a 35 percent credit in 2013 and thereafter.

The Mark creates authority for the formation of the Consumer Owned and Oriented Plans (CO–OPs). These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. These plans will offer consumer-focused alternatives to existing insurance plans. Six billion dollars in federal seed money would be provided for start-up costs and to meet state solvency requirements.

To ensure the insurance market reforms function properly, the Mark would create a personal responsibility requirement for health care coverage, with exceptions provided for religious conscience (as defined in Medicare) and undocumented individuals. Those who fail to meet the requirement are subject to a penalty. Appropriate exemptions are made from the penalty.

The Chairman's Mark does not require employers to offer health insurance. However, effective July 1, 2013, all employers with more than 50 employees who do not offer coverage would be required to reimburse the government for each full-time employee (defined as those working 30 or more hours a week) receiving a health care affordability tax credit in the exchange equal to the average national exchange credit and subsidy up to a cap of $400 per total number of employees (whether they are receiving a tax credit and subsidy or not). A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

In addition to provisions that expand health care coverage, the Chairman's Mark would make critical investments in policies to promote healthy living and help prevent costly chronic conditions like diabetes, cancer, heart disease and obesity. Preventive screenings enable doctors to detect diseases earlier, when treatment is most effective, thereby averting more serious, costly health problems later.

The Mark would provide Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan designed to address health risks and chronic health problems and to develop a schedule for regular recommended preventive screenings. It would eliminate out-of-pocket costs for recommended preventive services for Medicare beneficiaries and provide incentives for states to cover recommended services and immunizations in Medicaid. And finally, the Mark establishes an initiative to reward Medicare and Medicaid participants for healthier choices. Funding will be available to provide participants with incentives for completing evidence-based, healthy lifestyle programs and improving their health status. Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity.

The legislation makes significant steps to reform the health care delivery system. Medicare currently reimburses health care providers on the basis of the volume of care they provide—regardless of whether the treatment contributes to helping a patient recover. The Chairman's Mark includes various proposals to move the Medicare fee-for-service system towards paying for quality and value. These proposals include hospital value-based purchasing—and

value-based purchasing for other Medicare providers including physicians, home health agencies, nursing homes, long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers.

To encourage greater collaboration among health care providers, the Chairman's Mark would allow high-quality providers that coordinate care across a range of health care settings to share in the savings they achieve for the Medicare program. It would create an Innovation Center at the Centers for Medicare & Medicaid Services (CMS) that would have authority to test new patient-centered payment models designed to encourage evidence-based, coordinated care for Medicare, Medicaid, and CHIP. Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program. It would also implement a national pilot program on payment bundling and start to pay hospitals less for avoidable hospital readmissions.

Efforts to reduce costs and improve quality in the health care delivery system will require an investment in the health care infrastructure necessary to support coordinated quality care and create a more effective, efficient delivery system. The legislation would provide additional resources to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. The Mark would also invest in research on what treatments work best for which patients and ensure that information is available and accessible to patients and doctors, such as through the establishment of an independent institute to research the effectiveness of different health care treatments and strategies. These provisions are carefully crafted so that patients would never be denied treatment based on age, disability status or other related factors as a result of the research findings.

To promote primary care and maintain adequate access to health care providers, the Chairman's Mark would provide primary care practitioners and targeted general surgeons with a Medicare payment bonus of ten percent for five years. It would strengthen the health care workforce by increasing graduate medical education (GME) training positions through a slot re-distribution program for currently unused training slots, with priority given to increasing training in primary care and general surgery. The provision would also encourage additional training in outpatient settings, including teaching health centers, and ensure communities retain vital training slots if a hospital closes.

The Mark also improves the accuracy of Medicare payments to providers by reducing overpayments to providers. It would cancel a scheduled 21.5 percent reduction to physician payments in 2010 and replace the impending cut with a positive update. The legislation would improve the value of Medicare Advantage by reforming payments so that the program appropriately pays insurers for their costs and promotes plans that offer high quality, efficient health care for seniors. To preserve beneficiary access to certain services they now receive, the legislation would grandfather MA plans in areas where plans currently bid at or below 75 percent of traditional fee-for-service Medicare to deliver benefits, so plans will continue to offer the plans they currently offer and pay what they currently pay to deliver benefits for existing beneficiaries.

For rural providers, the Mark includes important provisions to ensure rural health care facilities and providers have the resources they need to continue delivering quality care in their communities. Specifically, the Mark would extend and improve many rural access protections.

Sharply rising costs throughout the health system threaten Medicare's sustainability in the long term. If costs are not constrained, the Medicare program will be insolvent by 2017. To ensure the fiscal solvency and sustainability of the Medicare program, the Chairman's Mark would create a new independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Commission would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. The Mark would also reduce annual market basket updates for hospitals, home health providers, nursing homes, hospice providers, long-term care hospitals and inpatient rehabilitation facilities, including adjustments to reflect expected gains in productivity. Payment updates for Part B providers would be reduced by an estimate of increased productivity, and income-related premiums would be adopted in Part D.

To improve the transparency of insurance products so that individuals know what they are purchasing, the services which are covered and the associated out-of-pocket costs, the Mark would create standards so that individuals receive an outline of coverage presented in a uniform format. The Mark would also require insurance companies to publish the share of their premium revenue that is used for administrative expenses and would impose new requirements on insurers to meet standards for the electronic exchange of payment and other health care information with hospitals, doctors and other providers.

Reducing fraud, waste, and abuse in Medicare, Medicaid and CHIP will reduce costs and improve quality throughout the system. The Medicare improper payment rate for 2008 was 3.6 percent of payments, or $10.4 billion and the National Health Care Anti-Fraud Association estimates that fraud amounts to at least three percent of total health care spending, or more than $60 billion per year. The Chairman's Mark includes several significant provisions to combat fraud, waste and abuse in our health care system.

The America's Healthy Future Act is fully offset and would reduce the deficit and reduce Federal health spending over the long run. In addition to the Medicare Commission, the other policy that contributes to this goal is the high cost insurance excise tax. Beginning in 2013, this provision would levy a non-deductible excise tax on insurance companies and plan administrators for any health insurance plan that is above the threshold of $8,000 for singles and $21,000 for family plans. The threshold would be higher for workers with high risk jobs or for retirees aged 55 and up. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. A transition

rule would increase the threshold for the 17 highest cost states for the first three years.

Other revenue measures include a limit on the amount of contributions to health Flexible Spending Accounts (FSAs) beginning in 2011, a provision to conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction, an increased penalty for use of HSA funds for non-qualified medical expenses, and an increase in the threshold for claiming the itemized deduction for medical expenses.

The legislation also includes an annual flat fee of $2.3 billion on the pharmaceutical manufacturing sector, an annual flat fee of $4 billion on the medical device manufacturing sector, and an annual flat fee of $6.7 billion on the health insurance sector. Each of these non-deductible fees would be allocated across the respective industry according to market share. The device fee would not apply to companies with sales of medical devices in the U.S. of $5 million or less and would not apply to sales of Class I products or Class II products that retail for less than $100 under the FDA product classification system.

Taken together, this legislation achieves the goals of expanding health care coverage to the uninsured, reducing health care costs and improving the quality of care by transforming the health care delivery system. This comprehensive legislation represents a significant milestone in our nation's pursuit of quality, affordable health care for all Americans.

LEGISLATIVE HISTORY AND COMMITTEE ACTION

The Finance Committee has spent two years working on health reform, learning about the problem and identifying solutions. In the past two years, the committee held 20 hearings on health care reform. Last June the committee hosted a day-long health care summit at the Library of Congress featuring Federal Reserve Chairman Ben Bernanke and Dr. J. Craig Venter, genomic research pioneer, as keynote speakers.

Leading up to the markup, the committee held three roundtable discussions reflecting the three major areas of reform—access, cost and quality. In connection with each roundtable—the committee hosted experts from around the country with many different perspectives. Finance Committee members asked many questions of these experts and delved into the issues. Along with each roundtable, the committee put out a detailed policy options paper and held three closed-door walk-through sessions to discuss those options.

In sum, the hearings, summit, roundtables and walk-through sessions demonstrated an open and exhaustive consideration of this health care proposal.

In moving forward with the markup, the Finance Committee distributed the Chairman's Mark and posted it on the committee website on September 16, a full week prior to the start of the markups. Members submitted 564 amendments to the Chairman's Mark, all of which were posted on the website—a measure in the name of transparency that has never been taken by the committee before.

The markup of America's Healthy Future Act lasted for eight days. These days were long days, often running past 10:00 p.m. On the last day of considering amendments, the committee worked past 2:00 a.m. All in all, it has been more than 22 years since the Finance Committee met for eight days on a single bill.

During those eight days, the committee considered 135 amendments and conducted 79 roll call votes, adopting 41 amendments. A final amendment was adopted prior to the vote on October 13, 2009 to report the bill. And the final vote to report the bill was 14–9.

The legislation resulting from the committee's effort is a balanced, sensible plan that takes the best ideas from both sides of the aisle. It achieves President Obama's vision to improve America's health care system, and it is a plan designed to get the 60 votes it needs to pass. The Congressional Budget Office confirms that the legislation will reduce the deficit by $81 billion in the first 10 years, and that the legislation will reduce the deficit further in the next 10 years. Coverage is expanded to 29 million Americans, increasing the rate of insurance to 94 percent at a cost of $829 billion.

II. EXPLANATION OF THE BILL

TITLE I—HEALTH CARE COVERAGE

Subtitle A—Insurance Market Reforms

SEC. 1001. INSURANCE MARKET REFORMS IN THE INDIVIDUAL AND SMALL GROUP MARKETS

The Committee Bill would amend the Social Security Act (42 U.S.C. 301 et seq.) by adding a new Title XXII at the end:

"TITLE XXII—HEALTH INSURANCE COVERAGE"

SEC. 2200. ENSURING ESSENTIAL AND AFFORDABLE HEALTH BENEFITS COVERAGE FOR ALL AMERICANS

Present Law

No provision.

Committee Bill

The purpose of Title I would be to ensure that all Americans have access to affordable and essential health benefits coverage (1) by requiring that all new health benefits plans offered to individuals and employers in the individual and small group market are qualified health benefit plans (QHBPs) that meet the insurance rating reforms and essential health benefits coverage requirements under this bill, (2) by establishing State exchanges to provide greater access to and information about QHBPs, (3) by making health benefits coverage more affordable with premium credits and cost-sharing subsidies, and (4) by establishing the CO-OP program to encourage the establishment of nonprofit health care cooperatives.

the case of an employer, to new employees and their dependents. Beginning July 1, 2013, Federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with the approval from the Secretary.

Health insurance coverage in the individual market (in effect before enactment) that is actuarially equivalent to a catastrophic plan for young individuals (as defined in Sec. 2243(c) of the bill), would be treated as grandfathered plans.

"Subpart 4—Continued Role of States"

Present Law

Pertaining to Sec. 2225–2227: Regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and includes requirements related to licensing, solvency, the issuance and renewal of coverage, benefits, rating, consumer protections, and other issues. Such rules vary from state to state. An insurance carrier must be licensed in each state in which it operates, and comply with the applicable laws and regulations of each state.

Committee Bill

SEC. 2225. CONTINUED STATE ENFORCEMENT OF INSURANCE REGULATIONS

No later than 12 months after enactment, the NAIC would develop a Model Regulation to implement the requirements for plans offered in the individual and small group markets within a state. The Secretary would promulgate regulations to implement the Model Regulation developed by the NAIC. If the NAIC does not establish the Model Regulation within the 12 months after enactment, the Secretary would establish Federal standards implementing the applicable requirements. States would have until July 1, 2013 to adopt and have in effect the Model Regulation or Federal standards established by the Secretary, or a state law or regulation that implements the applicable requirements.

If a state fails to adopt or substantially enforce the Model Regulation, Federal standards, or state laws or regulations, the Secretary would be required to enforce those provisions related to the issuance, sale, renewal, and offering of health benefits plans until the state adopts and enforces such provisions. The Secretary would have enforcement authority under Sec. 2722(b) of the Public Health Services Act to impose civil money penalties on plans that fail to meet such provisions. The Model Regulation, Federal standards, or state laws and regulations implemented by a state must include a requirement that adopted standards (including existing standards under state law that offer more protection to consumers than standards set forth in this title) are applied uniformly to all offerors of health benefits plans in the individual or small group market.

By no later than July 1, 2013, a state would be required to establish and have in operation one or more exchanges, including Small Business Health Options Program (SHOP) exchanges, that meet the requirements regarding the offer of QHBPs. If states do not es-

tablish these exchanges within 2 years of enactment (or if the Secretary determines the exchanges will not be operational by July 1, 2013), the Secretary would be required to contract with a nongovernmental entity to establish the exchanges within the state. States would be required to establish interim exchanges for use by state residents as soon as practicable in the period from January 1, 2010 to June 30, 2013. If these interim exchanges are not operational within a reasonable period after enactment, the Secretary would be required to contract with a nongovernmental entity to establish state exchanges during this interim period.

This title would not replace state laws that establish, implement, or continue any standards or requirements relating to health benefits plans that offer more protection to consumers than the protection offered by standards or requirements included in this title. These standards or requirements would refer to consumer protections (e.g. claims grievance procedures, external review of claims determinations, oversight of insurance agent practices, and others); premium rating reviews; solvency and reserve requirements related to health insurance issuers' licensures; and the assessment of sate-based premium taxes on health insurance issuers. The provisions in this title would not affect ERISA provisions with respect to group health plans.

States could institute programs to provide that offerors of qualified health benefit plans, small employers, and exchanges offering plans in the state's individual and small group market could automatically enroll individuals and employees in (or continue enrollment of individuals in) QHBPs. Automatic enrollment programs would be required to allow individuals or employees to opt out of any coverage in which they were automatically enrolled.

Each state would require offerors of QHBPs through an exchange to provide for a claims review process, to notify enrollees in clear language and in the enrollees' primary language of available internal and external appeals processes, and to allow enrollees to review their files, present evidence, and maintain their insurance coverage during the appeals process. States would be required to provide for an external review process that includes consumer protections set forth in the NAIC's Uniform External Review Model Act, and ensure that enrollees can seek judicial review through Federal or state procedures.

SEC. 2226. WAIVER OF HEALTH INSURANCE REFORM REQUIREMENTS

Present Law

No provision.

Committee Bill

A state could apply for a waiver of any and all requirements of Title I and the IRC for plan years beginning on or after July 1, 2015. The waiver application would have to (1) be filed at a time and manner specified by the Secretary, and (2) provide required information, including a comprehensive description of the State legislation or program for implementing a plan meeting the waiver requirements, and a 10-year budget plan that is budget neutral for the Federal Government.