



**Congressional Health Reform Legislation
 Key Provisions Affecting Children and Families**

	H.R. 3200 - House Tri-Committee America's Affordable Health Choices Act of 2009 (July 31, 2009 version, as passed by Committees)¹	Senate HELP Committee Affordable Health Choices Act (July 15, 2009 version, as passed by Committee)²
OVERALL APPROACH		
Structure	<p>Provides coverage options through three pathways:</p> <ul style="list-style-type: none"> • Requires employers (with exemptions for small businesses) to offer coverage with a premium contribution for workers and their dependents, or pay an annual assessment. • Establishes a national insurance Exchange for those without other options to purchase coverage – through a public plan, a nonprofit member-driven cooperative, or private insurers. Subsidies will be made available to help those below 400% FPL to purchase Exchange coverage. • Sets a national minimum Medicaid standard at 133% FPL. <p>Coverage provisions in effect beginning in 2013 (referred to in bill as “Yr 1”).</p>	<p>Provides coverage options through three pathways:</p> <ul style="list-style-type: none"> • Requires employers (with exemptions for small businesses) to offer coverage with a premium contribution for workers, or pay an annual assessment. • Creates state Gateways for those without other options to purchase coverage – through a public plan or private insurers. Subsidies will be made available to help those below 400% FPL to purchase Gateway coverage. • Envisions a national minimum Medicaid standard at 150% FPL (Committee does not have jurisdiction over Medicaid/CHIP.) <p>Coverage provisions generally take effect in 2013 or when Gateways become operational in individual states.</p>
Individual Coverage Mandate	<p>Individuals (and their dependent children) must have health insurance that meets minimum standards (includes employer coverage, Medicare, Medicaid, VA, etc.). Those without evidence of coverage will face a tax penalty of 2.5% of the difference between their adjusted gross income and the tax-filing threshold. The penalty will be capped at the cost of the average national premium in the Exchange.</p> <p>Mandate in effect beginning in 2013. Exceptions for non-resident aliens, those with religious objections, those not living in the country, and those who are not required to file a tax return. The Secretary of Health and Human Services (HHS) also will develop procedures for granting exemptions due to short lapses in coverage and financial hardship.</p>	<p>Individuals (and their dependent children) must have health insurance that meets minimum standards (includes employer coverage, Medicare, Medicaid, VA, etc.). Those without evidence of coverage will face a tax penalty of no more than \$750 per year. Penalty amounts adjusted in 2013 for “urban consumers.”</p> <p>Mandate in effect for individuals once their state has established a Gateway. Exceptions for members of a federally-recognized Indian tribe, those who have been without coverage for less than 90 days, or those who do not have access to affordable coverage (as determined by the Secretary of HHS, but broadly defined as a person who pays premium costs of 12.5% or more of adjusted gross income).</p>

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Coordination of Public Program and Exchange Coverage	<p>Each state must enter a Memorandum of Understanding with Exchange to coordinate coverage for Medicaid-eligible individuals entering through the Exchange:</p> <ul style="list-style-type: none"> • A limited number of Medicaid-eligible non-disabled childless adults who are also eligible for Exchange coverage (those who have been enrolled in private coverage in last six months) will have a choice to enroll in Medicaid or stay in the Exchange. If they initially apply for coverage through the Exchange, but then opt to enroll in Medicaid, the state must automatically enroll them into Medicaid. • Other Medicaid-eligible individuals who initially apply through the Exchange must be transferred to the appropriate state Medicaid agency. The individuals will, at state option, either be automatically enrolled in Medicaid or presumptively enrolled while the state Medicaid agency conducts a full eligibility determination. The state must use the income information provided by the Exchange. <p>The Exchange can contract with a state Medicaid agency to determine whether an Exchange-eligible person is eligible for the subsidies. States taking on this function will be reimbursed.</p> <p>CHIP children will be eligible for the Exchange on January 1, 2013. The Secretary of HHS must certify that coverage will be comparable and that procedures are in place for a transition to other forms of acceptable coverage without interruption of coverage.</p>	<p>Gateways must establish policies and procedures to assist individuals enrolling in Medicaid and CHIP. Gateways must consult with stakeholders, including state Medicaid agencies, to carry out these enrollment procedures. Children or parents eligible for CHIP will have the option to enroll in Gateways and receive premium subsidy.</p> <p>The Secretary of HHS will award grants to states or Gateways to contract with "navigators" to assist in enrolling uninsured individuals through public education and enrollment assistance. Navigators can include trade and professional organizations, unions, and consumer groups but cannot be a health insurer or receive financial assistance from an insurer.</p>
Immigrant Coverage	<p>"Non-resident aliens" are exempted from coverage mandate. Must be "lawfully present" in U.S. to receive Exchange subsidies.</p> <p>For Medicaid and CHIP, makes no changes to current rules on five-year waiting period for federal match; currently states can choose to lift the ban only for lawfully residing children and pregnant women.</p>	<p>Coverage mandate applies to citizens and those "lawfully present" in the U.S. Must be "lawfully present" in U.S. to obtain Gateway subsidies.</p> <p>For Medicaid and CHIP, makes no changes to current rules on five-year waiting period for federal match; currently states can choose to lift the ban only for lawfully residing children, pregnant women.</p>

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Congressional Budget Office (CBO) Analysis	<p>CBO analysis of July 14, 2009 bill:</p> <ul style="list-style-type: none"> • Costs \$1,042 billion over 10 years. • Projected to provide coverage to 94% of population. • Assumes 16 to 17 million individuals will remain uninsured including people eligible for but not enrolled in Medicaid. <p>CBO analysis of bill passed out of Committee on July 31st not available. Press accounts, however, detail that some of the changes made to bill in Energy and Commerce Committee projected to lower cost of plan by \$100 billion.</p>	<p>CBO analysis of July 1, 2009 bill:</p> <ul style="list-style-type: none"> • \$597 billion over 10 years (an additional cost of approximately \$500 billion for Medicaid expansion, which is assumed under legislation but not under the Committee's jurisdiction). • Projected to provide coverage to 88% of population (93-95% if Medicaid expansion taken into account). • Assumes 34 million individuals will remain uninsured (15 to 20 million if Medicaid expansion taken into account) including people eligible for Medicaid. <p>CBO analysis of bill passed out of Committee on July 15th not available.</p>
EMPLOYER SPONSORED COVERAGE		
Employer Requirements	<p>Employers must either:</p> <ul style="list-style-type: none"> • "Play" by offering coverage to their workers (including spouse and dependent children) and contributing at least 72.5% of the premium for single coverage and 65% for family coverage (pro-rated for part-time workers); or • "Pay" 8% or lower, depending on firm size, of payroll into a Health Insurance Exchange Trust Fund. <p>Employers who "play" must automatically enroll employees into the lowest cost health plan for individual coverage. Employees must be notified in advance and have 30 days to opt out.</p> <p>Coverage must meet minimum benefit standards but group health plans in place on January 1, 2013 are exempt until 2017 ("Yr 5"). Employers can apply for a hardship exemption.</p>	<p>Employers must either:</p> <ul style="list-style-type: none"> • "Play" by offering coverage to their workers and contributing at least 60% toward the premium. (No mention of spousal or dependent coverage.); or • "Pay" annual penalty of \$750 per full-time worker and \$375 per part-time worker (adjusted for inflation after 2013). The first 25 workers are exempted from the penalty. <p>Coverage must meet minimum benefit standards but group health plans in place at time of bill's enactment are exempt. New employees and family members may be added to such coverage.</p>
Small Businesses	Small businesses with an annual payroll at or under \$500,000 are exempt from the employer requirements. Under the "pay" option small businesses with an annual payroll between \$500,000 and	Employers with 25 or fewer employees are exempt from the employer requirements.

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	<p>\$750,000 will pay a smaller percentage of payroll, ranging from 2% to 6%.</p> <p>Subsidies are available to small businesses with no more than 25 employees and average wages below \$40,000. The amount varies by firm size and average wages, with the full credit (equal to 50% of employer premium costs) available to those with 10 or fewer employees and average annual wages of \$20,000 or less.</p>	<p>Subsidies are available to small businesses with no more than 50 employees, average wages below \$50,000 and that contribute at least 60% toward the premium. The amount varies by firm size and type of coverage (i.e. single v. family), with a bonus payment available if the employer contribution exceeds 60%. Firms can obtain subsidies for up to 3 years.</p>
HEALTH INSURANCE EXCHANGE		
Eligibility	<p>Individuals without other coverage and employers (phased in by firm size over time) can purchase coverage through a national Exchange (to be established in 2013). In certain circumstances states can establish their own Exchanges.</p> <p>Medicaid-eligible, non-disabled childless adults with private coverage for previous six months can enroll in Exchange. CHIP-eligible children are eligible for the Exchange and subsidies on January 1, 2013.</p>	<p>Individuals without other coverage and small employers can purchase coverage through a state Gateway (beginning in 2013 or when Gateways become operational in individual states).</p> <p>Medicaid-eligible individuals are not eligible to enroll in a Gateway. CHIP-eligible children and parents can enroll in a Gateway and receive subsidies.</p>
Benefits	<p>Exchange Commissioner will develop three coverage tiers: basic, enhanced, and premium. The differences between plans are based on variations in cost sharing levels for the average population (defined as a plan's actuarial value). A premium-plus plan offering additional benefits, such as adult dental, can also be provided.</p> <p>Health plans must provide a minimum benefits package (referred to as an "essential benefits package") that covers a comprehensive range of services including inpatient/outpatient hospital and clinic services, physician and other professional services, equipment and supplies, prescription drugs, rehabilitative and habilitative services, mental health and substance abuse services, preventive services, and maternity care. For children, well baby and well child care, oral health, vision and hearing services, equipment, and supplies must be covered. (Amendment in Education & Labor Committee requires package to include EPSDT services.)</p>	<p>Secretary of HHS will develop three coverage tiers: lowest, middle, and highest. The differences between plans are based on variations in cost sharing levels for the average population (defined as a plan's actuarial value).</p> <p>Health plans must provide a minimum benefits package (referred to as an "essential benefits package") that covers a comprehensive range of services including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, and preventive and wellness services. For children, pediatric services, including vision and dental, and preventive care and screenings identified in Bright Futures (the American Academy of Pediatrics' "gold standard" for preventive care) must be covered.</p>

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	Further details determined by new Health Benefits Advisory Committee and the Secretary of HHS.	Further details determined by the Secretary of HHS with the help of a one-time, temporary, independent advisory commission. States may require additional benefits for plans offered in that state but the state must assume any associated costs.
Premium Subsidies	<p>Individuals/families who enroll in the Exchange with income below 400% FPL can receive subsidies to apply toward the basic Exchange plan (in 2015-"Yr 3" can be applied to any plan). Size of the subsidy is tied to the average premium of the three lowest-cost basic plans in each geographic area.</p> <p>Based on a sliding scale with a maximum contribution level of 1.5% of income for individuals/families at or below 133% FPL and no more than 12% of income at 400% FPL. Gross adjusted income standard used but Exchange Commissioner to conduct study of application of income disregards.</p> <p>After 2013, the income contribution caps will be adjusted to reflect growth in premiums over time. Insurers, however, must get approval before they can increase premiums above 150% of the annual percentage increase in medical inflation. In addition, in 2014 ("Yr 2"), the subsidies will potentially be adjusted if savings are realized from a series of public option, Medicare, and Medicaid reforms (including allowing Medicare to negotiate drug prices).</p> <p>Employees whose employer "plays" are not eligible for Exchange subsidy unless, starting in 2014, their annual premium cost exceeds 12% of income. Their employers are required to pay a percentage of their average payroll per worker into the Fund.</p>	<p>Individuals/families who enroll in the Gateway with income between 150% and 400% FPL can receive subsidies to enroll in any Gateway plan. Size of the subsidy is tied to the average cost of the three lowest premium bids in each geographic area for each tier of coverage, with lower income families receiving higher subsidies.</p> <p>Based on a sliding scale with a maximum contribution level of no more than 1% of income for individuals/families with income at 150% FPL rising to 12.5% of income at 400% FPL. Gross adjusted income standard used. After 2013, the income contribution caps will be indexed to medical price inflation.</p> <p>Employees whose employer "plays" are not eligible for Exchange subsidy unless their annual premium cost exceeds 12.5% of adjusted gross income.</p>
Out-of-Pocket Costs (deductibles, coinsurance, copayments)	No cost sharing in the essential benefit package for preventive services and an annual out-of-pocket limit of \$5,000 for an individual or \$10,000 for a family. Encourages Exchange Commissioner to promote use of copayments rather than coinsurance. No annual or lifetime limits permitted.	<p>Minimal cost sharing for preventive services and annual out-of-pocket limit of \$5,950 for an individual and \$11,900 for a family in 2010. No annual or lifetime limits permitted.</p> <p>Cost sharing reduced on a sliding scale below 300% FPL. For those with income between 200% and 300% FPL, set at 50% of annual</p>

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	Cost sharing reduced for those with income below 400% FPL. Amount determined by an increase in the basic plan's cost sharing protections within different income tiers. For example, the actuarial value of the basic plan is 70%. The actuarial value will increase to 97% for the same plan for an individual/family with income at or below 133% FPL. The actuarial value means how much of the cost sharing is covered for the average population for the covered benefits.	limit (\$2,975 individual/\$5,950 family in 2010). For those with income below 200% FPL, set at 20% of annual limit (\$1,190 individual/\$2,380 family in 2010).
Enrollment & Renewal in Exchange Plans and Subsidies	<p>Exchange Commissioner will determine the enrollment process using mail, telephone, and electronic means. Must provide written materials, establish a telephone hotline, and maintain a website. Information must be provided in culturally and linguistically appropriate manner and using plain language.</p> <p>Subsidies will be administered by the Exchange, but can contract function out (e.g., to state Medicaid agencies). Eligibility for the subsidies based on adjusted gross income in the prior tax year. Accuracy of the information verified, when possible, via federal income tax data. Special procedures for people who do not file returns or who experience a significant change in circumstances.</p>	<p>Gateways will establish open enrollment periods and facilitate enrollment and renewal through electronic means. Must provide user-friendly materials that take into account language barriers and disabilities of individuals, and must consult with stakeholders during the development of materials.</p> <p>Secretary of HHS may award grants to states to enhance community-based enrollment through help lines, electronic systems, and public education campaigns, and establish national website linking to state Gateways.</p> <p>Subsidies will be administered by the Gateways. Eligibility for the subsidies based on adjusted gross income in the prior tax year. Accuracy of the information verified, when possible, via federal income tax data. Special procedures for people who do not file returns or who experience a significant change in circumstances.</p>
PUBLIC PROGRAMS (MEDICAID AND CHIP)		
Medicaid Eligibility	<p>Requires a minimum Medicaid eligibility level of 133% FPL, beginning in 2013, for:</p> <ul style="list-style-type: none"> • Traditional groups: Persons under 65 (children, parents and disabled adults) eligible for a state's Medicaid program as of June 16, 2009. (Based on net income standard.) • Non-Traditional groups: Non-disabled childless adults under 65 including those currently covered by waivers. (Income 	No provisions since Medicaid is not under Committee's jurisdiction. Original bill introduced on June 9, 2009 assumed a minimum Medicaid eligibility level of 150% FPL.

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	<p>standard to be determined by Secretary of HHS.)</p> <p>In addition, all uninsured newborns become newly eligible for Medicaid for 60 days (100% federal financing in 2013-2014; 90% beginning in 2015) while a determination is made of their eligibility for Medicaid or Exchange/subsidies.</p> <p>States can provide optional Medicaid coverage to low-income HIV-infected individuals (expires in 2013 once Exchange in place).</p>	
CHIP Eligibility	<p>CHIP will expire on September 30, 2013. On January 1, 2013, children in CHIP with income at or below 133% FPL will be shifted to Medicaid. Those with income above 133% FPL will be deemed eligible to enroll in Exchange plans. Before children are moved to Exchange, the Secretary of HHS must determine that:</p> <ul style="list-style-type: none"> • Transition procedures have been developed to move children to acceptable coverage without an interruption in coverage or of a written plan of treatment (if in place due to a medical condition); • The Exchange has the capacity to accept the CHIP children; and • The coverage provided by plans participating in the Exchange is comparable in terms of benefits and cost sharing to that provided by the average CHIP plan. <p>For subsidy purposes, a child's family income is deemed to be no greater than was determined for CHIP.</p>	No provisions since CHIP is not under Committee's jurisdiction.
Maintenance of Effort (MOE)	States are required to maintain eligibility standards, methodologies, and procedures no more restrictive than in effect as of June 16, 2009 for individuals in Medicaid and CHIP (including those covered under waivers). For CHIP, this MOE applies only through January 1, 2013.	Original bill (June 9, 2009) assumed states maintain existing Medicaid coverage eligibility levels above 150% FPL.

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Financing	<p>In Medicaid, increased federal financing (100% in 2013-2014; 90% beginning in 2015) for non-disabled, childless adults up to 133% FPL (whether previously covered through a waiver or not), traditional populations between a state's current income threshold and 133% FPL (including children shifted from CHIP), and uninsured newborns for first 60 days.</p> <p>However, states currently covering parents through waivers receive the increased federal financing between non-waiver eligibility standard and 133% FPL. MOE populations above 133% FPL receive regular federal match.</p> <p>Requires GAO to conduct reports on Medicaid FMAP formula and Medicaid administrative costs.</p> <p>Disproportionate Share Hospital (DSH) payments to states are reduced by \$10 billion over fiscal years 2017 to 2019.</p>	<p>Original bill (June 9, 2009) assumed states receive full federal financing for newly eligible individuals in Medicaid until fiscal year 2015.</p>
Benefits	<p>Current Medicaid benefit rules maintained with addition of mandatory coverage of preventive services for adults (no cost sharing allowed and funded through regular federal matching rate). Expanded eligibility for family planning will be an optional service rather than requiring a waiver. Benchmark benefits for adults on Medicaid must be equivalent to Exchange coverage.</p> <p>For CHIP children above 133% FPL moved into the Exchange, the Secretary of HHS must determine that benefits are comparable to that provided by the average CHIP plan.</p>	<p>No provisions related to Medicaid. Exchange benefits apply for children eligible for CHIP who enroll in a Gateway plan.</p>
Cost Sharing	<p>Current Medicaid cost sharing rules maintained.</p> <p>For CHIP children above 133% FPL moved into the Exchange, the Secretary of HHS must determine that cost sharing is comparable to that provided by the average CHIP plan.</p>	<p>No provisions related to Medicaid. Exchange cost sharing rules apply for children eligible for CHIP who enroll in Gateway plan.</p>

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Enrollment and Renewal	<ul style="list-style-type: none"> Beginning in 2013, states must eliminate any asset test used to determine eligibility for children, parents, and many childless adults (long term care and disability populations exempted) in Medicaid. Stand-alone CHIP programs will be required, effective January 1, 2010, to implement 12-month continuous eligibility until the program expires. States cannot have enrollment waiting periods for children in CHIP who are: under age 2, have lost employer health insurance, or have access only to unaffordable coverage in which costs exceed 10% of family income. (In effect 90 days after bill's enactment until program expires.) 	No provisions related to Medicaid and CHIP enrollment procedures except via requirements for coordination with Gateways.
Strengthening Public Programs	<ul style="list-style-type: none"> Higher Medicaid reimbursement rates for primary care services: 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012. New costs associated with rate increases will be fully funded by federal government until 2015 at which point the federal government will pay 90% of additional costs. In Medicaid, establishes a medical home pilot program for high-need beneficiaries. Also creates a pilot program in Medicaid to establish Accountable Care Organizations, a group of providers responsible for the quality and cost of health care for beneficiaries. 	Establishes standards and protocols to promote interoperability of federal program enrollment systems, including linkages between public programs, data matching, and the submission of documents electronically.
OTHER PROVISIONS		
Delivery System Reforms	<ul style="list-style-type: none"> Imposes new regulations on plans participating in the Exchange and in the small group insurance market including requiring guaranteed issue and renewal and eliminating the practice of denying coverage for pre-existing conditions. Simplifies health insurance administration by standardizing claims forms, health care transaction operating rules, and quality reporting requirements, and increasing electronic exchange of administrative and clinical data. 	<ul style="list-style-type: none"> Sets national insurance standards for individual and group insurance markets including requiring guaranteed issue and renewal and eliminating the practice of denying coverage for pre-existing conditions. Updates administrative simplification standards by requiring new technical standards to provide a common technical platform for administration of health care and means for the timely updating of standards for electronic data interchange.

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	<ul style="list-style-type: none"> • Provides new funding for medical home pilot programs. • Expands efforts to minimize fraud and abuse. • Establishes a Center for Medicaid and Medicaid Payment Innovation to study provider payment models that reduce program costs and enhance quality of care. • Extends CHIPRA's Medicaid/CHIP child quality measure provisions to maternity care and adult health services. 	<ul style="list-style-type: none"> • Provides grants for improving health system efficiency, including grants to support community medical home models. • Expands efforts to minimize fraud and abuse. • Supports long-term services and financing.
Prevention/ Wellness	<ul style="list-style-type: none"> • Eliminates any cost sharing for preventive services in the essential benefit package. • Develops a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. • Requires more collection, analysis and reporting of health and health care disparities (due to ethnic, geographic, or other population-specific differences) data. 	<ul style="list-style-type: none"> • Develops a national prevention and health promotion strategy that sets specific goals for improving health, supports an oral prevention and health campaign, and creates a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. • Increases support for immunizations, school-based clinics, employer wellness programs, chronic disease medication management, trauma care, and community health centers. • Establishes a national health quality initiative with reducing health disparities as one of its goals and requires more collection, analysis, and reporting of health disparities data. • Creates temporary "RightChoices" prevention programs to provide uninsured individuals who are not eligible for public programs with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs.

¹ This summary is based on the House Ways and Means, Energy and Commerce, and Education and Labor Committees' July 14, 2009 filed version of the America's Affordable Health Choices Act and amendments approved by each of the Committees.

² This summary is based on the Senate's Health, Education, Labor and Pensions (HELP) Committee's July 1, 2009 filed version of the Affordable Health Choices Act and the best information available for the version of the bill approved by Committee on July 15, 2009. The Committee has not filed a new version of the bill, but released a section-by-section summary: "In Historic Vote, HELP Committee Approves the Affordable Health Choices Act," http://help.senate.gov/Maj_press/2009_07_15_b.pdf.