

1 **TITLE I—QUALITY, AFFORDABLE**
2 **HEALTH CARE FOR ALL AMER-**
3 **ICANS**

4 **Subtitle A—Immediate Improve-**
5 **ments in Health Care Coverage**
6 **for All Americans**

7 **SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

9 *Part A of title XXVII of the Public Health Service Act*
10 *(42 U.S.C. 300gg et seq.) is amended—*

11 *(1) by striking the part heading and inserting*
12 *the following:*

13 **“PART A—INDIVIDUAL AND GROUP MARKET**
14 **REFORMS”;**

15 *(2) by redesignating sections 2704 through 2707*
16 *as sections 2725 through 2728, respectively;*

17 *(3) by redesignating sections 2711 through 2713*
18 *as sections 2731 through 2733, respectively;*

19 *(4) by redesignating sections 2721 through 2723*
20 *as sections 2735 through 2737, respectively; and*

21 *(5) by inserting after section 2702, the following:*

1 **“Subpart II—Improving Coverage**

2 **“SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.**

3 “(a) *IN GENERAL.*—A group health plan and a health
4 insurance issuer offering group or individual health insur-
5 ance coverage may not establish—

6 “(1) lifetime limits on the dollar value of benefits
7 for any participant or beneficiary; or

8 “(2) unreasonable annual limits (within the
9 meaning of section 223 of the Internal Revenue Code
10 of 1986) on the dollar value of benefits for any partic-
11 ipant or beneficiary.

12 “(b) *PER BENEFICIARY LIMITS.*—Subsection (a) shall
13 not be construed to prevent a group health plan or health
14 insurance coverage that is not required to provide essential
15 health benefits under section 1302(b) of the Patient Protec-
16 tion and Affordable Care Act from placing annual or life-
17 time per beneficiary limits on specific covered benefits to
18 the extent that such limits are otherwise permitted under
19 Federal or State law.

20 **“SEC. 2712. PROHIBITION ON RESCISSIONS.**

21 “A group health plan and a health insurance issuer
22 offering group or individual health insurance coverage shall
23 not rescind such plan or coverage with respect to an enrollee
24 once the enrollee is covered under such plan or coverage in-
25 volved, except that this section shall not apply to a covered
26 individual who has performed an act or practice that con-

1 *stitutes fraud or makes an intentional misrepresentation of*
2 *material fact as prohibited by the terms of the plan or cov-*
3 *erage. Such plan or coverage may not be cancelled except*
4 *with prior notice to the enrollee, and only as permitted*
5 *under section 2702(c) or 2742(b).*

6 **“SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.**

7 “(a) *IN GENERAL.*—A group health plan and a health
8 *insurance issuer offering group or individual health insur-*
9 *ance coverage shall, at a minimum provide coverage for and*
10 *shall not impose any cost sharing requirements for—*

11 “(1) *evidence-based items or services that have in*
12 *effect a rating of ‘A’ or ‘B’ in the current rec-*
13 *ommendations of the United States Preventive Serv-*
14 *ices Task Force;*

15 “(2) *immunizations that have in effect a rec-*
16 *ommendation from the Advisory Committee on Im-*
17 *munization Practices of the Centers for Disease Con-*
18 *trol and Prevention with respect to the individual in-*
19 *volved; and*

20 “(3) *with respect to infants, children, and ado-*
21 *lescents, evidence-informed preventive care and*
22 *screenings provided for in the comprehensive guide-*
23 *lines supported by the Health Resources and Services*
24 *Administration.*

1 “(4) *with respect to women, such additional pre-*
2 *ventive care and screenings not described in para-*
3 *graph (1) as provided for in comprehensive guidelines*
4 *supported by the Health Resources and Services Ad-*
5 *ministration for purposes of this paragraph.*

6 “(5) *for the purposes of this Act, and for the pur-*
7 *poses of any other provision of law, the current rec-*
8 *ommendations of the United States Preventive Service*
9 *Task Force regarding breast cancer screening, mam-*
10 *mography, and prevention shall be considered the*
11 *most current other than those issued in or around No-*
12 *vember 2009.*

13 *Nothing in this subsection shall be construed to prohibit a*
14 *plan or issuer from providing coverage for services in addi-*
15 *tion to those recommended by United States Preventive*
16 *Services Task Force or to deny coverage for services that*
17 *are not recommended by such Task Force.*

18 “(b) *INTERVAL.—*

19 “(1) *IN GENERAL.—The Secretary shall establish*
20 *a minimum interval between the date on which a rec-*
21 *ommendation described in subsection (a)(1) or (a)(2)*
22 *or a guideline under subsection (a)(3) is issued and*
23 *the plan year with respect to which the requirement*
24 *described in subsection (a) is effective with respect to*

1 *the service described in such recommendation or*
2 *guideline.*

3 “(2) *MINIMUM.*—*The interval described in para-*
4 *graph (1) shall not be less than 1 year.*

5 “(c) *VALUE-BASED INSURANCE DESIGN.*—*The Sec-*
6 *retary may develop guidelines to permit a group health*
7 *plan and a health insurance issuer offering group or indi-*
8 *vidual health insurance coverage to utilize value-based in-*
9 *surance designs.*

10 **“SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.**

11 “(a) *IN GENERAL.*—*A group health plan and a health*
12 *insurance issuer offering group or individual health insur-*
13 *ance coverage that provides dependent coverage of children*
14 *shall continue to make such coverage available for an adult*
15 *child (who is not married) until the child turns 26 years*
16 *of age. Nothing in this section shall require a health plan*
17 *or a health insurance issuer described in the preceding sen-*
18 *tence to make coverage available for a child of a child re-*
19 *ceiving dependent coverage.*

20 “(b) *REGULATIONS.*—*The Secretary shall promulgate*
21 *regulations to define the dependents to which coverage shall*
22 *be made available under subsection (a).*

23 “(c) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*
24 *tion shall be construed to modify the definition of ‘depend-*

1 *ent' as used in the Internal Revenue Code of 1986 with re-*
2 *spect to the tax treatment of the cost of coverage.*

3 **“SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM**
4 **EXPLANATION OF COVERAGE DOCUMENTS**
5 **AND STANDARDIZED DEFINITIONS.**

6 *“(a) IN GENERAL.—Not later than 12 months after the*
7 *date of enactment of the Patient Protection and Affordable*
8 *Care Act, the Secretary shall develop standards for use by*
9 *a group health plan and a health insurance issuer offering*
10 *group or individual health insurance coverage, in com-*
11 *piling and providing to enrollees a summary of benefits and*
12 *coverage explanation that accurately describes the benefits*
13 *and coverage under the applicable plan or coverage. In de-*
14 *veloping such standards, the Secretary shall consult with*
15 *the National Association of Insurance Commissioners (re-*
16 *ferred to in this section as the ‘NAIC’), a working group*
17 *composed of representatives of health insurance-related con-*
18 *sumer advocacy organizations, health insurance issuers,*
19 *health care professionals, patient advocates including those*
20 *representing individuals with limited English proficiency,*
21 *and other qualified individuals.*

22 *“(b) REQUIREMENTS.—The standards for the sum-*
23 *mary of benefits and coverage developed under subsection*
24 *(a) shall provide for the following:*

1 “(1) *APPEARANCE.*—*The standards shall ensure*
2 *that the summary of benefits and coverage is pre-*
3 *sented in a uniform format that does not exceed 4*
4 *pages in length and does not include print smaller*
5 *than 12-point font.*

6 “(2) *LANGUAGE.*—*The standards shall ensure*
7 *that the summary is presented in a culturally and*
8 *linguistically appropriate manner and utilizes termi-*
9 *nology understandable by the average plan enrollee.*

10 “(3) *CONTENTS.*—*The standards shall ensure*
11 *that the summary of benefits and coverage includes—*

12 “(A) *uniform definitions of standard insur-*
13 *ance terms and medical terms (consistent with*
14 *subsection (g)) so that consumers may compare*
15 *health insurance coverage and understand the*
16 *terms of coverage (or exception to such coverage);*

17 “(B) *a description of the coverage, includ-*
18 *ing cost sharing for—*

19 “(i) *each of the categories of the essen-*
20 *tial health benefits described in subpara-*
21 *graphs (A) through (J) of section 1302(b)(1)*
22 *of the Patient Protection and Affordable*
23 *Care Act; and*

24 “(ii) *other benefits, as identified by the*
25 *Secretary;*

1 “(C) the exceptions, reductions, and limita-
2 tions on coverage;

3 “(D) the cost-sharing provisions, including
4 deductible, coinsurance, and co-payment obliga-
5 tions;

6 “(E) the renewability and continuation of
7 coverage provisions;

8 “(F) a coverage facts label that includes ex-
9 amples to illustrate common benefits scenarios,
10 including pregnancy and serious or chronic med-
11 ical conditions and related cost sharing, such
12 scenarios to be based on recognized clinical prac-
13 tice guidelines;

14 “(G) a statement of whether the plan or cov-
15 erage—

16 “(i) provides minimum essential cov-
17 erage (as defined under section 5000A(f) of
18 the Internal Revenue Code 1986); and

19 “(ii) ensures that the plan or coverage
20 share of the total allowed costs of benefits
21 provided under the plan or coverage is not
22 less than 60 percent of such costs;

23 “(H) a statement that the outline is a sum-
24 mary of the policy or certificate and that the
25 coverage document itself should be consulted to

1 *determine the governing contractual provisions;*
2 *and*

3 *“(I) a contact number for the consumer to*
4 *call with additional questions and an Internet*
5 *web address where a copy of the actual indi-*
6 *vidual coverage policy or group certificate of cov-*
7 *erage can be reviewed and obtained.*

8 *“(c) PERIODIC REVIEW AND UPDATING.—The Sec-*
9 *retary shall periodically review and update, as appropriate,*
10 *the standards developed under this section.*

11 *“(d) REQUIREMENT TO PROVIDE.—*

12 *“(1) IN GENERAL.—Not later than 24 months*
13 *after the date of enactment of the Patient Protection*
14 *and Affordable Care Act, each entity described in*
15 *paragraph (3) shall provide, prior to any enrollment*
16 *restriction, a summary of benefits and coverage expla-*
17 *nation pursuant to the standards developed by the*
18 *Secretary under subsection (a) to—*

19 *“(A) an applicant at the time of applica-*
20 *tion;*

21 *“(B) an enrollee prior to the time of enroll-*
22 *ment or reenrollment, as applicable; and*

23 *“(C) a policyholder or certificate holder at*
24 *the time of issuance of the policy or delivery of*
25 *the certificate.*

1 “(2) *COMPLIANCE.*—*An entity described in para-*
2 *graph (3) is deemed to be in compliance with this sec-*
3 *tion if the summary of benefits and coverage described*
4 *in subsection (a) is provided in paper or electronic*
5 *form.*

6 “(3) *ENTITIES IN GENERAL.*—*An entity de-*
7 *scribed in this paragraph is—*

8 “(A) *a health insurance issuer (including a*
9 *group health plan that is not a self-insured plan)*
10 *offering health insurance coverage within the*
11 *United States; or*

12 “(B) *in the case of a self-insured group*
13 *health plan, the plan sponsor or designated ad-*
14 *ministrator of the plan (as such terms are de-*
15 *fined in section 3(16) of the Employee Retire-*
16 *ment Income Security Act of 1974).*

17 “(4) *NOTICE OF MODIFICATIONS.*—*If a group*
18 *health plan or health insurance issuer makes any ma-*
19 *terial modification in any of the terms of the plan or*
20 *coverage involved (as defined for purposes of section*
21 *102 of the Employee Retirement Income Security Act*
22 *of 1974) that is not reflected in the most recently pro-*
23 *vided summary of benefits and coverage, the plan or*
24 *issuer shall provide notice of such modification to en-*

1 rollees not later than 60 days prior to the date on
2 which such modification will become effective.

3 “(e) *PREEMPTION.*—The standards developed under
4 subsection (a) shall preempt any related State standards
5 that require a summary of benefits and coverage that pro-
6 vides less information to consumers than that required to
7 be provided under this section, as determined by the Sec-
8 retary.

9 “(f) *FAILURE TO PROVIDE.*—An entity described in
10 subsection (d)(3) that willfully fails to provide the informa-
11 tion required under this section shall be subject to a fine
12 of not more than \$1,000 for each such failure. Such failure
13 with respect to each enrollee shall constitute a separate of-
14 fense for purposes of this subsection.

15 “(g) *DEVELOPMENT OF STANDARD DEFINITIONS.*—

16 “(1) *IN GENERAL.*—The Secretary shall, by regu-
17 lation, provide for the development of standards for
18 the definitions of terms used in health insurance cov-
19 erage, including the insurance-related terms described
20 in paragraph (2) and the medical terms described in
21 paragraph (3).

22 “(2) *INSURANCE-RELATED TERMS.*—The insur-
23 ance-related terms described in this paragraph are
24 premium, deductible, co-insurance, co-payment, out-
25 of-pocket limit, preferred provider, non-preferred pro-

1 *vider, out-of-network co-payments, UCR (usual, cus-*
2 *tomary and reasonable) fees, excluded services, griev-*
3 *ance and appeals, and such other terms as the Sec-*
4 *retary determines are important to define so that con-*
5 *sumers may compare health insurance coverage and*
6 *understand the terms of their coverage.*

7 “(3) *MEDICAL TERMS.—The medical terms de-*
8 *scribed in this paragraph are hospitalization, hospital*
9 *outpatient care, emergency room care, physician serv-*
10 *ices, prescription drug coverage, durable medical*
11 *equipment, home health care, skilled nursing care, re-*
12 *habilitation services, hospice services, emergency med-*
13 *ical transportation, and such other terms as the Sec-*
14 *retary determines are important to define so that con-*
15 *sumers may compare the medical benefits offered by*
16 *health insurance and understand the extent of those*
17 *medical benefits (or exceptions to those benefits).*

18 **“SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON**
19 **SALARY.**

20 “(a) *IN GENERAL.—The plan sponsor of a group*
21 *health plan (other than a self-insured plan) may not estab-*
22 *lish rules relating to the health insurance coverage eligi-*
23 *bility (including continued eligibility) of any full-time em-*
24 *ployee under the terms of the plan that are based on the*
25 *total hourly or annual salary of the employee or otherwise*

1 *establish eligibility rules that have the effect of discrimi-*
2 *nating in favor of higher wage employees.*

3 “(b) *LIMITATION.*—Subsection (a) shall not be con-
4 *strued to prohibit a plan sponsor from establishing con-*
5 *tribution requirements for enrollment in the plan or cov-*
6 *erage that provide for the payment by employees with lower*
7 *hourly or annual compensation of a lower dollar or percent-*
8 *age contribution than the payment required of similarly sit-*
9 *uated employees with a higher hourly or annual compensa-*
10 *tion.*

11 **“SEC. 2717. ENSURING THE QUALITY OF CARE.**

12 “(a) *QUALITY REPORTING.*—

13 “(1) *IN GENERAL.*—Not later than 2 years after
14 *the date of enactment of the Patient Protection and*
15 *Affordable Care Act, the Secretary, in consultation*
16 *with experts in health care quality and stakeholders,*
17 *shall develop reporting requirements for use by a*
18 *group health plan, and a health insurance issuer of-*
19 *fering group or individual health insurance coverage,*
20 *with respect to plan or coverage benefits and health*
21 *care provider reimbursement structures that—*

22 “(A) *improve health outcomes through the*
23 *implementation of activities such as quality re-*
24 *porting, effective case management, care coordi-*
25 *nation, chronic disease management, and medi-*

1 *cation and care compliance initiatives, including*
2 *through the use of the medical homes model as*
3 *defined for purposes of section 3602 of the Pa-*
4 *tient Protection and Affordable Care Act, for*
5 *treatment or services under the plan or coverage;*

6 *“(B) implement activities to prevent hos-*
7 *pital readmissions through a comprehensive pro-*
8 *gram for hospital discharge that includes pa-*
9 *tient-centered education and counseling, com-*
10 *prehensive discharge planning, and post dis-*
11 *charge reinforcement by an appropriate health*
12 *care professional;*

13 *“(C) implement activities to improve pa-*
14 *tient safety and reduce medical errors through*
15 *the appropriate use of best clinical practices, evi-*
16 *dence based medicine, and health information*
17 *technology under the plan or coverage; and*

18 *“(D) implement wellness and health pro-*
19 *motion activities.*

20 *“(2) REPORTING REQUIREMENTS.—*

21 *“(A) IN GENERAL.—A group health plan*
22 *and a health insurance issuer offering group or*
23 *individual health insurance coverage shall annu-*
24 *ally submit to the Secretary, and to enrollees*
25 *under the plan or coverage, a report on whether*

1 *the benefits under the plan or coverage satisfy*
2 *the elements described in subparagraphs (A)*
3 *through (D) of paragraph (1).*

4 “(B) *TIMING OF REPORTS.*—*A report under*
5 *subparagraph (A) shall be made available to an*
6 *enrollee under the plan or coverage during each*
7 *open enrollment period.*

8 “(C) *AVAILABILITY OF REPORTS.*—*The Sec-*
9 *retary shall make reports submitted under sub-*
10 *paragraph (A) available to the public through an*
11 *Internet website.*

12 “(D) *PENALTIES.*—*In developing the re-*
13 *porting requirements under paragraph (1), the*
14 *Secretary may develop and impose appropriate*
15 *penalties for non-compliance with such require-*
16 *ments.*

17 “(E) *EXCEPTIONS.*—*In developing the re-*
18 *porting requirements under paragraph (1), the*
19 *Secretary may provide for exceptions to such re-*
20 *quirements for group health plans and health in-*
21 *surance issuers that substantially meet the goals*
22 *of this section.*

23 “(b) *WELLNESS AND PREVENTION PROGRAMS.*—*For*
24 *purposes of subsection (a)(1)(D), wellness and health pro-*
25 *motion activities may include personalized wellness and*

1 *prevention services, which are coordinated, maintained or*
2 *delivered by a health care provider, a wellness and preven-*
3 *tion plan manager, or a health, wellness or prevention serv-*
4 *ices organization that conducts health risk assessments or*
5 *offers ongoing face-to-face, telephonic or web-based interven-*
6 *tion efforts for each of the program’s participants, and*
7 *which may include the following wellness and prevention*
8 *efforts:*

- 9 “(1) *Smoking cessation.*
- 10 “(2) *Weight management.*
- 11 “(3) *Stress management.*
- 12 “(4) *Physical fitness.*
- 13 “(5) *Nutrition.*
- 14 “(6) *Heart disease prevention.*
- 15 “(7) *Healthy lifestyle support.*
- 16 “(8) *Diabetes prevention.*

17 “(c) *REGULATIONS.—Not later than 2 years after the*
18 *date of enactment of the Patient Protection and Affordable*
19 *Care Act, the Secretary shall promulgate regulations that*
20 *provide criteria for determining whether a reimbursement*
21 *structure is described in subsection (a).*

22 “(d) *STUDY AND REPORT.—Not later than 180 days*
23 *after the date on which regulations are promulgated under*
24 *subsection (c), the Government Accountability Office shall*
25 *review such regulations and conduct a study and submit*

1 *to the Committee on Health, Education, Labor, and Pen-*
2 *sions of the Senate and the Committee on Energy and Com-*
3 *merce of the House of Representatives a report regarding*
4 *the impact the activities under this section have had on the*
5 *quality and cost of health care.*

6 **“SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE**
7 **COVERAGE.**

8 *“(a) CLEAR ACCOUNTING FOR COSTS.—A health in-*
9 *surance issuer offering group or individual health insur-*
10 *ance coverage shall, with respect to each plan year, submit*
11 *to the Secretary a report concerning the percentage of total*
12 *premium revenue that such coverage expends—*

13 *“(1) on reimbursement for clinical services pro-*
14 *vided to enrollees under such coverage;*

15 *“(2) for activities that improve health care qual-*
16 *ity; and*

17 *“(3) on all other non-claims costs, including an*
18 *explanation of the nature of such costs, and excluding*
19 *State taxes and licensing or regulatory fees.*

20 *The Secretary shall make reports received under this section*
21 *available to the public on the Internet website of the Depart-*
22 *ment of Health and Human Services.*

23 *“(b) ENSURING THAT CONSUMERS RECEIVE VALUE*
24 *FOR THEIR PREMIUM PAYMENTS.—*

1 “(1) *REQUIREMENT TO PROVIDE VALUE FOR*
2 *PREMIUM PAYMENTS.*—*A health insurance issuer of-*
3 *fering group or individual health insurance coverage*
4 *shall, with respect to each plan year, provide an an-*
5 *nuual rebate to each enrollee under such coverage, on*
6 *a pro rata basis, in an amount that is equal to the*
7 *amount by which premium revenue expended by the*
8 *issuer on activities described in subsection (a)(3) ex-*
9 *ceeds—*

10 “(A) *with respect to a health insurance*
11 *issuer offering coverage in the group market, 20*
12 *percent, or such lower percentage as a State may*
13 *by regulation determine; or*

14 “(B) *with respect to a health insurance*
15 *issuer offering coverage in the individual market,*
16 *25 percent, or such lower percentage as a State*
17 *may by regulation determine, except that such*
18 *percentage shall be adjusted to the extent the Sec-*
19 *retary determines that the application of such*
20 *percentage with a State may destabilize the ex-*
21 *isting individual market in such State.*

22 “(2) *CONSIDERATION IN SETTING PERCENT-*
23 *AGES.*—*In determining the percentages under para-*
24 *graph (1), a State shall seek to ensure adequate par-*
25 *ticipation by health insurance issuers, competition in*

1 *the health insurance market in the State, and value*
2 *for consumers so that premiums are used for clinical*
3 *services and quality improvements.*

4 “(3) *TERMINATION.*—*The provisions of this sub-*
5 *section shall have no force or effect after December 31,*
6 *2013.*

7 “(c) *STANDARD HOSPITAL CHARGES.*—*Each hospital*
8 *operating within the United States shall for each year es-*
9 *tablish (and update) and make public (in accordance with*
10 *guidelines developed by the Secretary) a list of the hospital’s*
11 *standard charges for items and services provided by the hos-*
12 *pital, including for diagnosis-related groups established*
13 *under section 1886(d)(4) of the Social Security Act.*

14 “(d) *DEFINITIONS.*—*The Secretary, in consultation*
15 *with the National Association of Insurance Commissions,*
16 *shall establish uniform definitions for the activities reported*
17 *under subsection (a).*

18 **“SEC. 2719. APPEALS PROCESS.**

19 *“A group health plan and a health insurance issuer*
20 *offering group or individual health insurance coverage shall*
21 *implement an effective appeals process for appeals of cov-*
22 *erage determinations and claims, under which the plan or*
23 *issuer shall, at a minimum—*

24 “(1) *have in effect an internal claims appeal*
25 *process;*

1 “(2) provide notice to enrollees, in a culturally
2 and linguistically appropriate manner, of available
3 internal and external appeals processes, and the
4 availability of any applicable office of health insur-
5 ance consumer assistance or ombudsman established
6 under section 2793 to assist such enrollees with the
7 appeals processes;

8 “(3) allow an enrollee to review their file, to
9 present evidence and testimony as part of the appeals
10 process, and to receive continued coverage pending the
11 outcome of the appeals process; and

12 “(4) provide an external review process for such
13 plans and issuers that, at a minimum, includes the
14 consumer protections set forth in the Uniform Exter-
15 nal Review Model Act promulgated by the National
16 Association of Insurance Commissioners and is bind-
17 ing on such plans.”.

18 **SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.**

19 Part C of title XXVII of the Public Health Service Act
20 (42 U.S.C. 300gg–91 et seq.) is amended by adding at the
21 end the following:

22 **“SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.**

23 “(a) *IN GENERAL.*—The Secretary shall award grants
24 to States to enable such States (or the Exchanges operating

1 *in such States) to establish, expand, or provide support*
2 *for—*

3 “(1) *offices of health insurance consumer assist-*
4 *ance; or*

5 “(2) *health insurance ombudsman programs.*

6 “(b) *ELIGIBILITY.—*

7 “(1) *IN GENERAL.—To be eligible to receive a*
8 *grant, a State shall designate an independent office of*
9 *health insurance consumer assistance, or an ombuds-*
10 *man, that, directly or in coordination with State*
11 *health insurance regulators and consumer assistance*
12 *organizations, receives and responds to inquiries and*
13 *complaints concerning health insurance coverage with*
14 *respect to Federal health insurance requirements and*
15 *under State law.*

16 “(2) *CRITERIA.—A State that receives a grant*
17 *under this section shall comply with criteria estab-*
18 *lished by the Secretary for carrying out activities*
19 *under such grant.*

20 “(c) *DUTIES.—The office of health insurance consumer*
21 *assistance or health insurance ombudsman shall—*

22 “(1) *assist with the filing of complaints and ap-*
23 *peals, including filing appeals with the internal ap-*
24 *peal or grievance process of the group health plan or*

1 *health insurance issuer involved and providing infor-*
2 *mation about the external appeal process;*

3 *“(2) collect, track, and quantify problems and*
4 *inquiries encountered by consumers;*

5 *“(3) educate consumers on their rights and re-*
6 *sponsibilities with respect to group health plans and*
7 *health insurance coverage;*

8 *“(4) assist consumers with enrollment in a group*
9 *health plan or health insurance coverage by providing*
10 *information, referral, and assistance; and*

11 *“(5) resolve problems with obtaining premium*
12 *tax credits under section 36B of the Internal Revenue*
13 *Code of 1986.*

14 *“(d) DATA COLLECTION.—As a condition of receiving*
15 *a grant under subsection (a), an office of health insurance*
16 *consumer assistance or ombudsman program shall be re-*
17 *quired to collect and report data to the Secretary on the*
18 *types of problems and inquiries encountered by consumers.*
19 *The Secretary shall utilize such data to identify areas where*
20 *more enforcement action is necessary and shall share such*
21 *information with State insurance regulators, the Secretary*
22 *of Labor, and the Secretary of the Treasury for use in the*
23 *enforcement activities of such agencies.*

24 *“(e) FUNDING.—*

1 “(1) *INITIAL FUNDING.*—*There is hereby appro-*
 2 *propriated to the Secretary, out of any funds in the*
 3 *Treasury not otherwise appropriated, \$30,000,000 for*
 4 *the first fiscal year for which this section applies to*
 5 *carry out this section. Such amount shall remain*
 6 *available without fiscal year limitation.*

7 “(2) *AUTHORIZATION FOR SUBSEQUENT*
 8 *YEARS.*—*There is authorized to be appropriated to the*
 9 *Secretary for each fiscal year following the fiscal year*
 10 *described in paragraph (1), such sums as may be nec-*
 11 *essary to carry out this section.”.*

12 **SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR**
 13 **THEIR DOLLARS.**

14 *Part C of title XXVII of the Public Health Service Act*
 15 *(42 U.S.C. 300gg–91 et seq.), as amended by section 1002,*
 16 *is further amended by adding at the end the following:*

17 **“SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR**
 18 **THEIR DOLLARS.**

19 “(a) *INITIAL PREMIUM REVIEW PROCESS.*—

20 “(1) *IN GENERAL.*—*The Secretary, in conjunc-*
 21 *tion with States, shall establish a process for the an-*
 22 *nuual review, beginning with the 2010 plan year and*
 23 *subject to subsection (b)(2)(A), of unreasonable in-*
 24 *creases in premiums for health insurance coverage.*

1 “(2) *JUSTIFICATION AND DISCLOSURE.*—*The*
2 *process established under paragraph (1) shall require*
3 *health insurance issuers to submit to the Secretary*
4 *and the relevant State a justification for an unrea-*
5 *sonable premium increase prior to the implementa-*
6 *tion of the increase. Such issuers shall prominently*
7 *post such information on their Internet websites. The*
8 *Secretary shall ensure the public disclosure of infor-*
9 *mation on such increases and justifications for all*
10 *health insurance issuers.*

11 “(b) *CONTINUING PREMIUM REVIEW PROCESS.*—

12 “(1) *INFORMING SECRETARY OF PREMIUM IN-*
13 *CREASE PATTERNS.*—*As a condition of receiving a*
14 *grant under subsection (c)(1), a State, through its*
15 *Commissioner of Insurance, shall—*

16 “(A) *provide the Secretary with informa-*
17 *tion about trends in premium increases in health*
18 *insurance coverage in premium rating areas in*
19 *the State; and*

20 “(B) *make recommendations, as appro-*
21 *priate, to the State Exchange about whether par-*
22 *ticular health insurance issuers should be ex-*
23 *cluded from participation in the Exchange based*
24 *on a pattern or practice of excessive or unjusti-*
25 *fied premium increases.*

1 “(2) *MONITORING BY SECRETARY OF PREMIUM*
2 *INCREASES.*—

3 “(A) *IN GENERAL.*—*Beginning with plan*
4 *years beginning in 2014, the Secretary, in con-*
5 *junction with the States and consistent with the*
6 *provisions of subsection (a)(2), shall monitor*
7 *premium increases of health insurance coverage*
8 *offered through an Exchange and outside of an*
9 *Exchange.*

10 “(B) *CONSIDERATION IN OPENING EX-*
11 *CHANGE.*—*In determining under section*
12 *1312(f)(2)(B) of the Patient Protection and Af-*
13 *fordable Care Act whether to offer qualified*
14 *health plans in the large group market through*
15 *an Exchange, the State shall take into account*
16 *any excess of premium growth outside of the Ex-*
17 *change as compared to the rate of such growth*
18 *inside the Exchange.*

19 “(c) *GRANTS IN SUPPORT OF PROCESS.*—

20 “(1) *PREMIUM REVIEW GRANTS DURING 2010*
21 *THROUGH 2014.*—*The Secretary shall carry out a pro-*
22 *gram to award grants to States during the 5-year pe-*
23 *riod beginning with fiscal year 2010 to assist such*
24 *States in carrying out subsection (a), including—*

1 “(A) *in reviewing and, if appropriate under*
2 *State law, approving premium increases for*
3 *health insurance coverage; and*

4 “(B) *in providing information and rec-*
5 *ommendations to the Secretary under subsection*
6 *(b)(1).*

7 “(2) *FUNDING.—*

8 “(A) *IN GENERAL.—Out of all funds in the*
9 *Treasury not otherwise appropriated, there are*
10 *appropriated to the Secretary \$250,000,000, to*
11 *be available for expenditure for grants under*
12 *paragraph (1) and subparagraph (B).*

13 “(B) *FURTHER AVAILABILITY FOR INSUR-*
14 *ANCE REFORM AND CONSUMER PROTECTION.—If*
15 *the amounts appropriated under subparagraph*
16 *(A) are not fully obligated under grants under*
17 *paragraph (1) by the end of fiscal year 2014,*
18 *any remaining funds shall remain available to*
19 *the Secretary for grants to States for planning*
20 *and implementing the insurance reforms and*
21 *consumer protections under part A.*

22 “(C) *ALLOCATION.—The Secretary shall es-*
23 *tablish a formula for determining the amount of*
24 *any grant to a State under this subsection.*
25 *Under such formula—*

1 “(i) the Secretary shall consider the
2 number of plans of health insurance cov-
3 erage offered in each State and the popu-
4 lation of the State; and

5 “(ii) no State qualifying for a grant
6 under paragraph (1) shall receive less than
7 \$1,000,000, or more than \$5,000,000 for a
8 grant year.”.

9 **SEC. 1004. EFFECTIVE DATES.**

10 (a) *IN GENERAL.*—*Except as provided for in sub-*
11 *section (b), this subtitle (and the amendments made by this*
12 *subtitle) shall become effective for plan years beginning on*
13 *or after the date that is 6 months after the date of enactment*
14 *of this Act, except that the amendments made by sections*
15 *1002 and 1003 shall become effective for fiscal years begin-*
16 *ning with fiscal year 2010.*

17 (b) *SPECIAL RULE.*—*The amendments made by sec-*
18 *tions 1002 and 1003 shall take effect on the date of enact-*
19 *ment of this Act.*

1 ***Subtitle B—Immediate Actions to***
2 ***Preserve and Expand Coverage***

3 ***SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNIN-***
4 ***SURED INDIVIDUALS WITH A PREEXISTING***
5 ***CONDITION.***

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

12 *(b) ADMINISTRATION.—*

13 *(1) IN GENERAL.—The Secretary may carry out*
14 *the program under this section directly or through*
15 *contracts to eligible entities.*

16 *(2) ELIGIBLE ENTITIES.—To be eligible for a*
17 *contract under paragraph (1), an entity shall—*

18 *(A) be a State or nonprofit private entity;*

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

23 *(C) agree to utilize contract funding to es-*
24 *tablish and administer a qualified high risk pool*
25 *for eligible individuals.*

1 (3) *MAINTENANCE OF EFFORT.*—*To be eligible to*
2 *enter into a contract with the Secretary under this*
3 *subsection, a State shall agree not to reduce the an-*
4 *nuual amount the State expended for the operation of*
5 *one or more State high risk pools during the year pre-*
6 *ceding the year in which such contract is entered into.*

7 (c) *QUALIFIED HIGH RISK POOL.*—

8 (1) *IN GENERAL.*—*Amounts made available*
9 *under this section shall be used to establish a quali-*
10 *fied high risk pool that meets the requirements of*
11 *paragraph (2).*

12 (2) *REQUIREMENTS.*—*A qualified high risk pool*
13 *meets the requirements of this paragraph if such*
14 *pool—*

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

19 (B) *provides health insurance coverage—*

20 (i) *in which the issuer's share of the*
21 *total allowed costs of benefits provided*
22 *under such coverage is not less than 65 per-*
23 *cent of such costs; and*

24 (ii) *that has an out of pocket limit not*
25 *greater than the applicable amount de-*

1 scribed in section 223(c)(2) of the Internal
2 Revenue Code of 1986 for the year involved,
3 except that the Secretary may modify such
4 limit if necessary to ensure the pool meets
5 the actuarial value limit under clause (i);

6 (C) ensures that with respect to the pre-
7 mium rate charged for health insurance coverage
8 offered to eligible individuals through the high
9 risk pool, such rate shall—

10 (i) except as provided in clause (ii),
11 vary only as provided for under section
12 2701 of the Public Health Service Act (as
13 amended by this Act and notwithstanding
14 the date on which such amendments take ef-
15 fect);

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

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

20 (D) meets any other requirements deter-
21 mined appropriate by the Secretary.

22 (d) *ELIGIBLE INDIVIDUAL*.—An individual shall be
23 deemed to be an eligible individual for purposes of this sec-
24 tion if such individual—

1 (1) *is a citizen or national of the United States*
2 *or is lawfully present in the United States (as deter-*
3 *mined in accordance with section 1411);*

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

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

13 (e) *PROTECTION AGAINST DUMPING RISK BY INSUR-*
14 *ERS.—*

15 (1) *IN GENERAL.—The Secretary shall establish*
16 *criteria for determining whether health insurance*
17 *issuers and employment-based health plans have dis-*
18 *couraged an individual from remaining enrolled in*
19 *prior coverage based on that individual's health sta-*
20 *tus.*

21 (2) *SANCTIONS.—An issuer or employment-based*
22 *health plan shall be responsible for reimbursing the*
23 *program under this section for the medical expenses*
24 *incurred by the program for an individual who, based*
25 *on criteria established by the Secretary, the Secretary*

1 *finds was encouraged by the issuer to disenroll from*
2 *health benefits coverage prior to enrolling in coverage*
3 *through the program. The criteria shall include at*
4 *least the following circumstances:*

5 *(A) In the case of prior coverage obtained*
6 *through an employer, the provision by the em-*
7 *ployer, group health plan, or the issuer of money*
8 *or other financial consideration for disenrolling*
9 *from the coverage.*

10 *(B) In the case of prior coverage obtained*
11 *directly from an issuer or under an employment-*
12 *based health plan—*

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

16 *(ii) in the case of an individual whose*
17 *premium for the prior coverage exceeded the*
18 *premium required by the program (adjusted*
19 *based on the age factors applied to the prior*
20 *coverage)—*

21 *(I) the prior coverage is a policy*
22 *that is no longer being actively mar-*
23 *keted (as defined by the Secretary) by*
24 *the issuer; or*

1 (II) *the prior coverage is a policy*
2 *for which duration of coverage form*
3 *issue or health status are factors that*
4 *can be considered in determining pre-*
5 *miums at renewal.*

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

12 (f) *OVERSIGHT.—The Secretary shall establish—*

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

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

17 (g) *FUNDING; TERMINATION OF AUTHORITY.—*

18 (1) *IN GENERAL.—There is appropriated to the*
19 *Secretary, out of any moneys in the Treasury not oth-*
20 *erwise appropriated, \$5,000,000,000 to pay claims*
21 *against (and the administrative costs of) the high risk*
22 *pool under this section that are in excess of the*
23 *amount of premiums collected from eligible individ-*
24 *uals enrolled in the high risk pool. Such funds shall*
25 *be available without fiscal year limitation.*

1 (2) *INSUFFICIENT FUNDS.*—*If the Secretary esti-*
2 *mates for any fiscal year that the aggregate amounts*
3 *available for the payment of the expenses of the high*
4 *risk pool will be less than the actual amount of such*
5 *expenses, the Secretary shall make such adjustments*
6 *as are necessary to eliminate such deficit.*

7 (3) *TERMINATION OF AUTHORITY.*—

8 (A) *IN GENERAL.*—*Except as provided in*
9 *subparagraph (B), coverage of eligible individ-*
10 *uals under a high risk pool in a State shall ter-*
11 *minate on January 1, 2014.*

12 (B) *TRANSITION TO EXCHANGE.*—*The Sec-*
13 *retary shall develop procedures to provide for the*
14 *transition of eligible individuals enrolled in*
15 *health insurance coverage offered through a high*
16 *risk pool established under this section into*
17 *qualified health plans offered through an Ex-*
18 *change. Such procedures shall ensure that there*
19 *is no lapse in coverage with respect to the indi-*
20 *vidual and may extend coverage after the termi-*
21 *nation of the risk pool involved, if the Secretary*
22 *determines necessary to avoid such a lapse.*

23 (4) *LIMITATIONS.*—*The Secretary has the au-*
24 *thority to stop taking applications for participation*

1 *in the program under this section to comply with the*
2 *funding limitation provided for in paragraph (1).*

3 (5) *RELATION TO STATE LAWS.—The standards*
4 *established under this section shall supersede any*
5 *State law or regulation (other than State licensing*
6 *laws or State laws relating to plan solvency) with re-*
7 *spect to qualified high risk pools which are established*
8 *in accordance with this section.*

9 **SEC. 1102. REINSURANCE FOR EARLY RETIREES.**

10 (a) *ADMINISTRATION.—*

11 (1) *IN GENERAL.—Not later than 90 days after*
12 *the date of enactment of this Act, the Secretary shall*
13 *establish a temporary reinsurance program to provide*
14 *reimbursement to participating employment-based*
15 *plans for a portion of the cost of providing health in-*
16 *surance coverage to early retirees (and to the eligible*
17 *spouses, surviving spouses, and dependents of such re-*
18 *tirees) during the period beginning on the date on*
19 *which such program is established and ending on*
20 *January 1, 2014.*

21 (2) *REFERENCE.—In this section:*

22 (A) *HEALTH BENEFITS.—The term “health*
23 *benefits” means medical, surgical, hospital, pre-*
24 *scription drug, and such other benefits as shall*
25 *be determined by the Secretary, whether self-*

1 *funded, or delivered through the purchase of in-*
2 *surance or otherwise.*

3 (B) *EMPLOYMENT-BASED PLAN.*—*The term*
4 *“employment-based plan” means a group health*
5 *benefits plan that—*

6 (i) *is—*

7 (I) *maintained by one or more*
8 *current or former employers (including*
9 *without limitation any State or local*
10 *government or political subdivision*
11 *thereof), employee organization, a vol-*
12 *untary employees’ beneficiary associa-*
13 *tion, or a committee or board of indi-*
14 *viduals appointed to administer such*
15 *plan; or*

16 (II) *a multiemployer plan (as de-*
17 *fin ed in section 3(37) of the Employee*
18 *Retirement Income Security Act of*
19 *1974); and*

20 (ii) *provides health benefits to early re-*
21 *tirees.*

22 (C) *EARLY RETIREES.*—*The term “early re-*
23 *tirees” means individuals who are age 55 and*
24 *older but are not eligible for coverage under title*
25 *XVIII of the Social Security Act, and who are*

1 *not active employees of an employer maintain-*
2 *ing, or currently contributing to, the employ-*
3 *ment-based plan or of any employer that has*
4 *made substantial contributions to fund such*
5 *plan.*

6 **(b) PARTICIPATION.—**

7 **(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—***A*
8 *participating employment-based plan is an employ-*
9 *ment-based plan that—*

10 **(A)** *meets the requirements of paragraph (2)*
11 *with respect to health benefits provided under the*
12 *plan; and*

13 **(B)** *submits to the Secretary an application*
14 *for participation in the program, at such time,*
15 *in such manner, and containing such informa-*
16 *tion as the Secretary shall require.*

17 **(2) EMPLOYMENT-BASED HEALTH BENEFITS.—**
18 *An employment-based plan meets the requirements of*
19 *this paragraph if the plan—*

20 **(A)** *implements programs and procedures to*
21 *generate cost-savings with respect to participants*
22 *with chronic and high-cost conditions;*

23 **(B)** *provides documentation of the actual*
24 *cost of medical claims involved; and*

25 **(C)** *is certified by the Secretary.*

1 (c) *PAYMENTS.*—

2 (1) *SUBMISSION OF CLAIMS.*—

3 (A) *IN GENERAL.*—*A participating employ-*
4 *ment-based plan shall submit claims for reim-*
5 *bursement to the Secretary which shall contain*
6 *documentation of the actual costs of the items*
7 *and services for which each claim is being sub-*
8 *mitted.*

9 (B) *BASIS FOR CLAIMS.*—*Claims submitted*
10 *under subparagraph (A) shall be based on the ac-*
11 *tual amount expended by the participating em-*
12 *ployment-based plan involved within the plan*
13 *year for the health benefits provided to an early*
14 *retiree or the spouse, surviving spouse, or de-*
15 *pendent of such retiree. In determining the*
16 *amount of a claim for purposes of this sub-*
17 *section, the participating employment-based plan*
18 *shall take into account any negotiated price con-*
19 *cessions (such as discounts, direct or indirect*
20 *subsidies, rebates, and direct or indirect remu-*
21 *nerations) obtained by such plan with respect to*
22 *such health benefit. For purposes of determining*
23 *the amount of any such claim, the costs paid by*
24 *the early retiree or the retiree's spouse, surviving*
25 *spouse, or dependent in the form of deductibles,*

1 *co-payments, or co-insurance shall be included in*
2 *the amounts paid by the participating employ-*
3 *ment-based plan.*

4 (2) *PROGRAM PAYMENTS.*—*If the Secretary de-*
5 *termines that a participating employment-based plan*
6 *has submitted a valid claim under paragraph (1), the*
7 *Secretary shall reimburse such plan for 80 percent of*
8 *that portion of the costs attributable to such claim*
9 *that exceed \$15,000, subject to the limits contained in*
10 *paragraph (3).*

11 (3) *LIMIT.*—*To be eligible for reimbursement*
12 *under the program, a claim submitted by a partici-*
13 *parting employment-based plan shall not be less than*
14 *\$15,000 nor greater than \$90,000. Such amounts*
15 *shall be adjusted each fiscal year based on the per-*
16 *centage increase in the Medical Care Component of*
17 *the Consumer Price Index for all urban consumers*
18 *(rounded to the nearest multiple of \$1,000) for the*
19 *year involved.*

20 (4) *USE OF PAYMENTS.*—*Amounts paid to a par-*
21 *ticipating employment-based plan under this sub-*
22 *section shall be used to lower costs for the plan. Such*
23 *payments may be used to reduce premium costs for*
24 *an entity described in subsection (a)(2)(B)(i) or to re-*
25 *duce premium contributions, co-payments,*

1 *deductibles, co-insurance, or other out-of-pocket costs*
2 *for plan participants. Such payments shall not be*
3 *used as general revenues for an entity described in*
4 *subsection (a)(2)(B)(i). The Secretary shall develop a*
5 *mechanism to monitor the appropriate use of such*
6 *payments by such entities.*

7 (5) *PAYMENTS NOT TREATED AS INCOME.—Pay-*
8 *ments received under this subsection shall not be in-*
9 *cluded in determining the gross income of an entity*
10 *described in subsection (a)(2)(B)(i) that is maintain-*
11 *ing or currently contributing to a participating em-*
12 *ployment-based plan.*

13 (6) *APPEALS.—The Secretary shall establish—*

14 (A) *an appeals process to permit partici-*
15 *parting employment-based plans to appeal a de-*
16 *termination of the Secretary with respect to*
17 *claims submitted under this section; and*

18 (B) *procedures to protect against fraud,*
19 *waste, and abuse under the program.*

20 (d) *AUDITS.—The Secretary shall conduct annual au-*
21 *dits of claims data submitted by participating employment-*
22 *based plans under this section to ensure that such plans*
23 *are in compliance with the requirements of this section.*

24 (e) *FUNDING.—There is appropriated to the Secretary,*
25 *out of any moneys in the Treasury not otherwise appro-*

1 *priated, \$5,000,000,000 to carry out the program under this*
 2 *section. Such funds shall be available without fiscal year*
 3 *limitation.*

4 (f) *LIMITATION.—The Secretary has the authority to*
 5 *stop taking applications for participation in the program*
 6 *based on the availability of funding under subsection (e).*

7 **SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CON-**
 8 **SUMERS TO IDENTIFY AFFORDABLE COV-**
 9 **ERAGE OPTIONS.**

10 (a) *INTERNET PORTAL TO AFFORDABLE COVERAGE*
 11 *OPTIONS.—*

12 (1) *IMMEDIATE ESTABLISHMENT.—Not later*
 13 *than July 1, 2010, the Secretary, in consultation with*
 14 *the States, shall establish a mechanism, including an*
 15 *Internet website, through which a resident of any*
 16 *State may identify affordable health insurance cov-*
 17 *erage options in that State.*

18 (2) *CONNECTING TO AFFORDABLE COVERAGE.—*
 19 *An Internet website established under paragraph (1)*
 20 *shall, to the extent practicable, provide ways for resi-*
 21 *dents of any State to receive information on at least*
 22 *the following coverage options:*

23 (A) *Health insurance coverage offered by*
 24 *health insurance issuers, other than coverage that*

1 *provides reimbursement only for the treatment or*
2 *mitigation of—*

3 *(i) a single disease or condition; or*

4 *(ii) an unreasonably limited set of dis-*
5 *eases or conditions (as determined by the*
6 *Secretary);*

7 *(B) Medicaid coverage under title XIX of*
8 *the Social Security Act.*

9 *(C) Coverage under title XXI of the Social*
10 *Security Act.*

11 *(D) A State health benefits high risk pool,*
12 *to the extent that such high risk pool is offered*
13 *in such State; and*

14 *(E) Coverage under a high risk pool under*
15 *section 1101.*

16 **(b) ENHANCING COMPARATIVE PURCHASING OP-**
17 **TIONS.—**

18 *(1) IN GENERAL.—Not later than 60 days after*
19 *the date of enactment of this Act, the Secretary shall*
20 *develop a standardized format to be used for the pres-*
21 *entation of information relating to the coverage op-*
22 *tions described in subsection (a)(2). Such format*
23 *shall, at a minimum, require the inclusion of infor-*
24 *mation on the percentage of total premium revenue*
25 *expended on nonclinical costs (as reported under sec-*

1 *tion 2718(a) of the Public Health Service Act), eligi-*
2 *bility, availability, premium rates, and cost sharing*
3 *with respect to such coverage options and be con-*
4 *sistent with the standards adopted for the uniform ex-*
5 *planation of coverage as provided for in section 2715*
6 *of the Public Health Service Act.*

7 (2) *USE OF FORMAT.—The Secretary shall uti-*
8 *lize the format developed under paragraph (1) in*
9 *compiling information concerning coverage options on*
10 *the Internet website established under subsection (a).*

11 (c) *AUTHORITY TO CONTRACT.—The Secretary may*
12 *carry out this section through contracts entered into with*
13 *qualified entities.*

14 **SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.**

15 (a) *PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—*
16 *Section 261 of the Health Insurance Portability and Ac-*
17 *countability Act of 1996 (42 U.S.C. 1320d note) is amend-*
18 *ed—*

19 (1) *by inserting “uniform” before “standards”;*
20 *and*

21 (2) *by inserting “and to reduce the clerical bur-*
22 *den on patients, health care providers, and health*
23 *plans” before the period at the end.*

24 (b) *OPERATING RULES FOR HEALTH INFORMATION*
25 *TRANSACTIONS.—*

1 (1) *DEFINITION OF OPERATING RULES.*—Section
2 1171 of the Social Security Act (42 U.S.C. 1320d) is
3 amended by adding at the end the following:

4 “(9) *OPERATING RULES.*—The term ‘operating
5 rules’ means the necessary business rules and guide-
6 lines for the electronic exchange of information that
7 are not defined by a standard or its implementation
8 specifications as adopted for purposes of this part.”.

9 (2) *TRANSACTION STANDARDS; OPERATING*
10 *RULES AND COMPLIANCE.*—Section 1173 of the Social
11 Security Act (42 U.S.C. 1320d–2) is amended—

12 (A) in subsection (a)(2), by adding at the
13 end the following new subparagraph:

14 “(J) *Electronic funds transfers.*”;

15 (B) in subsection (a), by adding at the end
16 the following new paragraph:

17 “(4) *REQUIREMENTS FOR FINANCIAL AND ADMIN-*
18 *ISTRATIVE TRANSACTIONS.*—

19 “(A) *IN GENERAL.*—The standards and as-
20 sociated operating rules adopted by the Secretary
21 shall—

22 “(i) to the extent feasible and appro-
23 priate, enable determination of an individ-
24 ual’s eligibility and financial responsibility

1 *for specific services prior to or at the point*
2 *of care;*

3 “(ii) *be comprehensive, requiring mini-*
4 *mal augmentation by paper or other com-*
5 *munications;*

6 “(iii) *provide for timely acknowledg-*
7 *ment, response, and status reporting that*
8 *supports a transparent claims and denial*
9 *management process (including adjudica-*
10 *tion and appeals); and*

11 “(iv) *describe all data elements (in-*
12 *cluding reason and remark codes) in unam-*
13 *biguous terms, require that such data ele-*
14 *ments be required or conditioned upon set*
15 *values in other fields, and prohibit addi-*
16 *tional conditions (except where necessary to*
17 *implement State or Federal law, or to pro-*
18 *tect against fraud and abuse).*

19 “(B) *REDUCTION OF CLERICAL BURDEN.—*
20 *In adopting standards and operating rules for*
21 *the transactions referred to under paragraph (1),*
22 *the Secretary shall seek to reduce the number*
23 *and complexity of forms (including paper and*
24 *electronic forms) and data entry required by pa-*
25 *tients and providers.”; and*

1 (C) by adding at the end the following new
2 subsections:

3 “(g) OPERATING RULES.—

4 “(1) IN GENERAL.—The Secretary shall adopt a
5 single set of operating rules for each transaction re-
6 ferred to under subsection (a)(1) with the goal of cre-
7 ating as much uniformity in the implementation of
8 the electronic standards as possible. Such operating
9 rules shall be consensus-based and reflect the necessary
10 business rules affecting health plans and health care
11 providers and the manner in which they operate pur-
12 suant to standards issued under Health Insurance
13 Portability and Accountability Act of 1996.

14 “(2) OPERATING RULES DEVELOPMENT.—In
15 adopting operating rules under this subsection, the
16 Secretary shall consider recommendations for oper-
17 ating rules developed by a qualified nonprofit entity
18 that meets the following requirements:

19 “(A) The entity focuses its mission on ad-
20 ministrative simplification.

21 “(B) The entity demonstrates a multi-stake-
22 holder and consensus-based process for develop-
23 ment of operating rules, including representation
24 by or participation from health plans, health
25 care providers, vendors, relevant Federal agen-

1 *cies, and other standard development organiza-*
2 *tions.*

3 “(C) *The entity has a public set of guiding*
4 *principles that ensure the operating rules and*
5 *process are open and transparent, and supports*
6 *nondiscrimination and conflict of interest poli-*
7 *cies that demonstrate a commitment to open,*
8 *fair, and nondiscriminatory practices.*

9 “(D) *The entity builds on the transaction*
10 *standards issued under Health Insurance Port-*
11 *ability and Accountability Act of 1996.*

12 “(E) *The entity allows for public review*
13 *and updates of the operating rules.*

14 “(3) *REVIEW AND RECOMMENDATIONS.—The Na-*
15 *tional Committee on Vital and Health Statistics*
16 *shall—*

17 “(A) *advise the Secretary as to whether a*
18 *nonprofit entity meets the requirements under*
19 *paragraph (2);*

20 “(B) *review the operating rules developed*
21 *and recommended by such nonprofit entity;*

22 “(C) *determine whether such operating rules*
23 *represent a consensus view of the health care*
24 *stakeholders and are consistent with and do not*
25 *conflict with other existing standards;*

1 “(D) evaluate whether such operating rules
2 are consistent with electronic standards adopted
3 for health information technology; and

4 “(E) submit to the Secretary a rec-
5 ommendation as to whether the Secretary should
6 adopt such operating rules.

7 “(4) IMPLEMENTATION.—

8 “(A) IN GENERAL.—The Secretary shall
9 adopt operating rules under this subsection, by
10 regulation in accordance with subparagraph (C),
11 following consideration of the operating rules de-
12 veloped by the non-profit entity described in
13 paragraph (2) and the recommendation sub-
14 mitted by the National Committee on Vital and
15 Health Statistics under paragraph (3)(E) and
16 having ensured consultation with providers.

17 “(B) ADOPTION REQUIREMENTS; EFFECTIVE
18 DATES.—

19 “(i) ELIGIBILITY FOR A HEALTH PLAN
20 AND HEALTH CLAIM STATUS.—The set of
21 operating rules for eligibility for a health
22 plan and health claim status transactions
23 shall be adopted not later than July 1,
24 2011, in a manner ensuring that such oper-
25 ating rules are effective not later than Jan-

1 uary 1, 2013, and may allow for the use of
2 a machine readable identification card.

3 “(ii) *ELECTRONIC FUNDS TRANSFERS*
4 *AND HEALTH CARE PAYMENT AND REMIT-*
5 *TANCE ADVICE.*—*The set of operating rules*
6 *for electronic funds transfers and health*
7 *care payment and remittance advice trans-*
8 *actions shall—*

9 “(I) *allow for automated rec-*
10 *onciliation of the electronic payment*
11 *with the remittance advice; and*

12 “(II) *be adopted not later than*
13 *July 1, 2012, in a manner ensuring*
14 *that such operating rules are effective*
15 *not later than January 1, 2014.*

16 “(iii) *HEALTH CLAIMS OR EQUIVALENT*
17 *ENCOUNTER INFORMATION, ENROLLMENT*
18 *AND DISENROLLMENT IN A HEALTH PLAN,*
19 *HEALTH PLAN PREMIUM PAYMENTS, REFER-*
20 *RAL CERTIFICATION AND AUTHORIZATION.*—
21 *The set of operating rules for health claims*
22 *or equivalent encounter information, enroll-*
23 *ment and disenrollment in a health plan,*
24 *health plan premium payments, and refer-*
25 *ral certification and authorization trans-*

1 *actions shall be adopted not later than July*
2 *1, 2014, in a manner ensuring that such*
3 *operating rules are effective not later than*
4 *January 1, 2016.*

5 “(C) *EXPEDITED RULEMAKING.*—*The Sec-*
6 *retary shall promulgate an interim final rule*
7 *applying any standard or operating rule rec-*
8 *ommended by the National Committee on Vital*
9 *and Health Statistics pursuant to paragraph*
10 *(3). The Secretary shall accept and consider pub-*
11 *lic comments on any interim final rule published*
12 *under this subparagraph for 60 days after the*
13 *date of such publication.*

14 “(h) *COMPLIANCE.*—

15 “(1) *HEALTH PLAN CERTIFICATION.*—

16 “(A) *ELIGIBILITY FOR A HEALTH PLAN,*
17 *HEALTH CLAIM STATUS, ELECTRONIC FUNDS*
18 *TRANSFERS, HEALTH CARE PAYMENT AND RE-*
19 *MITTANCE ADVICE.*—*Not later than December 31,*
20 *2013, a health plan shall file a statement with*
21 *the Secretary, in such form as the Secretary may*
22 *require, certifying that the data and information*
23 *systems for such plan are in compliance with*
24 *any applicable standards (as described under*
25 *paragraph (7) of section 1171) and associated*

1 *operating rules (as described under paragraph*
2 *(9) of such section) for electronic funds transfers,*
3 *eligibility for a health plan, health claim status,*
4 *and health care payment and remittance advice,*
5 *respectively.*

6 *“(B) HEALTH CLAIMS OR EQUIVALENT EN-*
7 *COUNTER INFORMATION, ENROLLMENT AND*
8 *DISENROLLMENT IN A HEALTH PLAN, HEALTH*
9 *PLAN PREMIUM PAYMENTS, HEALTH CLAIMS AT-*
10 *TACHMENTS, REFERRAL CERTIFICATION AND AU-*
11 *THORIZATION.—Not later than December 31,*
12 *2015, a health plan shall file a statement with*
13 *the Secretary, in such form as the Secretary may*
14 *require, certifying that the data and information*
15 *systems for such plan are in compliance with*
16 *any applicable standards and associated oper-*
17 *ating rules for health claims or equivalent en-*
18 *counter information, enrollment and*
19 *disenrollment in a health plan, health plan pre-*
20 *mium payments, health claims attachments, and*
21 *referral certification and authorization, respec-*
22 *tively. A health plan shall provide the same level*
23 *of documentation to certify compliance with such*
24 *transactions as is required to certify compliance*

1 with the transactions specified in subparagraph
2 (A).

3 “(2) *DOCUMENTATION OF COMPLIANCE.*—A
4 health plan shall provide the Secretary, in such form
5 as the Secretary may require, with adequate docu-
6 mentation of compliance with the standards and op-
7 erating rules described under paragraph (1). A health
8 plan shall not be considered to have provided ade-
9 quate documentation and shall not be certified as
10 being in compliance with such standards, unless the
11 health plan—

12 “(A) demonstrates to the Secretary that the
13 plan conducts the electronic transactions speci-
14 fied in paragraph (1) in a manner that fully
15 complies with the regulations of the Secretary;
16 and

17 “(B) provides documentation showing that
18 the plan has completed end-to-end testing for
19 such transactions with their partners, such as
20 hospitals and physicians.

21 “(3) *SERVICE CONTRACTS.*—A health plan shall
22 be required to ensure that any entities that provide
23 services pursuant to a contract with such health plan
24 shall comply with any applicable certification and
25 compliance requirements (and provide the Secretary

1 *with adequate documentation of such compliance)*
2 *under this subsection.*

3 “(4) *CERTIFICATION BY OUTSIDE ENTITY.—The*
4 *Secretary may designate independent, outside entities*
5 *to certify that a health plan has complied with the re-*
6 *quirements under this subsection, provided that the*
7 *certification standards employed by such entities are*
8 *in accordance with any standards or operating rules*
9 *issued by the Secretary.*

10 “(5) *COMPLIANCE WITH REVISED STANDARDS*
11 *AND OPERATING RULES.—*

12 “(A) *IN GENERAL.—A health plan (includ-*
13 *ing entities described under paragraph (3)) shall*
14 *file a statement with the Secretary, in such form*
15 *as the Secretary may require, certifying that the*
16 *data and information systems for such plan are*
17 *in compliance with any applicable revised stand-*
18 *ards and associated operating rules under this*
19 *subsection for any interim final rule promul-*
20 *gated by the Secretary under subsection (i)*
21 *that—*

22 “(i) *amends any standard or operating*
23 *rule described under paragraph (1) of this*
24 *subsection; or*

1 “(i) establishes a standard (as de-
2 scribed under subsection (a)(1)(B)) or asso-
3 ciated operating rules (as described under
4 subsection (i)(5)) for any other financial
5 and administrative transactions.

6 “(B) DATE OF COMPLIANCE.—A health plan
7 shall comply with such requirements not later
8 than the effective date of the applicable standard
9 or operating rule.

10 “(6) AUDITS OF HEALTH PLANS.—The Secretary
11 shall conduct periodic audits to ensure that health
12 plans (including entities described under paragraph
13 (3)) are in compliance with any standards and oper-
14 ating rules that are described under paragraph (1) or
15 subsection (i)(5).

16 “(i) REVIEW AND AMENDMENT OF STANDARDS AND
17 OPERATING RULES.—

18 “(1) ESTABLISHMENT.—Not later than January
19 1, 2014, the Secretary shall establish a review com-
20 mittee (as described under paragraph (4)).

21 “(2) EVALUATIONS AND REPORTS.—

22 “(A) HEARINGS.—Not later than April 1,
23 2014, and not less than biennially thereafter, the
24 Secretary, acting through the review committee,
25 shall conduct hearings to evaluate and review the

1 *adopted standards and operating rules estab-*
2 *lished under this section.*

3 *“(B) REPORT.—Not later than July 1,*
4 *2014, and not less than biennially thereafter, the*
5 *review committee shall provide recommendations*
6 *for updating and improving such standards and*
7 *operating rules. The review committee shall rec-*
8 *ommend a single set of operating rules per trans-*
9 *action standard and maintain the goal of cre-*
10 *ating as much uniformity as possible in the im-*
11 *plementation of the electronic standards.*

12 *“(3) INTERIM FINAL RULEMAKING.—*

13 *“(A) IN GENERAL.—Any recommendations*
14 *to amend adopted standards and operating rules*
15 *that have been approved by the review committee*
16 *and reported to the Secretary under paragraph*
17 *(2)(B) shall be adopted by the Secretary through*
18 *promulgation of an interim final rule not later*
19 *than 90 days after receipt of the committee’s re-*
20 *port.*

21 *“(B) PUBLIC COMMENT.—*

22 *“(i) PUBLIC COMMENT PERIOD.—The*
23 *Secretary shall accept and consider public*
24 *comments on any interim final rule pub-*

1 lished under this paragraph for 60 days
2 after the date of such publication.

3 “(ii) *EFFECTIVE DATE.*—The effective
4 date of any amendment to existing stand-
5 ards or operating rules that is adopted
6 through an interim final rule published
7 under this paragraph shall be 25 months
8 following the close of such public comment
9 period.

10 “(4) *REVIEW COMMITTEE.*—

11 “(A) *DEFINITION.*—For the purposes of this
12 subsection, the term ‘review committee’ means a
13 committee chartered by or within the Depart-
14 ment of Health and Human services that has
15 been designated by the Secretary to carry out
16 this subsection, including—

17 “(i) the National Committee on Vital
18 and Health Statistics; or

19 “(ii) any appropriate committee as de-
20 termined by the Secretary.

21 “(B) *COORDINATION OF HIT STANDARDS.*—
22 In developing recommendations under this sub-
23 section, the review committee shall ensure coordi-
24 nation, as appropriate, with the standards that
25 support the certified electronic health record tech-

1 *nology approved by the Office of the National*
2 *Coordinator for Health Information Technology.*

3 *“(5) OPERATING RULES FOR OTHER STANDARDS*
4 *ADOPTED BY THE SECRETARY.—The Secretary shall*
5 *adopt a single set of operating rules (pursuant to the*
6 *process described under subsection (g)) for any trans-*
7 *action for which a standard had been adopted pursu-*
8 *ant to subsection (a)(1)(B).*

9 *“(j) PENALTIES.—*

10 *“(1) PENALTY FEE.—*

11 *“(A) IN GENERAL.—Not later than April 1,*
12 *2014, and annually thereafter, the Secretary*
13 *shall assess a penalty fee (as determined under*
14 *subparagraph (B)) against a health plan that*
15 *has failed to meet the requirements under sub-*
16 *section (h) with respect to certification and docu-*
17 *mentation of compliance with—*

18 *“(i) the standards and associated oper-*
19 *ating rules described under paragraph (1)*
20 *of such subsection; and*

21 *“(ii) a standard (as described under*
22 *subsection (a)(1)(B)) and associated oper-*
23 *ating rules (as described under subsection*
24 *(i)(5)) for any other financial and adminis-*
25 *trative transactions.*

1 “(B) *FEE AMOUNT.*—Subject to subpara-
2 graphs (C), (D), and (E), the Secretary shall as-
3 sess a penalty fee against a health plan in the
4 amount of \$1 per covered life until certification
5 is complete. The penalty shall be assessed per
6 person covered by the plan for which its data
7 systems for major medical policies are not in
8 compliance and shall be imposed against the
9 health plan for each day that the plan is not in
10 compliance with the requirements under sub-
11 section (h).

12 “(C) *ADDITIONAL PENALTY FOR MISREPRE-*
13 *SENTATION.*—A health plan that knowingly pro-
14 vides inaccurate or incomplete information in a
15 statement of certification or documentation of
16 compliance under subsection (h) shall be subject
17 to a penalty fee that is double the amount that
18 would otherwise be imposed under this sub-
19 section.

20 “(D) *ANNUAL FEE INCREASE.*—The amount
21 of the penalty fee imposed under this subsection
22 shall be increased on an annual basis by the an-
23 nual percentage increase in total national health
24 care expenditures, as determined by the Sec-
25 retary.

1 “(E) *PENALTY LIMIT.*—A penalty fee as-
2 sessed against a health plan under this sub-
3 section shall not exceed, on an annual basis—

4 “(i) an amount equal to \$20 per cov-
5 ered life under such plan; or

6 “(ii) an amount equal to \$40 per cov-
7 ered life under the plan if such plan has
8 knowingly provided inaccurate or incom-
9 plete information (as described under sub-
10 paragraph (C)).

11 “(F) *DETERMINATION OF COVERED INDIVID-*
12 *UALS.*—The Secretary shall determine the num-
13 ber of covered lives under a health plan based
14 upon the most recent statements and filings that
15 have been submitted by such plan to the Securi-
16 ties and Exchange Commission.

17 “(2) *NOTICE AND DISPUTE PROCEDURE.*—The
18 Secretary shall establish a procedure for assessment of
19 penalty fees under this subsection that provides a
20 health plan with reasonable notice and a dispute reso-
21 lution procedure prior to provision of a notice of as-
22 sessment by the Secretary of the Treasury (as de-
23 scribed under paragraph (4)(B)).

24 “(3) *PENALTY FEE REPORT.*—Not later than
25 May 1, 2014, and annually thereafter, the Secretary

1 *shall provide the Secretary of the Treasury with a re-*
2 *port identifying those health plans that have been as-*
3 *essed a penalty fee under this subsection.*

4 *“(4) COLLECTION OF PENALTY FEE.—*

5 *“(A) IN GENERAL.—The Secretary of the*
6 *Treasury, acting through the Financial Manage-*
7 *ment Service, shall administer the collection of*
8 *penalty fees from health plans that have been*
9 *identified by the Secretary in the penalty fee re-*
10 *port provided under paragraph (3).*

11 *“(B) NOTICE.—Not later than August 1,*
12 *2014, and annually thereafter, the Secretary of*
13 *the Treasury shall provide notice to each health*
14 *plan that has been assessed a penalty fee by the*
15 *Secretary under this subsection. Such notice*
16 *shall include the amount of the penalty fee as-*
17 *essed by the Secretary and the due date for pay-*
18 *ment of such fee to the Secretary of the Treasury*
19 *(as described in subparagraph (C)).*

20 *“(C) PAYMENT DUE DATE.—Payment by a*
21 *health plan for a penalty fee assessed under this*
22 *subsection shall be made to the Secretary of the*
23 *Treasury not later than November 1, 2014, and*
24 *annually thereafter.*

1 “(D) *UNPAID PENALTY FEES.*—*Any amount*
2 *of a penalty fee assessed against a health plan*
3 *under this subsection for which payment has not*
4 *been made by the due date provided under sub-*
5 *paragraph (C) shall be—*

6 “(i) *increased by the interest accrued*
7 *on such amount, as determined pursuant to*
8 *the underpayment rate established under*
9 *section 6621 of the Internal Revenue Code*
10 *of 1986; and*

11 “(ii) *treated as a past-due, legally en-*
12 *forceable debt owed to a Federal agency for*
13 *purposes of section 6402(d) of the Internal*
14 *Revenue Code of 1986.*

15 “(E) *ADMINISTRATIVE FEES.*—*Any fee*
16 *charged or allocated for collection activities con-*
17 *ducted by the Financial Management Service*
18 *will be passed on to a health plan on a pro-rata*
19 *basis and added to any penalty fee collected from*
20 *the plan.”.*

21 (c) *PROMULGATION OF RULES.*—

22 (1) *UNIQUE HEALTH PLAN IDENTIFIER.*—*The*
23 *Secretary shall promulgate a final rule to establish a*
24 *unique health plan identifier (as described in section*
25 *1173(b) of the Social Security Act (42 U.S.C. 1320d-*

1 2(b))) based on the input of the National Committee
2 on Vital and Health Statistics. The Secretary may do
3 so on an interim final basis and such rule shall be
4 effective not later than October 1, 2012.

5 (2) *ELECTRONIC FUNDS TRANSFER.*—The Sec-
6 retary shall promulgate a final rule to establish a
7 standard for electronic funds transfers (as described
8 in section 1173(a)(2)(J) of the Social Security Act, as
9 added by subsection (b)(2)(A)). The Secretary may do
10 so on an interim final basis and shall adopt such
11 standard not later than January 1, 2012, in a man-
12 ner ensuring that such standard is effective not later
13 than January 1, 2014.

14 (3) *HEALTH CLAIMS ATTACHMENTS.*—The Sec-
15 retary shall promulgate a final rule to establish a
16 transaction standard and a single set of associated
17 operating rules for health claims attachments (as de-
18 scribed in section 1173(a)(2)(B) of the Social Secu-
19 rity Act (42 U.S.C. 1320d–2(a)(2)(B))) that is con-
20 sistent with the X12 Version 5010 transaction stand-
21 ards. The Secretary may do so on an interim final
22 basis and shall adopt a transaction standard and a
23 single set of associated operating rules not later than
24 January 1, 2014, in a manner ensuring that such
25 standard is effective not later than January 1, 2016.

1 (d) *EXPANSION OF ELECTRONIC TRANSACTIONS IN*
2 *MEDICARE.*—Section 1862(a) of the Social Security Act (42
3 *U.S.C. 1395y(a)*) is amended—

4 (1) in paragraph (23), by striking the “or” at
5 the end;

6 (2) in paragraph (24), by striking the period
7 and inserting “; or”; and

8 (3) by inserting after paragraph (24) the fol-
9 lowing new paragraph:

10 “(25) not later than January 1, 2014, for which
11 the payment is other than by electronic funds transfer
12 (EFT) or an electronic remittance in a form as speci-
13 fied in ASC X12 835 Health Care Payment and Re-
14 mittance Advice or subsequent standard.”.

15 **SEC. 1105. EFFECTIVE DATE.**

16 This subtitle shall take effect on the date of enactment
17 of this Act.

18 **Subtitle C—Quality Health Insur-**
19 **ance Coverage for All Americans**

20 **PART I—HEALTH INSURANCE MARKET REFORMS**

21 **SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

22 **ACT.**

23 Part A of title XXVII of the Public Health Service Act
24 (42 *U.S.C. 300gg et seq.*), as amended by section 1001, is
25 further amended—

1 (1) *by striking the heading for subpart 1 and in-*
2 *serting the following:*

3 **“Subpart I—General Reform”;**

4 (2)(A) *in section 2701 (42 U.S.C. 300gg), by*
5 *striking the section heading and subsection (a) and*
6 *inserting the following:*

7 **“SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EX-**
8 **CLUSIONS OR OTHER DISCRIMINATION**
9 **BASED ON HEALTH STATUS.**

10 “(a) *IN GENERAL.—A group health plan and a health*
11 *insurance issuer offering group or individual health insur-*
12 *ance coverage may not impose any preexisting condition*
13 *exclusion with respect to such plan or coverage.”; and*

14 (B) *by transferring such section (as amended by*
15 *subparagraph (A)) so as to appear after the section*
16 *2703 added by paragraph (4);*

17 (3)(A) *in section 2702 (42 U.S.C. 300gg-1)—*

18 (i) *by striking the section heading and all*
19 *that follows through subsection (a);*

20 (ii) *in subsection (b)—*

21 (I) *by striking “health insurance issuer*
22 *offering health insurance coverage in con-*
23 *nection with a group health plan” each*
24 *place that such appears and inserting*

1 “health insurance issuer offering group or
2 individual health insurance coverage”; and

3 (II) in paragraph (2)(A)—

4 (aa) by inserting “or individual”
5 after “employer”; and

6 (bb) by inserting “or individual
7 health coverage, as the case may be”
8 before the semicolon; and

9 (iii) in subsection (e)—

10 (I) by striking “(a)(1)(F)” and insert-
11 ing “(a)(6)”;

12 (II) by striking “2701” and inserting
13 “2704”; and

14 (III) by striking “2721(a)” and insert-
15 ing “2735(a)”;

16 (B) by transferring such section (as amend-
17 ed by subparagraph (A)) to appear after section
18 2705(a) as added by paragraph (4); and

19 (4) by inserting after the subpart heading (as
20 added by paragraph (1)) the following:

21 **“SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.**

22 “(a) PROHIBITING DISCRIMINATORY PREMIUM
23 RATES.—

24 “(1) IN GENERAL.—With respect to the premium
25 rate charged by a health insurance issuer for health

1 *insurance coverage offered in the individual or small*
2 *group market—*

3 “(A) *such rate shall vary with respect to the*
4 *particular plan or coverage involved only by—*

5 “(i) *whether such plan or coverage cov-*
6 *ers an individual or family;*

7 “(ii) *rating area, as established in ac-*
8 *cordance with paragraph (2);*

9 “(iii) *age, except that such rate shall*
10 *not vary by more than 3 to 1 for adults*
11 *(consistent with section 2707(c)); and*

12 “(iv) *tobacco use, except that such rate*
13 *shall not vary by more than 1.5 to 1; and*

14 “(B) *such rate shall not vary with respect*
15 *to the particular plan or coverage involved by*
16 *any other factor not described in subparagraph*
17 *(A).*

18 “(2) *RATING AREA.—*

19 “(A) *IN GENERAL.—Each State shall estab-*
20 *lish 1 or more rating areas within that State for*
21 *purposes of applying the requirements of this*
22 *title.*

23 “(B) *SECRETARIAL REVIEW.—The Sec-*
24 *retary shall review the rating areas established*
25 *by each State under subparagraph (A) to ensure*

1 *the adequacy of such areas for purposes of car-*
2 *rying out the requirements of this title. If the*
3 *Secretary determines a State's rating areas are*
4 *not adequate, or that a State does not establish*
5 *such areas, the Secretary may establish rating*
6 *areas for that State.*

7 “(3) *PERMISSIBLE AGE BANDS.—The Secretary,*
8 *in consultation with the National Association of In-*
9 *surance Commissioners, shall define the permissible*
10 *age bands for rating purposes under paragraph*
11 *(1)(A)(iii).*

12 “(4) *APPLICATION OF VARIATIONS BASED ON AGE*
13 *OR TOBACCO USE.—With respect to family coverage*
14 *under a group health plan or health insurance cov-*
15 *erage, the rating variations permitted under clauses*
16 *(iii) and (iv) of paragraph (1)(A) shall be applied*
17 *based on the portion of the premium that is attrib-*
18 *utable to each family member covered under the plan*
19 *or coverage.*

20 “(5) *SPECIAL RULE FOR LARGE GROUP MAR-*
21 *KET.—If a State permits health insurance issuers*
22 *that offer coverage in the large group market in the*
23 *State to offer such coverage through the State Ex-*
24 *change (as provided for under section 1312(f)(2)(B) of*
25 *the Patient Protection and Affordable Care Act), the*

1 *provisions of this subsection shall apply to all cov-*
2 *erage offered in such market in the State.*

3 **“SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.**

4 *“(a) GUARANTEED ISSUANCE OF COVERAGE IN THE*
5 *INDIVIDUAL AND GROUP MARKET.—Subject to subsections*
6 *(b) through (e), each health insurance issuer that offers*
7 *health insurance coverage in the individual or group mar-*
8 *ket in a State must accept every employer and individual*
9 *in the State that applies for such coverage.*

10 *“(b) ENROLLMENT.—*

11 *“(1) RESTRICTION.—A health insurance issuer*
12 *described in subsection (a) may restrict enrollment in*
13 *coverage described in such subsection to open or spe-*
14 *cial enrollment periods.*

15 *“(2) ESTABLISHMENT.—A health insurance*
16 *issuer described in subsection (a) shall, in accordance*
17 *with the regulations promulgated under paragraph*
18 *(3), establish special enrollment periods for qualifying*
19 *events (under section 603 of the Employee Retirement*
20 *Income Security Act of 1974).*

21 *“(3) REGULATIONS.—The Secretary shall pro-*
22 *mulgate regulations with respect to enrollment periods*
23 *under paragraphs (1) and (2).*

1 **“SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.**

2 “(a) *IN GENERAL.*—*Except as provided in this section,*
3 *if a health insurance issuer offers health insurance coverage*
4 *in the individual or group market, the issuer must renew*
5 *or continue in force such coverage at the option of the plan*
6 *sponsor or the individual, as applicable.*

7 **“SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDI-**
8 **VIDUAL PARTICIPANTS AND BENEFICIARIES**
9 **BASED ON HEALTH STATUS.**

10 “(a) *IN GENERAL.*—*A group health plan and a health*
11 *insurance issuer offering group or individual health insur-*
12 *ance coverage may not establish rules for eligibility (includ-*
13 *ing continued eligibility) of any individual to enroll under*
14 *the terms of the plan or coverage based on any of the fol-*
15 *lowing health status-related factors in relation to the indi-*
16 *vidual or a dependent of the individual:*

17 “(1) *Health status.*

18 “(2) *Medical condition (including both physical*
19 *and mental illnesses).*

20 “(3) *Claims experience.*

21 “(4) *Receipt of health care.*

22 “(5) *Medical history.*

23 “(6) *Genetic information.*

24 “(7) *Evidence of insurability (including condi-*
25 *tions arising out of acts of domestic violence).*

26 “(8) *Disability.*

1 “(9) *Any other health status-related factor deter-*
2 *mined appropriate by the Secretary.*”

3 “(j) *PROGRAMS OF HEALTH PROMOTION OR DISEASE*
4 *PREVENTION.—*”

5 “(1) *GENERAL PROVISIONS.—*”

6 “(A) *GENERAL RULE.—For purposes of sub-*
7 *section (b)(2)(B), a program of health promotion*
8 *or disease prevention (referred to in this sub-*
9 *section as a ‘wellness program’) shall be a pro-*
10 *gram offered by an employer that is designed to*
11 *promote health or prevent disease that meets the*
12 *applicable requirements of this subsection.*”

13 “(B) *NO CONDITIONS BASED ON HEALTH*
14 *STATUS FACTOR.—If none of the conditions for*
15 *obtaining a premium discount or rebate or other*
16 *reward for participation in a wellness program*
17 *is based on an individual satisfying a standard*
18 *that is related to a health status factor, such*
19 *wellness program shall not violate this section if*
20 *participation in the program is made available*
21 *to all similarly situated individuals and the re-*
22 *quirements of paragraph (2) are complied with.*”

23 “(C) *CONDITIONS BASED ON HEALTH STA-*
24 *TUS FACTOR.—If any of the conditions for ob-*
25 *taining a premium discount or rebate or other*

1 *reward for participation in a wellness program*
2 *is based on an individual satisfying a standard*
3 *that is related to a health status factor, such*
4 *wellness program shall not violate this section if*
5 *the requirements of paragraph (3) are complied*
6 *with.*

7 “(2) *WELLNESS PROGRAMS NOT SUBJECT TO RE-*
8 *QUIREMENTS.—If none of the conditions for obtaining*
9 *a premium discount or rebate or other reward under*
10 *a wellness program as described in paragraph (1)(B)*
11 *are based on an individual satisfying a standard that*
12 *is related to a health status factor (or if such a*
13 *wellness program does not provide such a reward), the*
14 *wellness program shall not violate this section if par-*
15 *ticipation in the program is made available to all*
16 *similarly situated individuals. The following pro-*
17 *grams shall not have to comply with the requirements*
18 *of paragraph (3) if participation in the program is*
19 *made available to all similarly situated individuals:*

20 “(A) *A program that reimburses all or part*
21 *of the cost for memberships in a fitness center.*

22 “(B) *A diagnostic testing program that pro-*
23 *vides a reward for participation and does not*
24 *base any part of the reward on outcomes.*

1 “(C) A program that encourages preventive
2 care related to a health condition through the
3 waiver of the copayment or deductible require-
4 ment under group health plan for the costs of
5 certain items or services related to a health con-
6 dition (such as prenatal care or well-baby visits).

7 “(D) A program that reimburses individ-
8 uals for the costs of smoking cessation programs
9 without regard to whether the individual quits
10 smoking.

11 “(E) A program that provides a reward to
12 individuals for attending a periodic health edu-
13 cation seminar.

14 “(3) WELLNESS PROGRAMS SUBJECT TO RE-
15 QUIREMENTS.—If any of the conditions for obtaining
16 a premium discount, rebate, or reward under a
17 wellness program as described in paragraph (1)(C) is
18 based on an individual satisfying a standard that is
19 related to a health status factor, the wellness program
20 shall not violate this section if the following require-
21 ments are complied with:

22 “(A) The reward for the wellness program,
23 together with the reward for other wellness pro-
24 grams with respect to the plan that requires sat-
25 isfaction of a standard related to a health status

1 *factor, shall not exceed 30 percent of the cost of*
2 *employee-only coverage under the plan. If, in ad-*
3 *dition to employees or individuals, any class of*
4 *dependents (such as spouses or spouses and de-*
5 *pendent children) may participate fully in the*
6 *wellness program, such reward shall not exceed*
7 *30 percent of the cost of the coverage in which*
8 *an employee or individual and any dependents*
9 *are enrolled. For purposes of this paragraph, the*
10 *cost of coverage shall be determined based on the*
11 *total amount of employer and employee contribu-*
12 *tions for the benefit package under which the em-*
13 *ployee is (or the employee and any dependents*
14 *are) receiving coverage. A reward may be in the*
15 *form of a discount or rebate of a premium or*
16 *contribution, a waiver of all or part of a cost-*
17 *sharing mechanism (such as deductibles, copay-*
18 *ments, or coinsurance), the absence of a sur-*
19 *charge, or the value of a benefit that would other-*
20 *wise not be provided under the plan. The Secre-*
21 *taries of Labor, Health and Human Services,*
22 *and the Treasury may increase the reward avail-*
23 *able under this subparagraph to up to 50 percent*
24 *of the cost of coverage if the Secretaries deter-*
25 *mine that such an increase is appropriate.*

1 “(B) *The wellness program shall be reason-*
2 *ably designed to promote health or prevent dis-*
3 *ease. A program complies with the preceding sen-*
4 *tence if the program has a reasonable chance of*
5 *improving the health of, or preventing disease in,*
6 *participating individuals and it is not overly*
7 *burdensome, is not a subterfuge for discrimi-*
8 *nating based on a health status factor, and is*
9 *not highly suspect in the method chosen to pro-*
10 *mote health or prevent disease.*

11 “(C) *The plan shall give individuals eligible*
12 *for the program the opportunity to qualify for*
13 *the reward under the program at least once each*
14 *year.*

15 “(D) *The full reward under the wellness*
16 *program shall be made available to all similarly*
17 *situated individuals. For such purpose, among*
18 *other things:*

19 “(i) *The reward is not available to all*
20 *similarly situated individuals for a period*
21 *unless the wellness program allows—*

22 “(I) *for a reasonable alternative*
23 *standard (or waiver of the otherwise*
24 *applicable standard) for obtaining the*
25 *reward for any individual for whom,*

1 *for that period, it is unreasonably dif-*
2 *ficult due to a medical condition to*
3 *satisfy the otherwise applicable stand-*
4 *ard; and*

5 *“(II) for a reasonable alternative*
6 *standard (or waiver of the otherwise*
7 *applicable standard) for obtaining the*
8 *reward for any individual for whom,*
9 *for that period, it is medically inadvis-*
10 *able to attempt to satisfy the otherwise*
11 *applicable standard.*

12 *“(ii) If reasonable under the cir-*
13 *cumstances, the plan or issuer may seek*
14 *verification, such as a statement from an*
15 *individual’s physician, that a health status*
16 *factor makes it unreasonably difficult or*
17 *medically inadvisable for the individual to*
18 *satisfy or attempt to satisfy the otherwise*
19 *applicable standard.*

20 *“(E) The plan or issuer involved shall dis-*
21 *close in all plan materials describing the terms*
22 *of the wellness program the availability of a rea-*
23 *sonable alternative standard (or the possibility of*
24 *waiver of the otherwise applicable standard) re-*
25 *quired under subparagraph (D). If plan mate-*

1 *rials disclose that such a program is available,*
2 *without describing its terms, the disclosure under*
3 *this subparagraph shall not be required.*

4 “(k) *EXISTING PROGRAMS.*—*Nothing in this section*
5 *shall prohibit a program of health promotion or disease pre-*
6 *vention that was established prior to the date of enactment*
7 *of this section and applied with all applicable regulations,*
8 *and that is operating on such date, from continuing to be*
9 *carried out for as long as such regulations remain in effect.*

10 “(l) *WELLNESS PROGRAM DEMONSTRATION*
11 *PROJECT.*—

12 “(1) *IN GENERAL.*—*Not later than July 1, 2014,*
13 *the Secretary, in consultation with the Secretary of*
14 *the Treasury and the Secretary of Labor, shall estab-*
15 *lish a 10-State demonstration project under which*
16 *participating States shall apply the provisions of sub-*
17 *section (j) to programs of health promotion offered by*
18 *a health insurance issuer that offers health insurance*
19 *coverage in the individual market in such State.*

20 “(2) *EXPANSION OF DEMONSTRATION*
21 *PROJECT.*—*If the Secretary, in consultation with the*
22 *Secretary of the Treasury and the Secretary of Labor,*
23 *determines that the demonstration project described in*
24 *paragraph (1) is effective, such Secretaries may, be-*

1 *ginning on July 1, 2017 expand such demonstration*
2 *project to include additional participating States.*

3 “(3) *REQUIREMENTS.*—

4 “(A) *MAINTENANCE OF COVERAGE.*—*The*
5 *Secretary, in consultation with the Secretary of*
6 *the Treasury and the Secretary of Labor, shall*
7 *not approve the participation of a State in the*
8 *demonstration project under this section unless*
9 *the Secretaries determine that the State’s project*
10 *is designed in a manner that—*

11 “(i) *will not result in any decrease in*
12 *coverage; and*

13 “(ii) *will not increase the cost to the*
14 *Federal Government in providing credits*
15 *under section 36B of the Internal Revenue*
16 *Code of 1986 or cost-sharing assistance*
17 *under section 1402 of the Patient Protection*
18 *and Affordable Care Act.*

19 “(B) *OTHER REQUIREMENTS.*—*States that*
20 *participate in the demonstration project under*
21 *this subsection—*

22 “(i) *may permit premium discounts or*
23 *rebates or the modification of otherwise ap-*
24 *plicable copayments or deductibles for ad-*
25 *herence to, or participation in, a reasonably*

1 *designed program of health promotion and*
2 *disease prevention;*

3 *“(ii) shall ensure that requirements of*
4 *consumer protection are met in programs of*
5 *health promotion in the individual market;*

6 *“(iii) shall require verification from*
7 *health insurance issuers that offer health in-*
8 *surance coverage in the individual market*
9 *of such State that premium discounts—*

10 *“(I) do not create undue burdens*
11 *for individuals insured in the indi-*
12 *vidual market;*

13 *“(II) do not lead to cost shifting;*
14 *and*

15 *“(III) are not a subterfuge for dis-*
16 *crimination;*

17 *“(iv) shall ensure that consumer data*
18 *is protected in accordance with the require-*
19 *ments of section 264(c) of the Health Insur-*
20 *ance Portability and Accountability Act of*
21 *1996 (42 U.S.C. 1320d–2 note); and*

22 *“(v) shall ensure and demonstrate to*
23 *the satisfaction of the Secretary that the*
24 *discounts or other rewards provided under*
25 *the project reflect the expected level of par-*

1 *ticipation in the wellness program involved*
2 *and the anticipated effect the program will*
3 *have on utilization or medical claim costs.*

4 “(m) *REPORT.—*

5 “(1) *IN GENERAL.—Not later than 3 years after*
6 *the date of enactment of the Patient Protection and*
7 *Affordable Care Act, the Secretary, in consultation*
8 *with the Secretary of the Treasury and the Secretary*
9 *of Labor, shall submit a report to the appropriate*
10 *committees of Congress concerning—*

11 “(A) *the effectiveness of wellness programs*
12 *(as defined in subsection (j)) in promoting health*
13 *and preventing disease;*

14 “(B) *the impact of such wellness programs*
15 *on the access to care and affordability of cov-*
16 *erage for participants and non-participants of*
17 *such programs;*

18 “(C) *the impact of premium-based and cost-*
19 *sharing incentives on participant behavior and*
20 *the role of such programs in changing behavior;*
21 *and*

22 “(D) *the effectiveness of different types of re-*
23 *wards.*

24 “(2) *DATA COLLECTION.—In preparing the re-*
25 *port described in paragraph (1), the Secretaries shall*

1 gather relevant information from employers who pro-
2 vide employees with access to wellness programs, in-
3 cluding State and Federal agencies.

4 “(n) *REGULATIONS.*—Nothing in this section shall be
5 construed as prohibiting the Secretaries of Labor, Health
6 and Human Services, or the Treasury from promulgating
7 regulations in connection with this section.

8 **“SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.**

9 “(a) *PROVIDERS.*—A group health plan and a health
10 insurance issuer offering group or individual health insur-
11 ance coverage shall not discriminate with respect to partici-
12 pation under the plan or coverage against any health care
13 provider who is acting within the scope of that provider’s
14 license or certification under applicable State law. This sec-
15 tion shall not require that a group health plan or health
16 insurance issuer contract with any health care provider
17 willing to abide by the terms and conditions for participa-
18 tion established by the plan or issuer. Nothing in this sec-
19 tion shall be construed as preventing a group health plan,
20 a health insurance issuer, or the Secretary from establishing
21 varying reimbursement rates based on quality or perform-
22 ance measures.

23 “(b) *INDIVIDUALS.*—The provisions of section 1558 of
24 the Patient Protection and Affordable Care Act (relating
25 to non-discrimination) shall apply with respect to a group

1 *health plan or health insurance issuer offering group or in-*
2 *dividual health insurance coverage.*

3 **“SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COV-**
4 **ERAGE.**

5 “(a) *COVERAGE FOR ESSENTIAL HEALTH BENEFITS*
6 *PACKAGE.*—*A health insurance issuer that offers health in-*
7 *surance coverage in the individual or small group market*
8 *shall ensure that such coverage includes the essential health*
9 *benefits package required under section 1302(a) of the Pa-*
10 *tient Protection and Affordable Care Act.*

11 “(b) *COST-SHARING UNDER GROUP HEALTH*
12 *PLANS.*—*A group health plan shall ensure that any annual*
13 *cost-sharing imposed under the plan does not exceed the*
14 *limitations provided for under paragraphs (1) and (2) of*
15 *section 1302(c).*

16 “(c) *CHILD-ONLY PLANS.*—*If a health insurance issuer*
17 *offers health insurance coverage in any level of coverage*
18 *specified under section 1302(d) of the Patient Protection*
19 *and Affordable Care Act, the issuer shall also offer such cov-*
20 *erage in that level as a plan in which the only enrollees*
21 *are individuals who, as of the beginning of a plan year,*
22 *have not attained the age of 21.*

23 “(d) *DENTAL ONLY.*—*This section shall not apply to*
24 *a plan described in section 1302(d)(2)(B)(ii)(I).*

1 **“SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.**

2 *“A group health plan and a health insurance issuer*
3 *offering group or individual health insurance coverage shall*
4 *not apply any waiting period (as defined in section*
5 *2704(b)(4)) that exceeds 90 days.”.*

6 **PART II—OTHER PROVISIONS**

7 **SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXIST-**
8 **ING COVERAGE.**

9 *(a) NO CHANGES TO EXISTING COVERAGE.—*

10 *(1) IN GENERAL.—Nothing in this Act (or an*
11 *amendment made by this Act) shall be construed to*
12 *require that an individual terminate coverage under*
13 *a group health plan or health insurance coverage in*
14 *which such individual was enrolled on the date of en-*
15 *actment of this Act.*

16 *(2) CONTINUATION OF COVERAGE.—With respect*
17 *to a group health plan or health insurance coverage*
18 *in which an individual was enrolled on the date of*
19 *enactment of this Act, this subtitle and subtitle A*
20 *(and the amendments made by such subtitles) shall*
21 *not apply to such plan or coverage, regardless of*
22 *whether the individual renews such coverage after*
23 *such date of enactment.*

24 *(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CUR-*
25 *RENT COVERAGE.—With respect to a group health plan or*
26 *health insurance coverage in which an individual was en-*

1 rolled on the date of enactment of this Act and which is
2 renewed after such date, family members of such individual
3 shall be permitted to enroll in such plan or coverage if such
4 enrollment is permitted under the terms of the plan in effect
5 as of such date of enactment.

6 (c) *ALLOWANCE FOR NEW EMPLOYEES TO JOIN CUR-*
7 *RENT PLAN.*—A group health plan that provides coverage
8 on the date of enactment of this Act may provide for the
9 enrolling of new employees (and their families) in such
10 plan, and this subtitle and subtitle A (and the amendments
11 made by such subtitles) shall not apply with respect to such
12 plan and such new employees (and their families).

13 (d) *EFFECT ON COLLECTIVE BARGAINING AGREE-*
14 *MENTS.*—In the case of health insurance coverage main-
15 tained pursuant to one or more collective bargaining agree-
16 ments between employee representatives and one or more
17 employers that was ratified before the date of enactment of
18 this Act, the provisions of this subtitle and subtitle A (and
19 the amendments made by such subtitles) shall not apply
20 until the date on which the last of the collective bargaining
21 agreements relating to the coverage terminates. Any cov-
22 erage amendment made pursuant to a collective bargaining
23 agreement relating to the coverage which amends the cov-
24 erage solely to conform to any requirement added by this

1 *subtitle or subtitle A (or amendments) shall not be treated*
2 *as a termination of such collective bargaining agreement.*

3 (e) *DEFINITION.—In this title, the term “grand-*
4 *fathered health plan” means any group health plan or*
5 *health insurance coverage to which this section applies.*

6 **SEC. 1252. RATING REFORMS MUST APPLY UNIFORMLY TO**
7 **ALL HEALTH INSURANCE ISSUERS AND**
8 **GROUP HEALTH PLANS.**

9 *Any standard or requirement adopted by a State pur-*
10 *suant to this title, or any amendment made by this title,*
11 *shall be applied uniformly to all health plans in each insur-*
12 *ance market to which the standard and requirements apply.*
13 *The preceding sentence shall also apply to a State standard*
14 *or requirement relating to the standard or requirement re-*
15 *quired by this title (or any such amendment) that is not*
16 *the same as the standard or requirement but that is not*
17 *preempted under section 1321(d).*

18 **SEC. 1253. EFFECTIVE DATES.**

19 *This subtitle (and the amendments made by this sub-*
20 *title) shall become effective for plan years beginning on or*
21 *after January 1, 2014.*

1 ***Subtitle D—Available Coverage***
2 ***Choices for All Americans***

3 ***PART I—ESTABLISHMENT OF QUALIFIED HEALTH***
4 ***PLANS***

5 ***SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.***

6 (a) *QUALIFIED HEALTH PLAN.*—*In this title:*

7 (1) *IN GENERAL.*—*The term “qualified health*
8 *plan” means a health plan that—*

9 (A) *has in effect a certification (which may*
10 *include a seal or other indication of approval)*
11 *that such plan meets the criteria for certification*
12 *described in section 1311(c) issued or recognized*
13 *by each Exchange through which such plan is of-*
14 *fered;*

15 (B) *provides the essential health benefits*
16 *package described in section 1302(a); and*

17 (C) *is offered by a health insurance issuer*
18 *that—*

19 (i) *is licensed and in good standing to*
20 *offer health insurance coverage in each*
21 *State in which such issuer offers health in-*
22 *surance coverage under this title;*

23 (ii) *agrees to offer at least one quali-*
24 *fied health plan in the silver level and at*

1 *least one plan in the gold level in each such*
2 *Exchange;*

3 *(iii) agrees to charge the same pre-*
4 *mium rate for each qualified health plan of*
5 *the issuer without regard to whether the*
6 *plan is offered through an Exchange or*
7 *whether the plan is offered directly from the*
8 *issuer or through an agent; and*

9 *(iv) complies with the regulations de-*
10 *veloped by the Secretary under section*
11 *1311(d) and such other requirements as an*
12 *applicable Exchange may establish.*

13 (2) *INCLUSION OF CO-OP PLANS AND COMMUNITY*
14 *HEALTH INSURANCE OPTION.—Any reference in this*
15 *title to a qualified health plan shall be deemed to in-*
16 *clude a qualified health plan offered through the CO-*
17 *OP program under section 1322 or a community*
18 *health insurance option under section 1323, unless*
19 *specifically provided for otherwise.*

20 (b) *TERMS RELATING TO HEALTH PLANS.—In this*
21 *title:*

22 (1) *HEALTH PLAN.—*

23 (A) *IN GENERAL.—The term “health plan”*
24 *means health insurance coverage and a group*
25 *health plan.*

1 (B) *EXCEPTION FOR SELF-INSURED PLANS*
2 AND MEWAS.—*Except to the extent specifically*
3 *provided by this title, the term “health plan”*
4 *shall not include a group health plan or multiple*
5 *employer welfare arrangement to the extent the*
6 *plan or arrangement is not subject to State in-*
7 *surance regulation under section 514 of the Em-*
8 *ployee Retirement Income Security Act of 1974.*

9 (2) *HEALTH INSURANCE COVERAGE AND*
10 *ISSUER.—The terms “health insurance coverage” and*
11 *“health insurance issuer” have the meanings given*
12 *such terms by section 2791(b) of the Public Health*
13 *Service Act.*

14 (3) *GROUP HEALTH PLAN.—The term “group*
15 *health plan” has the meaning given such term by sec-*
16 *tion 2791(a) of the Public Health Service Act.*

17 **SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.**

18 (a) *ESSENTIAL HEALTH BENEFITS PACKAGE.—In*
19 *this title, the term “essential health benefits package”*
20 *means, with respect to any health plan, coverage that—*

21 (1) *provides for the essential health benefits de-*
22 *finied by the Secretary under subsection (b);*

23 (2) *limits cost-sharing for such coverage in ac-*
24 *cordance with subsection (c); and*

1 (3) *subject to subsection (e), provides either the*
2 *bronze, silver, gold, or platinum level of coverage de-*
3 *scribed in subsection (d).*

4 (b) *ESSENTIAL HEALTH BENEFITS.—*

5 (1) *IN GENERAL.—Subject to paragraph (2), the*
6 *Secretary shall define the essential health benefits, ex-*
7 *cept that such benefits shall include at least the fol-*
8 *lowing general categories and the items and services*
9 *covered within the categories:*

10 (A) *Ambulatory patient services.*

11 (B) *Emergency services.*

12 (C) *Hospitalization.*

13 (D) *Maternity and newborn care.*

14 (E) *Mental health and substance use dis-*
15 *order services, including behavioral health treat-*
16 *ment.*

17 (F) *Prescription drugs.*

18 (G) *Rehabilitative and habilitative services*
19 *and devices.*

20 (H) *Laboratory services.*

21 (I) *Preventive and wellness services and*
22 *chronic disease management.*

23 (J) *Pediatric services, including oral and*
24 *vision care.*

25 (2) *LIMITATION.—*

1 (A) *IN GENERAL.*—*The Secretary shall en-*
2 *sure that the scope of the essential health benefits*
3 *under paragraph (1) is equal to the scope of ben-*
4 *efits provided under a typical employer plan, as*
5 *determined by the Secretary. To inform this de-*
6 *termination, the Secretary of Labor shall con-*
7 *duct a survey of employer-sponsored coverage to*
8 *determine the benefits typically covered by em-*
9 *ployers, including multiemployer plans, and pro-*
10 *vide a report on such survey to the Secretary.*

11 (B) *CERTIFICATION.*—*In defining the essen-*
12 *tial health benefits described in paragraph (1),*
13 *and in revising the benefits under paragraph*
14 *(4)(H), the Secretary shall submit a report to the*
15 *appropriate committees of Congress containing a*
16 *certification from the Chief Actuary of the Cen-*
17 *ters for Medicare & Medicaid Services that such*
18 *essential health benefits meet the limitation de-*
19 *scribed in paragraph (2).*

20 (3) *NOTICE AND HEARING.*—*In defining the es-*
21 *sential health benefits described in paragraph (1),*
22 *and in revising the benefits under paragraph (4)(H),*
23 *the Secretary shall provide notice and an opportunity*
24 *for public comment.*

1 (4) *REQUIRED ELEMENTS FOR CONSIDER-*
2 *ATION.—In defining the essential health benefits*
3 *under paragraph (1), the Secretary shall—*

4 (A) *ensure that such essential health benefits*
5 *reflect an appropriate balance among the cat-*
6 *egories described in such subsection, so that bene-*
7 *fits are not unduly weighted toward any cat-*
8 *egory;*

9 (B) *not make coverage decisions, determine*
10 *reimbursement rates, establish incentive pro-*
11 *grams, or design benefits in ways that discrimi-*
12 *nate against individuals because of their age,*
13 *disability, or expected length of life;*

14 (C) *take into account the health care needs*
15 *of diverse segments of the population, including*
16 *women, children, persons with disabilities, and*
17 *other groups;*

18 (D) *ensure that health benefits established*
19 *as essential not be subject to denial to individ-*
20 *uals against their wishes on the basis of the indi-*
21 *viduals' age or expected length of life or of the*
22 *individuals' present or predicted disability, de-*
23 *gree of medical dependency, or quality of life;*

24 (E) *provide that a qualified health plan*
25 *shall not be treated as providing coverage for the*

1 *essential health benefits described in paragraph*
2 *(1) unless the plan provides that—*

3 *(i) coverage for emergency department*
4 *services will be provided without imposing*
5 *any requirement under the plan for prior*
6 *authorization of services or any limitation*
7 *on coverage where the provider of services*
8 *does not have a contractual relationship*
9 *with the plan for the providing of services*
10 *that is more restrictive than the require-*
11 *ments or limitations that apply to emer-*
12 *gency department services received from*
13 *providers who do have such a contractual*
14 *relationship with the plan; and*

15 *(ii) if such services are provided out-of-*
16 *network, the cost-sharing requirement (ex-*
17 *pressed as a copayment amount or coinsur-*
18 *ance rate) is the same requirement that*
19 *would apply if such services were provided*
20 *in-network;*

21 *(F) provide that if a plan described in sec-*
22 *tion 1311(b)(2)(B)(ii) (relating to stand-alone*
23 *dental benefits plans) is offered through an Ex-*
24 *change, another health plan offered through such*
25 *Exchange shall not fail to be treated as a quali-*

1 *fied health plan solely because the plan does not*
2 *offer coverage of benefits offered through the*
3 *stand-alone plan that are otherwise required*
4 *under paragraph (1)(J); and*

5 *(G) periodically review the essential health*
6 *benefits under paragraph (1), and provide a re-*
7 *port to Congress and the public that contains—*

8 *(i) an assessment of whether enrollees*
9 *are facing any difficulty accessing needed*
10 *services for reasons of coverage or cost;*

11 *(ii) an assessment of whether the essen-*
12 *tial health benefits needs to be modified or*
13 *updated to account for changes in medical*
14 *evidence or scientific advancement;*

15 *(iii) information on how the essential*
16 *health benefits will be modified to address*
17 *any such gaps in access or changes in the*
18 *evidence base;*

19 *(iv) an assessment of the potential of*
20 *additional or expanded benefits to increase*
21 *costs and the interactions between the addi-*
22 *tion or expansion of benefits and reductions*
23 *in existing benefits to meet actuarial limi-*
24 *tations described in paragraph (2); and*

1 (H) periodically update the essential health
2 benefits under paragraph (1) to address any
3 gaps in access to coverage or changes in the evi-
4 dence base the Secretary identifies in the review
5 conducted under subparagraph (G).

6 (5) *RULE OF CONSTRUCTION.*—Nothing in this
7 title shall be construed to prohibit a health plan from
8 providing benefits in excess of the essential health ben-
9 efits described in this subsection.

10 (c) *REQUIREMENTS RELATING TO COST-SHARING.*—

11 (1) *ANNUAL LIMITATION ON COST-SHARING.*—

12 (A) *2014.*—The cost-sharing incurred under
13 a health plan with respect to self-only coverage
14 or coverage other than self-only coverage for a
15 plan year beginning in 2014 shall not exceed the
16 dollar amounts in effect under section
17 223(c)(2)(A)(ii) of the Internal Revenue Code of
18 1986 for self-only and family coverage, respec-
19 tively, for taxable years beginning in 2014.

20 (B) *2015 AND LATER.*—In the case of any
21 plan year beginning in a calendar year after
22 2014, the limitation under this paragraph
23 shall—

24 (i) in the case of self-only coverage, be
25 equal to the dollar amount under subpara-

1 *graph (A) for self-only coverage for plan*
2 *years beginning in 2014, increased by an*
3 *amount equal to the product of that amount*
4 *and the premium adjustment percentage*
5 *under paragraph (4) for the calendar year;*
6 *and*

7 *(ii) in the case of other coverage, twice*
8 *the amount in effect under clause (i).*

9 *If the amount of any increase under clause (i)*
10 *is not a multiple of \$50, such increase shall be*
11 *rounded to the next lowest multiple of \$50.*

12 (2) *ANNUAL LIMITATION ON DEDUCTIBLES FOR*
13 *EMPLOYER-SPONSORED PLANS.—*

14 (A) *IN GENERAL.—In the case of a health*
15 *plan offered in the small group market, the de-*
16 *ductible under the plan shall not exceed—*

17 *(i) \$2,000 in the case of a plan cov-*
18 *ering a single individual; and*

19 *(ii) \$4,000 in the case of any other*
20 *plan.*

21 *The amounts under clauses (i) and (ii) may be*
22 *increased by the maximum amount of reimburse-*
23 *ment which is reasonably available to a partici-*
24 *pant under a flexible spending arrangement de-*
25 *scribed in section 106(c)(2) of the Internal Rev-*

1 *enue Code of 1986 (determined without regard to*
2 *any salary reduction arrangement).*

3 *(B) INDEXING OF LIMITS.—In the case of*
4 *any plan year beginning in a calendar year*
5 *after 2014—*

6 *(i) the dollar amount under subpara-*
7 *graph (A)(i) shall be increased by an*
8 *amount equal to the product of that amount*
9 *and the premium adjustment percentage*
10 *under paragraph (4) for the calendar year;*
11 *and*

12 *(ii) the dollar amount under subpara-*
13 *graph (A)(ii) shall be increased to an*
14 *amount equal to twice the amount in effect*
15 *under subparagraph (A)(i) for plan years*
16 *beginning in the calendar year, determined*
17 *after application of clause (i).*

18 *If the amount of any increase under clause (i)*
19 *is not a multiple of \$50, such increase shall be*
20 *rounded to the next lowest multiple of \$50.*

21 *(C) ACTUARIAL VALUE.—The limitation*
22 *under this paragraph shall be applied in such a*
23 *manner so as to not affect the actuarial value of*
24 *any health plan, including a plan in the bronze*
25 *level.*

1 (D) *COORDINATION WITH PREVENTIVE LIM-*
2 *ITS.—Nothing in this paragraph shall be con-*
3 *strued to allow a plan to have a deductible under*
4 *the plan apply to benefits described in section*
5 *2713 of the Public Health Service Act.*

6 (3) *COST-SHARING.—In this title—*

7 (A) *IN GENERAL.—The term “cost-sharing”*
8 *includes—*

9 (i) *deductibles, coinsurance, copay-*
10 *ments, or similar charges; and*

11 (ii) *any other expenditure required of*
12 *an insured individual which is a qualified*
13 *medical expense (within the meaning of sec-*
14 *tion 223(d)(2) of the Internal Revenue Code*
15 *of 1986) with respect to essential health ben-*
16 *efits covered under the plan.*

17 (B) *EXCEPTIONS.—Such term does not in-*
18 *clude premiums, balance billing amounts for*
19 *non-network providers, or spending for non-cov-*
20 *ered services.*

21 (4) *PREMIUM ADJUSTMENT PERCENTAGE.—For*
22 *purposes of paragraphs (1)(B)(i) and (2)(B)(i), the*
23 *premium adjustment percentage for any calendar*
24 *year is the percentage (if any) by which the average*
25 *per capita premium for health insurance coverage in*

1 *the United States for the preceding calendar year (as*
2 *estimated by the Secretary no later than October 1 of*
3 *such preceding calendar year) exceeds such average*
4 *per capita premium for 2013 (as determined by the*
5 *Secretary).*

6 *(d) LEVELS OF COVERAGE.—*

7 *(1) LEVELS OF COVERAGE DEFINED.—The levels*
8 *of coverage described in this subsection are as follows:*

9 *(A) BRONZE LEVEL.—A plan in the bronze*
10 *level shall provide a level of coverage that is de-*
11 *signed to provide benefits that are actuarially*
12 *equivalent to 60 percent of the full actuarial*
13 *value of the benefits provided under the plan.*

14 *(B) SILVER LEVEL.—A plan in the silver*
15 *level shall provide a level of coverage that is de-*
16 *signed to provide benefits that are actuarially*
17 *equivalent to 70 percent of the full actuarial*
18 *value of the benefits provided under the plan.*

19 *(C) GOLD LEVEL.—A plan in the gold level*
20 *shall provide a level of coverage that is designed*
21 *to provide benefits that are actuarially equiva-*
22 *lent to 80 percent of the full actuarial value of*
23 *the benefits provided under the plan.*

24 *(D) PLATINUM LEVEL.—A plan in the plat-*
25 *inum level shall provide a level of coverage that*

1 *is designed to provide benefits that are actuari-*
2 *ally equivalent to 90 percent of the full actuarial*
3 *value of the benefits provided under the plan.*

4 (2) *ACTUARIAL VALUE.—*

5 (A) *IN GENERAL.—Under regulations issued*
6 *by the Secretary, the level of coverage of a plan*
7 *shall be determined on the basis that the essential*
8 *health benefits described in subsection (b) shall*
9 *be provided to a standard population (and with-*
10 *out regard to the population the plan may actu-*
11 *ally provide benefits to).*

12 (B) *EMPLOYER CONTRIBUTIONS.—The Sec-*
13 *retary may issue regulations under which em-*
14 *ployer contributions to a health savings account*
15 *(within the meaning of section 223 of the Inter-*
16 *nal Revenue Code of 1986) may be taken into ac-*
17 *count in determining the level of coverage for a*
18 *plan of the employer.*

19 (C) *APPLICATION.—In determining under*
20 *this title, the Public Health Service Act, or the*
21 *Internal Revenue Code of 1986 the percentage of*
22 *the total allowed costs of benefits provided under*
23 *a group health plan or health insurance coverage*
24 *that are provided by such plan or coverage, the*

1 *rules contained in the regulations under this*
2 *paragraph shall apply.*

3 (3) *ALLOWABLE VARIANCE.*—*The Secretary shall*
4 *develop guidelines to provide for a de minimis vari-*
5 *ation in the actuarial valuations used in determining*
6 *the level of coverage of a plan to account for dif-*
7 *ferences in actuarial estimates.*

8 (4) *PLAN REFERENCE.*—*In this title, any ref-*
9 *erence to a bronze, silver, gold, or platinum plan shall*
10 *be treated as a reference to a qualified health plan*
11 *providing a bronze, silver, gold, or platinum level of*
12 *coverage, as the case may be.*

13 (e) *CATASTROPHIC PLAN.*—

14 (1) *IN GENERAL.*—*A health plan not providing*
15 *a bronze, silver, gold, or platinum level of coverage*
16 *shall be treated as meeting the requirements of sub-*
17 *section (d) with respect to any plan year if—*

18 (A) *the only individuals who are eligible to*
19 *enroll in the plan are individuals described in*
20 *paragraph (2); and*

21 (B) *the plan provides—*

22 (i) *except as provided in clause (ii),*
23 *the essential health benefits determined*
24 *under subsection (b), except that the plan*
25 *provides no benefits for any plan year until*

1 *the individual has incurred cost-sharing ex-*
2 *penditures in an amount equal to the annual*
3 *limitation in effect under subsection (c)(1)*
4 *for the plan year (except as provided for in*
5 *section 2713); and*

6 *(ii) coverage for at least three primary*
7 *care visits.*

8 (2) *INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—*
9 *An individual is described in this paragraph for any*
10 *plan year if the individual—*

11 *(A) has not attained the age of 30 before the*
12 *beginning of the plan year; or*

13 *(B) has a certification in effect for any plan*
14 *year under this title that the individual is ex-*
15 *empt from the requirement under section 5000A*
16 *of the Internal Revenue Code of 1986 by reason*
17 *of—*

18 *(i) section 5000A(e)(1) of such Code*
19 *(relating to individuals without affordable*
20 *coverage); or*

21 *(ii) section 5000A(e)(5) of such Code*
22 *(relating to individuals with hardships).*

23 (3) *RESTRICTION TO INDIVIDUAL MARKET.—If a*
24 *health insurance issuer offers a health plan described*

1 *in this subsection, the issuer may only offer the plan*
2 *in the individual market.*

3 *(f) CHILD-ONLY PLANS.—If a qualified health plan is*
4 *offered through the Exchange in any level of coverage speci-*
5 *fied under subsection (d), the issuer shall also offer that*
6 *plan through the Exchange in that level as a plan in which*
7 *the only enrollees are individuals who, as of the beginning*
8 *of a plan year, have not attained the age of 21, and such*
9 *plan shall be treated as a qualified health plan.*

10 **SEC. 1303. SPECIAL RULES.**

11 *(a) SPECIAL RULES RELATING TO COVERAGE OF*
12 *ABORTION SERVICES.—*

13 *(1) VOLUNTARY CHOICE OF COVERAGE OF ABOR-*
14 *TION SERVICES.—*

15 *(A) IN GENERAL.—Notwithstanding any*
16 *other provision of this title (or any amendment*
17 *made by this title), and subject to subparagraphs*
18 *(C) and (D)—*

19 *(i) nothing in this title (or any amend-*
20 *ment made by this title), shall be construed*
21 *to require a qualified health plan to provide*
22 *coverage of services described in subpara-*
23 *graph (B)(i) or (B)(ii) as part of its essen-*
24 *tial health benefits for any plan year; and*

1 (ii) the issuer of a qualified health
2 plan shall determine whether or not the
3 plan provides coverage of services described
4 in subparagraph (B)(i) or (B)(ii) as part of
5 such benefits for the plan year.

6 (B) ABORTION SERVICES.—

7 (i) ABORTIONS FOR WHICH PUBLIC
8 FUNDING IS PROHIBITED.—The services de-
9 scribed in this clause are abortions for
10 which the expenditure of Federal funds ap-
11 propriated for the Department of Health
12 and Human Services is not permitted,
13 based on the law as in effect as of the date
14 that is 6 months before the beginning of the
15 plan year involved.

16 (ii) ABORTIONS FOR WHICH PUBLIC
17 FUNDING IS ALLOWED.—The services de-
18 scribed in this clause are abortions for
19 which the expenditure of Federal funds ap-
20 propriated for the Department of Health
21 and Human Services is permitted, based on
22 the law as in effect as of the date that is 6
23 months before the beginning of the plan
24 year involved.

1 (C) *PROHIBITION ON FEDERAL FUNDS FOR*
2 *ABORTION SERVICES IN COMMUNITY HEALTH IN-*
3 *SURANCE OPTION.—*

4 (i) *DETERMINATION BY SECRETARY.—*

5 *The Secretary may not determine, in ac-*
6 *cordance with subparagraph (A)(ii), that*
7 *the community health insurance option es-*
8 *tablished under section 1323 shall provide*
9 *coverage of services described in subpara-*
10 *graph (B)(i) as part of benefits for the plan*
11 *year unless the Secretary—*

12 (I) *assures compliance with the*
13 *requirements of paragraph (2);*

14 (II) *assures, in accordance with*
15 *applicable provisions of generally ac-*
16 *cepted accounting requirements, circu-*
17 *lar on funds management of the Office*
18 *of Management and Budget, and guid-*
19 *ance on accounting of the Government*
20 *Accountability Office, that no Federal*
21 *funds are used for such coverage; and*

22 (III) *notwithstanding section*
23 *1323(e)(1)(C) or any other provision of*
24 *this title, takes all necessary steps to*
25 *assure that the United States does not*

1 *bear the insurance risk for a commu-*
2 *nity health insurance option's coverage*
3 *of services described in subparagraph*
4 *(B)(i).*

5 *(ii) STATE REQUIREMENT.—If a State*
6 *requires, in addition to the essential health*
7 *benefits required under section 1323(b)(3)*
8 *(A), coverage of services described in sub-*
9 *paragraph (B)(i) for enrollees of a commu-*
10 *nity health insurance option offered in such*
11 *State, the State shall assure that no funds*
12 *flowing through or from the community*
13 *health insurance option, and no other Fed-*
14 *eral funds, pay or defray the cost of pro-*
15 *viding coverage of services described in sub-*
16 *paragraph (B)(i). The United States shall*
17 *not bear the insurance risk for a State's re-*
18 *quired coverage of services described in sub-*
19 *paragraph (B)(i).*

20 *(iii) EXCEPTIONS.—Nothing in this*
21 *subparagraph shall apply to coverage of*
22 *services described in subparagraph (B)(ii)*
23 *by the community health insurance option.*
24 *Services described in subparagraph (B)(ii)*
25 *shall be covered to the same extent as such*

1 *services are covered under title XIX of the*
2 *Social Security Act.*

3 *(D) ASSURED AVAILABILITY OF VARIED*
4 *COVERAGE THROUGH EXCHANGES.—*

5 *(i) IN GENERAL.—The Secretary shall*
6 *assure that with respect to qualified health*
7 *plans offered in any Exchange established*
8 *pursuant to this title—*

9 *(I) there is at least one such plan*
10 *that provides coverage of services de-*
11 *scribed in clauses (i) and (ii) of sub-*
12 *paragraph (B); and*

13 *(II) there is at least one such plan*
14 *that does not provide coverage of serv-*
15 *ices described in subparagraph (B)(i).*

16 *(ii) SPECIAL RULES.—For purposes of*
17 *clause (i)—*

18 *(I) a plan shall be treated as de-*
19 *scribed in clause (i)(II) if the plan*
20 *does not provide coverage of services*
21 *described in either subparagraph (B)(i)*
22 *or (B)(ii); and*

23 *(II) if a State has one Exchange*
24 *covering more than 1 insurance mar-*
25 *ket, the Secretary shall meet the re-*

1 *quirements of clause (i) separately*
2 *with respect to each such market.*

3 (2) *PROHIBITION ON THE USE OF FEDERAL*
4 *FUNDS.—*

5 (A) *IN GENERAL.—If a qualified health*
6 *plan provides coverage of services described in*
7 *paragraph (1)(B)(i), the issuer of the plan shall*
8 *not use any amount attributable to any of the*
9 *following for purposes of paying for such serv-*
10 *ices:*

11 (i) *The credit under section 36B of the*
12 *Internal Revenue Code of 1986 (and the*
13 *amount (if any) of the advance payment of*
14 *the credit under section 1412 of the Patient*
15 *Protection and Affordable Care Act).*

16 (ii) *Any cost-sharing reduction under*
17 *section 1402 of the Patient Protection and*
18 *Affordable Care Act (and the amount (if*
19 *any) of the advance payment of the reduc-*
20 *tion under section 1412 of the Patient Pro-*
21 *tection and Affordable Care Act).*

22 (B) *SEGREGATION OF FUNDS.—In the case*
23 *of a plan to which subparagraph (A) applies, the*
24 *issuer of the plan shall, out of amounts not de-*
25 *scribed in subparagraph (A), segregate an*

1 *amount equal to the actuarial amounts deter-*
2 *mined under subparagraph (C) for all enrollees*
3 *from the amounts described in subparagraph*
4 *(A).*

5 (C) *ACTUARIAL VALUE OF OPTIONAL SERV-*
6 *ICE COVERAGE.—*

7 (i) *IN GENERAL.—The Secretary shall*
8 *estimate the basic per enrollee, per month*
9 *cost, determined on an average actuarial*
10 *basis, for including coverage under a quali-*
11 *fied health plan of the services described in*
12 *paragraph (1)(B)(i).*

13 (ii) *CONSIDERATIONS.—In making*
14 *such estimate, the Secretary—*

15 (I) *may take into account the im-*
16 *pect on overall costs of the inclusion of*
17 *such coverage, but may not take into*
18 *account any cost reduction estimated*
19 *to result from such services, including*
20 *prenatal care, delivery, or postnatal*
21 *care;*

22 (II) *shall estimate such costs as if*
23 *such coverage were included for the en-*
24 *tire population covered; and*

1 (III) may not estimate such a cost
2 at less than \$1 per enrollee, per month.

3 (3) *PROVIDER CONSCIENCE PROTECTIONS.*—No
4 individual health care provider or health care facility
5 may be discriminated against because of a willingness
6 or an unwillingness, if doing so is contrary to the re-
7 ligious or moral beliefs of the provider or facility, to
8 provide, pay for, provide coverage of, or refer for
9 abortions.

10 (b) *APPLICATION OF STATE AND FEDERAL LAWS RE-*
11 *GARDING ABORTION.*—

12 (1) *NO PREEMPTION OF STATE LAWS REGARDING*
13 *ABORTION.*—Nothing in this Act shall be construed to
14 preempt or otherwise have any effect on State laws re-
15 garding the prohibition of (or requirement of) cov-
16 erage, funding, or procedural requirements on abor-
17 tions, including parental notification or consent for
18 the performance of an abortion on a minor.

19 (2) *NO EFFECT ON FEDERAL LAWS REGARDING*
20 *ABORTION.*—

21 (A) *IN GENERAL.*—Nothing in this Act shall
22 be construed to have any effect on Federal laws
23 regarding—

24 (i) conscience protection;

1 (ii) *willingness or refusal to provide*
2 *abortion; and*

3 (iii) *discrimination on the basis of the*
4 *willingness or refusal to provide, pay for,*
5 *cover, or refer for abortion or to provide or*
6 *participate in training to provide abortion.*

7 (3) *NO EFFECT ON FEDERAL CIVIL RIGHTS*
8 *LAW.—Nothing in this subsection shall alter the rights*
9 *and obligations of employees and employers under*
10 *title VII of the Civil Rights Act of 1964.*

11 (c) *APPLICATION OF EMERGENCY SERVICES LAWS.—*
12 *Nothing in this Act shall be construed to relieve any health*
13 *care provider from providing emergency services as required*
14 *by State or Federal law, including section 1867 of the So-*
15 *cial Security Act (popularly known as “EMTALA”).*

16 **SEC. 1304. RELATED DEFINITIONS.**

17 (a) *DEFINITIONS RELATING TO MARKETS.—In this*
18 *title:*

19 (1) *GROUP MARKET.—The term “group market”*
20 *means the health insurance market under which indi-*
21 *viduals obtain health insurance coverage (directly or*
22 *through any arrangement) on behalf of themselves*
23 *(and their dependents) through a group health plan*
24 *maintained by an employer.*

1 (2) *INDIVIDUAL MARKET.*—*The term “individual*
2 *market” means the market for health insurance cov-*
3 *erage offered to individuals other than in connection*
4 *with a group health plan.*

5 (3) *LARGE AND SMALL GROUP MARKETS.*—*The*
6 *terms “large group market” and “small group mar-*
7 *ket” mean the health insurance market under which*
8 *individuals obtain health insurance coverage (directly*
9 *or through any arrangement) on behalf of themselves*
10 *(and their dependents) through a group health plan*
11 *maintained by a large employer (as defined in sub-*
12 *section (b)(1)) or by a small employer (as defined in*
13 *subsection (b)(2)), respectively.*

14 (b) *EMPLOYERS.*—*In this title:*

15 (1) *LARGE EMPLOYER.*—*The term “large em-*
16 *ployer” means, in connection with a group health*
17 *plan with respect to a calendar year and a plan year,*
18 *an employer who employed an average of at least 101*
19 *employees on business days during the preceding cal-*
20 *endar year and who employs at least 1 employee on*
21 *the first day of the plan year.*

22 (2) *SMALL EMPLOYER.*—*The term “small em-*
23 *ployer” means, in connection with a group health*
24 *plan with respect to a calendar year and a plan year,*
25 *an employer who employed an average of at least 1*

1 *but not more than 100 employees on business days*
2 *during the preceding calendar year and who employs*
3 *at least 1 employee on the first day of the plan year.*

4 (3) *STATE OPTION TO TREAT 50 EMPLOYEES AS*
5 *SMALL.—In the case of plan years beginning before*
6 *January 1, 2016, a State may elect to apply this sub-*
7 *section by substituting “51 employees” for “101 em-*
8 *ployees” in paragraph (1) and by substituting “50*
9 *employees” for “100 employees” in paragraph (2).*

10 (4) *RULES FOR DETERMINING EMPLOYER*
11 *SIZE.—For purposes of this subsection—*

12 (A) *APPLICATION OF AGGREGATION RULE*
13 *FOR EMPLOYERS.—All persons treated as a sin-*
14 *gle employer under subsection (b), (c), (m), or*
15 *(o) of section 414 of the Internal Revenue Code*
16 *of 1986 shall be treated as 1 employer.*

17 (B) *EMPLOYERS NOT IN EXISTENCE IN PRE-*
18 *CEDING YEAR.—In the case of an employer which*
19 *was not in existence throughout the preceding*
20 *calendar year, the determination of whether such*
21 *employer is a small or large employer shall be*
22 *based on the average number of employees that*
23 *it is reasonably expected such employer will em-*
24 *ploy on business days in the current calendar*
25 *year.*

1 (C) *PREDECESSORS.*—*Any reference in this*
2 *subsection to an employer shall include a ref-*
3 *erence to any predecessor of such employer.*

4 (D) *CONTINUATION OF PARTICIPATION FOR*
5 *GROWING SMALL EMPLOYERS.*—*If—*

6 (i) *a qualified employer that is a small*
7 *employer makes enrollment in qualified*
8 *health plans offered in the small group mar-*
9 *ket available to its employees through an*
10 *Exchange; and*

11 (ii) *the employer ceases to be a small*
12 *employer by reason of an increase in the*
13 *number of employees of such employer;*

14 *the employer shall continue to be treated as a*
15 *small employer for purposes of this subtitle for*
16 *the period beginning with the increase and end-*
17 *ing with the first day on which the employer*
18 *does not make such enrollment available to its*
19 *employees.*

20 (e) *SECRETARY.*—*In this title, the term “Secretary”*
21 *means the Secretary of Health and Human Services.*

22 (d) *STATE.*—*In this title, the term “State” means each*
23 *of the 50 States and the District of Columbia.*

1 **PART II—CONSUMER CHOICES AND INSURANCE**
2 **COMPETITION THROUGH HEALTH BENEFIT**
3 **EXCHANGES**

4 **SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT**
5 **PLANS.**

6 *(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN*
7 *HEALTH BENEFIT EXCHANGES.—*

8 *(1) PLANNING AND ESTABLISHMENT GRANTS.—*

9 *There shall be appropriated to the Secretary, out of*
10 *any moneys in the Treasury not otherwise appro-*
11 *priated, an amount necessary to enable the Secretary*
12 *to make awards, not later than 1 year after the date*
13 *of enactment of this Act, to States in the amount*
14 *specified in paragraph (2) for the uses described in*
15 *paragraph (3).*

16 *(2) AMOUNT SPECIFIED.—For each fiscal year,*
17 *the Secretary shall determine the total amount that*
18 *the Secretary will make available to each State for*
19 *grants under this subsection.*

20 *(3) USE OF FUNDS.—A State shall use amounts*
21 *awarded under this subsection for activities (includ-*
22 *ing planning activities) related to establishing an*
23 *American Health Benefit Exchange, as described in*
24 *subsection (b).*

25 *(4) RENEWABILITY OF GRANT.—*

1 (A) *IN GENERAL.*—*Subject to subsection*
2 *(d)(4), the Secretary may renew a grant award-*
3 *ed under paragraph (1) if the State recipient of*
4 *such grant—*

5 *(i) is making progress, as determined*
6 *by the Secretary, toward—*

7 *(I) establishing an Exchange; and*

8 *(II) implementing the reforms de-*
9 *scribed in subtitles A and C (and the*
10 *amendments made by such subtitles);*
11 *and*

12 *(ii) is meeting such other benchmarks*
13 *as the Secretary may establish.*

14 (B) *LIMITATION.*—*No grant shall be award-*
15 *ed under this subsection after January 1, 2015.*

16 (5) *TECHNICAL ASSISTANCE TO FACILITATE PAR-*
17 *TICIPATION IN SHOP EXCHANGES.*—*The Secretary*
18 *shall provide technical assistance to States to facili-*
19 *tate the participation of qualified small businesses in*
20 *such States in SHOP Exchanges.*

21 (b) *AMERICAN HEALTH BENEFIT EXCHANGES.*—

22 (1) *IN GENERAL.*—*Each State shall, not later*
23 *than January 1, 2014, establish an American Health*
24 *Benefit Exchange (referred to in this title as an “Ex-*
25 *change”) for the State that—*

1 (A) facilitates the purchase of qualified
2 health plans;

3 (B) provides for the establishment of a
4 Small Business Health Options Program (in this
5 title referred to as a “SHOP Exchange”) that is
6 designed to assist qualified employers in the
7 State who are small employers in facilitating the
8 enrollment of their employees in qualified health
9 plans offered in the small group market in the
10 State; and

11 (C) meets the requirements of subsection (d).

12 (2) *MERGER OF INDIVIDUAL AND SHOP EX-*
13 *CHANGES.*—A State may elect to provide only one
14 Exchange in the State for providing both Exchange
15 and SHOP Exchange services to both qualified indi-
16 viduals and qualified small employers, but only if the
17 Exchange has adequate resources to assist such indi-
18 viduals and employers.

19 (c) *RESPONSIBILITIES OF THE SECRETARY.*—

20 (1) *IN GENERAL.*—The Secretary shall, by regu-
21 lation, establish criteria for the certification of health
22 plans as qualified health plans. Such criteria shall re-
23 quire that, to be certified, a plan shall, at a min-
24 imum—

1 (A) meet marketing requirements, and not
2 employ marketing practices or benefit designs
3 that have the effect of discouraging the enroll-
4 ment in such plan by individuals with signifi-
5 cant health needs;

6 (B) ensure a sufficient choice of providers
7 (in a manner consistent with applicable network
8 adequacy provisions under section 2702(c) of the
9 Public Health Service Act), and provide infor-
10 mation to enrollees and prospective enrollees on
11 the availability of in-network and out-of-network
12 providers;

13 (C) include within health insurance plan
14 networks those essential community providers,
15 where available, that serve predominately low-in-
16 come, medically-underserved individuals, such as
17 health care providers defined in section
18 340B(a)(4) of the Public Health Service Act and
19 providers described in section
20 1927(c)(1)(D)(i)(IV) of the Social Security Act
21 as set forth by section 221 of Public Law 111-
22 8, except that nothing in this subparagraph shall
23 be construed to require any health plan to pro-
24 vide coverage for any specific medical procedure;

1 (D)(i) be accredited with respect to local
2 performance on clinical quality measures such as
3 the Healthcare Effectiveness Data and Informa-
4 tion Set, patient experience ratings on a stand-
5 dardized Consumer Assessment of Healthcare Pro-
6 viders and Systems survey, as well as consumer
7 access, utilization management, quality assur-
8 ance, provider credentialing, complaints and ap-
9 peals, network adequacy and access, and patient
10 information programs by any entity recognized
11 by the Secretary for the accreditation of health
12 insurance issuers or plans (so long as any such
13 entity has transparent and rigorous methodo-
14 logical and scoring criteria); or

15 (ii) receive such accreditation within a pe-
16 riod established by an Exchange for such accred-
17 itation that is applicable to all qualified health
18 plans;

19 (E) implement a quality improvement
20 strategy described in subsection (g)(1);

21 (F) utilize a uniform enrollment form that
22 qualified individuals and qualified employers
23 may use (either electronically or on paper) in
24 enrolling in qualified health plans offered
25 through such Exchange, and that takes into ac-

1 *count criteria that the National Association of*
2 *Insurance Commissioners develops and submits*
3 *to the Secretary;*

4 (G) *utilize the standard format established*
5 *for presenting health benefits plan options; and*

6 (H) *provide information to enrollees and*
7 *prospective enrollees, and to each Exchange in*
8 *which the plan is offered, on any quality meas-*
9 *ures for health plan performance endorsed under*
10 *section 399JJ of the Public Health Service Act,*
11 *as applicable.*

12 (2) *RULE OF CONSTRUCTION.—Nothing in para-*
13 *graph (1)(C) shall be construed to require a qualified*
14 *health plan to contract with a provider described in*
15 *such paragraph if such provider refuses to accept the*
16 *generally applicable payment rates of such plan.*

17 (3) *RATING SYSTEM.—The Secretary shall de-*
18 *velop a rating system that would rate qualified health*
19 *plans offered through an Exchange in each benefits*
20 *level on the basis of the relative quality and price.*
21 *The Exchange shall include the quality rating in the*
22 *information provided to individuals and employers*
23 *through the Internet portal established under para-*
24 *graph (4).*

1 (4) *ENROLLEE SATISFACTION SYSTEM.*—*The Sec-*
2 *retary shall develop an enrollee satisfaction survey*
3 *system that would evaluate the level of enrollee satis-*
4 *faction with qualified health plans offered through an*
5 *Exchange, for each such qualified health plan that*
6 *had more than 500 enrollees in the previous year. The*
7 *Exchange shall include enrollee satisfaction informa-*
8 *tion in the information provided to individuals and*
9 *employers through the Internet portal established*
10 *under paragraph (5) in a manner that allows indi-*
11 *viduals to easily compare enrollee satisfaction levels*
12 *between comparable plans.*

13 (5) *INTERNET PORTALS.*—*The Secretary shall—*

14 (A) *continue to operate, maintain, and up-*
15 *date the Internet portal developed under section*
16 *1103(a) and to assist States in developing and*
17 *maintaining their own such portal; and*

18 (B) *make available for use by Exchanges a*
19 *model template for an Internet portal that may*
20 *be used to direct qualified individuals and quali-*
21 *fied employers to qualified health plans, to assist*
22 *such individuals and employers in determining*
23 *whether they are eligible to participate in an*
24 *Exchange or eligible for a premium tax credit or*
25 *cost-sharing reduction, and to present standard-*

1 *ized information (including quality ratings) re-*
2 *garding qualified health plans offered through an*
3 *Exchange to assist consumers in making easy*
4 *health insurance choices.*

5 *Such template shall include, with respect to each*
6 *qualified health plan offered through the Exchange in*
7 *each rating area, access to the uniform outline of cov-*
8 *erage the plan is required to provide under section*
9 *2716 of the Public Health Service Act and to a copy*
10 *of the plan's written policy.*

11 (6) *ENROLLMENT PERIODS.—The Secretary shall*
12 *require an Exchange to provide for—*

13 (A) *an initial open enrollment, as deter-*
14 *mined by the Secretary (such determination to*
15 *be made not later than July 1, 2012);*

16 (B) *annual open enrollment periods, as de-*
17 *termined by the Secretary for calendar years*
18 *after the initial enrollment period;*

19 (C) *special enrollment periods specified in*
20 *section 9801 of the Internal Revenue Code of*
21 *1986 and other special enrollment periods under*
22 *circumstances similar to such periods under part*
23 *D of title XVIII of the Social Security Act; and*

1 (D) special monthly enrollment periods for
2 Indians (as defined in section 4 of the Indian
3 Health Care Improvement Act).

4 (d) REQUIREMENTS.—

5 (1) IN GENERAL.—An Exchange shall be a gov-
6 ernmental agency or nonprofit entity that is estab-
7 lished by a State.

8 (2) OFFERING OF COVERAGE.—

9 (A) IN GENERAL.—An Exchange shall make
10 available qualified health plans to qualified indi-
11 viduals and qualified employers.

12 (B) LIMITATION.—

13 (i) IN GENERAL.—An Exchange may
14 not make available any health plan that is
15 not a qualified health plan.

16 (ii) OFFERING OF STAND-ALONE DEN-
17 TAL BENEFITS.—Each Exchange within a
18 State shall allow an issuer of a plan that
19 only provides limited scope dental benefits
20 meeting the requirements of section
21 9832(c)(2)(A) of the Internal Revenue Code
22 of 1986 to offer the plan through the Ex-
23 change (either separately or in conjunction
24 with a qualified health plan) if the plan

1 *provides pediatric dental benefits meeting*
2 *the requirements of section 1302(b)(1)(J)).*

3 (3) *RULES RELATING TO ADDITIONAL REQUIRED*
4 *BENEFITS.—*

5 (A) *IN GENERAL.—Except as provided in*
6 *subparagraph (B), an Exchange may make*
7 *available a qualified health plan notwith-*
8 *standing any provision of law that may require*
9 *benefits other than the essential health benefits*
10 *specified under section 1302(b).*

11 (B) *STATES MAY REQUIRE ADDITIONAL*
12 *BENEFITS.—*

13 (i) *IN GENERAL.—Subject to the re-*
14 *quirements of clause (ii), a State may re-*
15 *quire that a qualified health plan offered in*
16 *such State offer benefits in addition to the*
17 *essential health benefits specified under sec-*
18 *tion 1302(b).*

19 (ii) *STATE MUST ASSUME COST.—A*
20 *State shall make payments to or on behalf*
21 *of an individual eligible for the premium*
22 *tax credit under section 36B of the Internal*
23 *Revenue Code of 1986 and any cost-sharing*
24 *reduction under section 1402 to defray the*
25 *cost to the individual of any additional ben-*

1 *efits described in clause (i) which are not el-*
2 *igible for such credit or reduction under sec-*
3 *tion 36B(b)(3)(D) of such Code and section*
4 *1402(c)(4).*

5 (4) *FUNCTIONS.*—*An Exchange shall, at a min-*
6 *imum—*

7 (A) *implement procedures for the certifi-*
8 *cation, recertification, and decertification, con-*
9 *sistent with guidelines developed by the Sec-*
10 *retary under subsection (c), of health plans as*
11 *qualified health plans;*

12 (B) *provide for the operation of a toll-free*
13 *telephone hotline to respond to requests for assist-*
14 *ance;*

15 (C) *maintain an Internet website through*
16 *which enrollees and prospective enrollees of*
17 *qualified health plans may obtain standardized*
18 *comparative information on such plans;*

19 (D) *assign a rating to each qualified health*
20 *plan offered through such Exchange in accord-*
21 *ance with the criteria developed by the Secretary*
22 *under subsection (c)(3);*

23 (E) *utilize a standardized format for pre-*
24 *senting health benefits plan options in the Ex-*
25 *change, including the use of the uniform outline*

1 of coverage established under section 2715 of the
2 Public Health Service Act;

3 (F) in accordance with section 1413, inform
4 individuals of eligibility requirements for the
5 medicaid program under title XIX of the Social
6 Security Act, the CHIP program under title XXI
7 of such Act, or any applicable State or local pub-
8 lic program and if through screening of the ap-
9 plication by the Exchange, the Exchange deter-
10 mines that such individuals are eligible for any
11 such program, enroll such individuals in such
12 program;

13 (G) establish and make available by elec-
14 tronic means a calculator to determine the ac-
15 tual cost of coverage after the application of any
16 premium tax credit under section 36B of the In-
17 ternal Revenue Code of 1986 and any cost-shar-
18 ing reduction under section 1402;

19 (H) subject to section 1411, grant a certifi-
20 cation attesting that, for purposes of the indi-
21 vidual responsibility penalty under section
22 5000A of the Internal Revenue Code of 1986, an
23 individual is exempt from the individual re-
24 quirement or from the penalty imposed by such
25 section because—

1 (i) *there is no affordable qualified*
2 *health plan available through the Exchange,*
3 *or the individual's employer, covering the*
4 *individual; or*

5 (ii) *the individual meets the require-*
6 *ments for any other such exemption from*
7 *the individual responsibility requirement or*
8 *penalty;*

9 (I) *transfer to the Secretary of the Treas-*
10 *ury—*

11 (i) *a list of the individuals who are*
12 *issued a certification under subparagraph*
13 *(H), including the name and taxpayer iden-*
14 *tification number of each individual;*

15 (ii) *the name and taxpayer identifica-*
16 *tion number of each individual who was an*
17 *employee of an employer but who was deter-*
18 *mined to be eligible for the premium tax*
19 *credit under section 36B of the Internal*
20 *Revenue Code of 1986 because—*

21 (I) *the employer did not provide*
22 *minimum essential coverage; or*

23 (II) *the employer provided such*
24 *minimum essential coverage but it was*
25 *determined under section 36B(c)(2)(C)*

1 of such Code to either be unaffordable
2 to the employee or not provide the re-
3 quired minimum actuarial value; and
4 (iii) the name and taxpayer identifica-
5 tion number of each individual who notifies
6 the Exchange under section 1411(b)(4) that
7 they have changed employers and of each
8 individual who ceases coverage under a
9 qualified health plan during a plan year
10 (and the effective date of such cessation);

11 (J) provide to each employer the name of
12 each employee of the employer described in sub-
13 paragraph (I)(ii) who ceases coverage under a
14 qualified health plan during a plan year (and
15 the effective date of such cessation); and

16 (K) establish the Navigator program de-
17 scribed in subsection (i).

18 (5) *FUNDING LIMITATIONS.*—

19 (A) *NO FEDERAL FUNDS FOR CONTINUED*
20 *OPERATIONS.*—*In establishing an Exchange*
21 *under this section, the State shall ensure that*
22 *such Exchange is self-sustaining beginning on*
23 *January 1, 2015, including allowing the Ex-*
24 *change to charge assessments or user fees to par-*

1 *ticipating health insurance issuers, or to other-*
2 *wise generate funding, to support its operations.*

3 *(B) PROHIBITING WASTEFUL USE OF*
4 *FUNDS.—In carrying out activities under this*
5 *subsection, an Exchange shall not utilize any*
6 *funds intended for the administrative and oper-*
7 *ational expenses of the Exchange for staff re-*
8 *treats, promotional giveaways, excessive executive*
9 *compensation, or promotion of Federal or State*
10 *legislative and regulatory modifications.*

11 *(6) CONSULTATION.—An Exchange shall consult*
12 *with stakeholders relevant to carrying out the activi-*
13 *ties under this section, including—*

14 *(A) health care consumers who are enrollees*
15 *in qualified health plans;*

16 *(B) individuals and entities with experience*
17 *in facilitating enrollment in qualified health*
18 *plans;*

19 *(C) representatives of small businesses and*
20 *self-employed individuals;*

21 *(D) State Medicaid offices; and*

22 *(E) advocates for enrolling hard to reach*
23 *populations.*

24 *(7) PUBLICATION OF COSTS.—An Exchange shall*
25 *publish the average costs of licensing, regulatory fees,*

1 *and any other payments required by the Exchange,*
2 *and the administrative costs of such Exchange, on an*
3 *Internet website to educate consumers on such costs.*
4 *Such information shall also include monies lost to*
5 *waste, fraud, and abuse.*

6 *(e) CERTIFICATION.—*

7 *(1) IN GENERAL.—An Exchange may certify a*
8 *health plan as a qualified health plan if—*

9 *(A) such health plan meets the requirements*
10 *for certification as promulgated by the Secretary*
11 *under subsection (c)(1); and*

12 *(B) the Exchange determines that making*
13 *available such health plan through such Ex-*
14 *change is in the interests of qualified individuals*
15 *and qualified employers in the State or States in*
16 *which such Exchange operates, except that the*
17 *Exchange may not exclude a health plan—*

18 *(i) on the basis that such plan is a fee-*
19 *for-service plan;*

20 *(ii) through the imposition of premium*
21 *price controls; or*

22 *(iii) on the basis that the plan provides*
23 *treatments necessary to prevent patients'*
24 *deaths in circumstances the Exchange deter-*
25 *mines are inappropriate or too costly.*

1 (2) *PREMIUM CONSIDERATIONS.*—*The Exchange*
2 *shall require health plans seeking certification as*
3 *qualified health plans to submit a justification for*
4 *any premium increase prior to implementation of the*
5 *increase. Such plans shall prominently post such in-*
6 *formation on their websites. The Exchange may take*
7 *this information, and the information and the rec-*
8 *ommendations provided to the Exchange by the State*
9 *under section 2794(b)(1) of the Public Health Service*
10 *Act (relating to patterns or practices of excessive or*
11 *unjustified premium increases), into consideration*
12 *when determining whether to make such health plan*
13 *available through the Exchange. The Exchange shall*
14 *take into account any excess of premium growth out-*
15 *side the Exchange as compared to the rate of such*
16 *growth inside the Exchange, including information*
17 *reported by the States.*

18 (f) *FLEXIBILITY.*—

19 (1) *REGIONAL OR OTHER INTERSTATE EX-*
20 *CHANGES.*—*An Exchange may operate in more than*
21 *one State if—*

22 (A) *each State in which such Exchange op-*
23 *erates permits such operation; and*

24 (B) *the Secretary approves such regional or*
25 *interstate Exchange.*

1 (2) *SUBSIDIARY EXCHANGES.*—*A State may es-*
2 *tablish one or more subsidiary Exchanges if—*

3 (A) *each such Exchange serves a geographi-*
4 *cally distinct area; and*

5 (B) *the area served by each such Exchange*
6 *is at least as large as a rating area described in*
7 *section 2701(a) of the Public Health Service Act.*

8 (3) *AUTHORITY TO CONTRACT.*—

9 (A) *IN GENERAL.*—*A State may elect to au-*
10 *thorize an Exchange established by the State*
11 *under this section to enter into an agreement*
12 *with an eligible entity to carry out 1 or more re-*
13 *sponsibilities of the Exchange.*

14 (B) *ELIGIBLE ENTITY.*—*In this paragraph,*
15 *the term “eligible entity” means—*

16 (i) *a person—*

17 (I) *incorporated under, and sub-*
18 *ject to the laws of, 1 or more States;*

19 (II) *that has demonstrated experi-*
20 *ence on a State or regional basis in the*
21 *individual and small group health in-*
22 *surance markets and in benefits cov-*
23 *erage; and*

24 (III) *that is not a health insur-*
25 *ance issuer or that is treated under*

1 *subsection (a) or (b) of section 52 of*
2 *the Internal Revenue Code of 1986 as*
3 *a member of the same controlled group*
4 *of corporations (or under common con-*
5 *trol with) as a health insurance issuer;*
6 *or*

7 *(ii) the State medicaid agency under*
8 *title XIX of the Social Security Act.*

9 *(g) REWARDING QUALITY THROUGH MARKET-BASED*
10 *INCENTIVES.—*

11 *(1) STRATEGY DESCRIBED.—A strategy described*
12 *in this paragraph is a payment structure that pro-*
13 *vides increased reimbursement or other incentives*
14 *for—*

15 *(A) improving health outcomes through the*
16 *implementation of activities that shall include*
17 *quality reporting, effective case management,*
18 *care coordination, chronic disease management,*
19 *medication and care compliance initiatives, in-*
20 *cluding through the use of the medical home*
21 *model, for treatment or services under the plan*
22 *or coverage;*

23 *(B) the implementation of activities to pre-*
24 *vent hospital readmissions through a comprehen-*
25 *sive program for hospital discharge that includes*

1 *patient-centered education and counseling, com-*
2 *prehensive discharge planning, and post dis-*
3 *charge reinforcement by an appropriate health*
4 *care professional;*

5 (C) *the implementation of activities to im-*
6 *prove patient safety and reduce medical errors*
7 *through the appropriate use of best clinical prac-*
8 *tices, evidence based medicine, and health infor-*
9 *mation technology under the plan or coverage;*
10 *and*

11 (D) *the implementation of wellness and*
12 *health promotion activities.*

13 (2) *GUIDELINES.—The Secretary, in consulta-*
14 *tion with experts in health care quality and stake-*
15 *holders, shall develop guidelines concerning the mat-*
16 *ters described in paragraph (1).*

17 (3) *REQUIREMENTS.—The guidelines developed*
18 *under paragraph (2) shall require the periodic report-*
19 *ing to the applicable Exchange of the activities that*
20 *a qualified health plan has conducted to implement a*
21 *strategy described in paragraph (1).*

22 (h) *QUALITY IMPROVEMENT.—*

23 (1) *ENHANCING PATIENT SAFETY.—Beginning on*
24 *January 1, 2015, a qualified health plan may con-*
25 *tract with—*

1 (A) a hospital with greater than 50 beds
2 only if such hospital—

3 (i) utilizes a patient safety evaluation
4 system as described in part C of title IX of
5 the Public Health Service Act; and

6 (ii) implements a mechanism to ensure
7 that each patient receives a comprehensive
8 program for hospital discharge that includes
9 patient-centered education and counseling,
10 comprehensive discharge planning, and post
11 discharge reinforcement by an appropriate
12 health care professional; or

13 (B) a health care provider only if such pro-
14 vider implements such mechanisms to improve
15 health care quality as the Secretary may by reg-
16 ulation require.

17 (2) *EXCEPTIONS.*—The Secretary may establish
18 reasonable exceptions to the requirements described in
19 paragraph (1).

20 (3) *ADJUSTMENT.*—The Secretary may by regu-
21 lation adjust the number of beds described in para-
22 graph (1)(A).

23 (i) *NAVIGATORS.*—

24 (1) *IN GENERAL.*—An Exchange shall establish a
25 program under which it awards grants to entities de-

1 *scribed in paragraph (2) to carry out the duties de-*
2 *scribed in paragraph (3).*

3 (2) *ELIGIBILITY.—*

4 (A) *IN GENERAL.—To be eligible to receive*
5 *a grant under paragraph (1), an entity shall*
6 *demonstrate to the Exchange involved that the*
7 *entity has existing relationships, or could readily*
8 *establish relationships, with employers and em-*
9 *ployees, consumers (including uninsured and*
10 *underinsured consumers), or self-employed indi-*
11 *viduals likely to be qualified to enroll in a quali-*
12 *fied health plan.*

13 (B) *TYPES.—Entities described in subpara-*
14 *graph (A) may include trade, industry, and pro-*
15 *fessional associations, commercial fishing indus-*
16 *try organizations, ranching and farming organi-*
17 *zations, community and consumer-focused non-*
18 *profit groups, chambers of commerce, unions,*
19 *small business development centers, other licensed*
20 *insurance agents and brokers, and other entities*
21 *that—*

22 (i) *are capable of carrying out the du-*
23 *ties described in paragraph (3);*

24 (ii) *meet the standards described in*
25 *paragraph (4); and*

1 (iii) provide information consistent
2 with the standards developed under para-
3 graph (5).

4 (3) *DUTIES.*—An entity that serves as a navi-
5 gator under a grant under this subsection shall—

6 (A) conduct public education activities to
7 raise awareness of the availability of qualified
8 health plans;

9 (B) distribute fair and impartial informa-
10 tion concerning enrollment in qualified health
11 plans, and the availability of premium tax cred-
12 its under section 36B of the Internal Revenue
13 Code of 1986 and cost-sharing reductions under
14 section 1402;

15 (C) facilitate enrollment in qualified health
16 plans;

17 (D) provide referrals to any applicable of-
18 fice of health insurance consumer assistance or
19 health insurance ombudsman established under
20 section 2793 of the Public Health Service Act, or
21 any other appropriate State agency or agencies,
22 for any enrollee with a grievance, complaint, or
23 question regarding their health plan, coverage, or
24 a determination under such plan or coverage;
25 and

1 (E) provide information in a manner that
2 is culturally and linguistically appropriate to
3 the needs of the population being served by the
4 Exchange or Exchanges.

5 (4) STANDARDS.—

6 (A) IN GENERAL.—The Secretary shall es-
7 tablish standards for navigators under this sub-
8 section, including provisions to ensure that any
9 private or public entity that is selected as a nav-
10 igator is qualified, and licensed if appropriate,
11 to engage in the navigator activities described in
12 this subsection and to avoid conflicts of interest.
13 Under such standards, a navigator shall not—

14 (i) be a health insurance issuer; or

15 (ii) receive any consideration directly
16 or indirectly from any health insurance
17 issuer in connection with the enrollment of
18 any qualified individuals or employees of a
19 qualified employer in a qualified health
20 plan.

21 (5) FAIR AND IMPARTIAL INFORMATION AND
22 SERVICES.—The Secretary, in collaboration with
23 States, shall develop standards to ensure that infor-
24 mation made available by navigators is fair, accu-
25 rate, and impartial.

1 (6) *FUNDING.*—*Grants under this subsection*
2 *shall be made from the operational funds of the Ex-*
3 *change and not Federal funds received by the State to*
4 *establish the Exchange.*

5 (j) *APPLICABILITY OF MENTAL HEALTH PARITY.*—
6 *Section 2726 of the Public Health Service Act shall apply*
7 *to qualified health plans in the same manner and to the*
8 *same extent as such section applies to health insurance*
9 *issuers and group health plans.*

10 (k) *CONFLICT.*—*An Exchange may not establish rules*
11 *that conflict with or prevent the application of regulations*
12 *promulgated by the Secretary under this subtitle.*

13 **SEC. 1312. CONSUMER CHOICE.**

14 (a) *CHOICE.*—

15 (1) *QUALIFIED INDIVIDUALS.*—*A qualified indi-*
16 *vidual may enroll in any qualified health plan avail-*
17 *able to such individual.*

18 (2) *QUALIFIED EMPLOYERS.*—

19 (A) *EMPLOYER MAY SPECIFY LEVEL.*—*A*
20 *qualified employer may provide support for cov-*
21 *erage of employees under a qualified health plan*
22 *by selecting any level of coverage under section*
23 *1302(d) to be made available to employees*
24 *through an Exchange.*

1 (B) *EMPLOYEE MAY CHOOSE PLANS WITHIN*
2 *A LEVEL.*—*Each employee of a qualified em-*
3 *ployer that elects a level of coverage under sub-*
4 *paragraph (A) may choose to enroll in a quali-*
5 *fied health plan that offers coverage at that level.*

6 (b) *PAYMENT OF PREMIUMS BY QUALIFIED INDIVID-*
7 *UALS.*—*A qualified individual enrolled in any qualified*
8 *health plan may pay any applicable premium owed by such*
9 *individual to the health insurance issuer issuing such quali-*
10 *fied health plan.*

11 (c) *SINGLE RISK POOL.*—

12 (1) *INDIVIDUAL MARKET.*—*A health insurance*
13 *issuer shall consider all enrollees in all health plans*
14 *(other than grandfathered health plans) offered by*
15 *such issuer in the individual market, including those*
16 *enrollees who do not enroll in such plans through the*
17 *Exchange, to be members of a single risk pool.*

18 (2) *SMALL GROUP MARKET.*—*A health insurance*
19 *issuer shall consider all enrollees in all health plans*
20 *(other than grandfathered health plans) offered by*
21 *such issuer in the small group market, including those*
22 *enrollees who do not enroll in such plans through the*
23 *Exchange, to be members of a single risk pool.*

24 (3) *MERGER OF MARKETS.*—*A State may re-*
25 *quire the individual and small group insurance mar-*

1 *kets within a State to be merged if the State deter-*
2 *mines appropriate.*

3 (4) *STATE LAW.—A State law requiring grand-*
4 *fathered health plans to be included in a pool de-*
5 *scribed in paragraph (1) or (2) shall not apply.*

6 (d) *EMPOWERING CONSUMER CHOICE.—*

7 (1) *CONTINUED OPERATION OF MARKET OUTSIDE*
8 *EXCHANGES.—Nothing in this title shall be construed*
9 *to prohibit—*

10 (A) *a health insurance issuer from offering*
11 *outside of an Exchange a health plan to a quali-*
12 *fied individual or qualified employer; and*

13 (B) *a qualified individual from enrolling*
14 *in, or a qualified employer from selecting for its*
15 *employees, a health plan offered outside of an*
16 *Exchange.*

17 (2) *CONTINUED OPERATION OF STATE BENEFIT*
18 *REQUIREMENTS.—Nothing in this title shall be con-*
19 *strued to terminate, abridge, or limit the operation of*
20 *any requirement under State law with respect to any*
21 *policy or plan that is offered outside of an Exchange*
22 *to offer benefits.*

23 (3) *VOLUNTARY NATURE OF AN EXCHANGE.—*

24 (A) *CHOICE TO ENROLL OR NOT TO EN-*
25 *ROLL.—Nothing in this title shall be construed to*

1 *restrict the choice of a qualified individual to en-*
2 *roll or not to enroll in a qualified health plan*
3 *or to participate in an Exchange.*

4 *(B) PROHIBITION AGAINST COMPELLED EN-*
5 *ROLLMENT.—Nothing in this title shall be con-*
6 *strued to compel an individual to enroll in a*
7 *qualified health plan or to participate in an Ex-*
8 *change.*

9 *(C) INDIVIDUALS ALLOWED TO ENROLL IN*
10 *ANY PLAN.—A qualified individual may enroll*
11 *in any qualified health plan, except that in the*
12 *case of a catastrophic plan described in section*
13 *1302(e), a qualified individual may enroll in the*
14 *plan only if the individual is eligible to enroll in*
15 *the plan under section 1302(e)(2).*

16 *(D) MEMBERS OF CONGRESS IN THE EX-*
17 *CHANGE.—*

18 *(i) REQUIREMENT.—Notwithstanding*
19 *any other provision of law, after the effec-*
20 *tive date of this subtitle, the only health*
21 *plans that the Federal Government may*
22 *make available to Members of Congress and*
23 *congressional staff with respect to their serv-*
24 *ice as a Member of Congress or congress-*
25 *ional staff shall be health plans that are—*

1 (I) *created under this Act (or an*
2 *amendment made by this Act); or*

3 (II) *offered through an Exchange*
4 *established under this Act (or an*
5 *amendment made by this Act).*

6 (ii) *DEFINITIONS.—In this section:*

7 (I) *MEMBER OF CONGRESS.—The*
8 *term “Member of Congress” means any*
9 *member of the House of Representa-*
10 *tives or the Senate.*

11 (II) *CONGRESSIONAL STAFF.—The*
12 *term “congressional staff” means all*
13 *full-time and part-time employees em-*
14 *ployed by the official office of a Mem-*
15 *ber of Congress, whether in Wash-*
16 *ington, DC or outside of Washington,*
17 *DC.*

18 (4) *NO PENALTY FOR TRANSFERRING TO MIN-*
19 *IMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—*
20 *An Exchange, or a qualified health plan offered*
21 *through an Exchange, shall not impose any penalty*
22 *or other fee on an individual who cancels enrollment*
23 *in a plan because the individual becomes eligible for*
24 *minimum essential coverage (as defined in section*
25 *5000A(f) of the Internal Revenue Code of 1986 with-*

1 out regard to paragraph (1)(C) or (D) thereof) or
2 such coverage becomes affordable (within the meaning
3 of section 36B(c)(2)(C) of such Code).

4 (e) *ENROLLMENT THROUGH AGENTS OR BROKERS.*—
5 The Secretary shall establish procedures under which a
6 State may allow agents or brokers—

7 (1) to enroll individuals in any qualified health
8 plans in the individual or small group market as
9 soon as the plan is offered through an Exchange in
10 the State; and

11 (2) to assist individuals in applying for pre-
12 mium tax credits and cost-sharing reductions for
13 plans sold through an Exchange.

14 Such procedures may include the establishment of rate
15 schedules for broker commissions paid by health benefits
16 plans offered through an exchange.

17 (f) *QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS*
18 *LIMITED TO CITIZENS AND LAWFUL RESIDENTS.*—

19 (1) *QUALIFIED INDIVIDUALS.*—*In this title:*

20 (A) *IN GENERAL.*—*The term “qualified in-*
21 *dividual” means, with respect to an Exchange,*
22 *an individual who—*

23 (i) *is seeking to enroll in a qualified*
24 *health plan in the individual market offered*
25 *through the Exchange; and*

1 (ii) resides in the State that established
2 the Exchange (except with respect to terri-
3 torial agreements under section 1312(f)).

4 (B) *INCARCERATED INDIVIDUALS EX-*
5 *CLUDED.*—An individual shall not be treated as
6 a qualified individual if, at the time of enroll-
7 ment, the individual is incarcerated, other than
8 incarceration pending the disposition of charges.

9 (2) *QUALIFIED EMPLOYER.*—In this title:

10 (A) *IN GENERAL.*—The term “qualified em-
11 ployer” means a small employer that elects to
12 make all full-time employees of such employer el-
13 igible for 1 or more qualified health plans offered
14 in the small group market through an Exchange
15 that offers qualified health plans.

16 (B) *EXTENSION TO LARGE GROUPS.*—

17 (i) *IN GENERAL.*—Beginning in 2017,
18 each State may allow issuers of health in-
19 surance coverage in the large group market
20 in the State to offer qualified health plans
21 in such market through an Exchange. Noth-
22 ing in this subparagraph shall be construed
23 as requiring the issuer to offer such plans
24 through an Exchange.

1 (ii) *LARGE EMPLOYERS ELIGIBLE.*—If
2 a State under clause (i) allows issuers to
3 offer qualified health plans in the large
4 group market through an Exchange, the
5 term “qualified employer” shall include a
6 large employer that elects to make all full-
7 time employees of such employer eligible for
8 1 or more qualified health plans offered in
9 the large group market through the Ex-
10 change.

11 (3) *ACCESS LIMITED TO LAWFUL RESIDENTS.*—
12 If an individual is not, or is not reasonably expected
13 to be for the entire period for which enrollment is
14 sought, a citizen or national of the United States or
15 an alien lawfully present in the United States, the in-
16 dividual shall not be treated as a qualified individual
17 and may not be covered under a qualified health plan
18 in the individual market that is offered through an
19 Exchange.

20 **SEC. 1313. FINANCIAL INTEGRITY.**

21 (a) *ACCOUNTING FOR EXPENDITURES.*—

22 (1) *IN GENERAL.*—An Exchange shall keep an
23 accurate accounting of all activities, receipts, and ex-
24 penditures and shall annually submit to the Secretary
25 a report concerning such accountings.

1 (2) *INVESTIGATIONS.*—*The Secretary, in coordi-*
2 *nation with the Inspector General of the Department*
3 *of Health and Human Services, may investigate the*
4 *affairs of an Exchange, may examine the properties*
5 *and records of an Exchange, and may require peri-*
6 *odic reports in relation to activities undertaken by an*
7 *Exchange. An Exchange shall fully cooperate in any*
8 *investigation conducted under this paragraph.*

9 (3) *AUDITS.*—*An Exchange shall be subject to*
10 *annual audits by the Secretary.*

11 (4) *PATTERN OF ABUSE.*—*If the Secretary deter-*
12 *mines that an Exchange or a State has engaged in*
13 *serious misconduct with respect to compliance with*
14 *the requirements of, or carrying out of activities re-*
15 *quired under, this title, the Secretary may rescind*
16 *from payments otherwise due to such State involved*
17 *under this or any other Act administered by the Sec-*
18 *retary an amount not to exceed 1 percent of such pay-*
19 *ments per year until corrective actions are taken by*
20 *the State that are determined to be adequate by the*
21 *Secretary.*

22 (5) *PROTECTIONS AGAINST FRAUD AND ABUSE.*—
23 *With respect to activities carried out under this title,*
24 *the Secretary shall provide for the efficient and non-*

1 *discriminatory administration of Exchange activities*
2 *and implement any measure or procedure that—*

3 *(A) the Secretary determines is appropriate*
4 *to reduce fraud and abuse in the administration*
5 *of this title; and*

6 *(B) the Secretary has authority to imple-*
7 *ment under this title or any other Act.*

8 *(6) APPLICATION OF THE FALSE CLAIMS ACT.—*

9 *(A) IN GENERAL.—Payments made by,*
10 *through, or in connection with an Exchange are*
11 *subject to the False Claims Act (31 U.S.C. 3729*
12 *et seq.) if those payments include any Federal*
13 *funds. Compliance with the requirements of this*
14 *Act concerning eligibility for a health insurance*
15 *issuer to participate in the Exchange shall be a*
16 *material condition of an issuer's entitlement to*
17 *receive payments, including payments of pre-*
18 *mium tax credits and cost-sharing reductions,*
19 *through the Exchange.*

20 *(B) DAMAGES.—Notwithstanding para-*
21 *graph (1) of section 3729(a) of title 31, United*
22 *States Code, and subject to paragraph (2) of such*
23 *section, the civil penalty assessed under the False*
24 *Claims Act on any person found liable under*
25 *such Act as described in subparagraph (A) shall*

1 *be increased by not less than 3 times and not*
2 *more than 6 times the amount of damages which*
3 *the Government sustains because of the act of*
4 *that person.*

5 **(b) GAO OVERSIGHT.**—*Not later than 5 years after*
6 *the first date on which Exchanges are required to be oper-*
7 *ational under this title, the Comptroller General shall con-*
8 *duct an ongoing study of Exchange activities and the enroll-*
9 *ees in qualified health plans offered through Exchanges.*
10 *Such study shall review—*

11 *(1) the operations and administration of Ex-*
12 *changes, including surveys and reports of qualified*
13 *health plans offered through Exchanges and on the ex-*
14 *perience of such plans (including data on enrollees in*
15 *Exchanges and individuals purchasing health insur-*
16 *ance coverage outside of Exchanges), the expenses of*
17 *Exchanges, claims statistics relating to qualified*
18 *health plans, complaints data relating to such plans,*
19 *and the manner in which Exchanges meet their goals;*

20 *(2) any significant observations regarding the*
21 *utilization and adoption of Exchanges;*

22 *(3) where appropriate, recommendations for im-*
23 *provements in the operations or policies of Exchanges;*
24 *and*

1 (4) *how many physicians, by area and specialty,*
2 *are not taking or accepting new patients enrolled in*
3 *Federal Government health care programs, and the*
4 *adequacy of provider networks of Federal Government*
5 *health care programs.*

6 **PART III—STATE FLEXIBILITY RELATING TO**
7 **EXCHANGES**

8 **SEC. 1321. STATE FLEXIBILITY IN OPERATION AND EN-**
9 **FORCEMENT OF EXCHANGES AND RELATED**
10 **REQUIREMENTS.**

11 (a) *ESTABLISHMENT OF STANDARDS.—*

12 (1) *IN GENERAL.—The Secretary shall, as soon*
13 *as practicable after the date of enactment of this Act,*
14 *issue regulations setting standards for meeting the re-*
15 *quirements under this title, and the amendments*
16 *made by this title, with respect to—*

17 (A) *the establishment and operation of Ex-*
18 *changes (including SHOP Exchanges);*

19 (B) *the offering of qualified health plans*
20 *through such Exchanges;*

21 (C) *the establishment of the reinsurance and*
22 *risk adjustment programs under part V; and*

23 (D) *such other requirements as the Sec-*
24 *retary determines appropriate.*

1 *The preceding sentence shall not apply to standards*
2 *for requirements under subtitles A and C (and the*
3 *amendments made by such subtitles) for which the*
4 *Secretary issues regulations under the Public Health*
5 *Service Act.*

6 (2) *CONSULTATION.—In issuing the regulations*
7 *under paragraph (1), the Secretary shall consult with*
8 *the National Association of Insurance Commissioners*
9 *and its members and with health insurance issuers,*
10 *consumer organizations, and such other individuals*
11 *as the Secretary selects in a manner designed to en-*
12 *sure balanced representation among interested par-*
13 *ties.*

14 (b) *STATE ACTION.—Each State that elects, at such*
15 *time and in such manner as the Secretary may prescribe,*
16 *to apply the requirements described in subsection (a) shall,*
17 *not later than January 1, 2014, adopt and have in effect—*

18 (1) *the Federal standards established under sub-*
19 *section (a); or*

20 (2) *a State law or regulation that the Secretary*
21 *determines implements the standards within the*
22 *State.*

23 (c) *FAILURE TO ESTABLISH EXCHANGE OR IMPLE-*
24 *MENT REQUIREMENTS.—*

25 (1) *IN GENERAL.—If—*

1 (A) a State is not an electing State under
2 subsection (b); or

3 (B) the Secretary determines, on or before
4 January 1, 2013, that an electing State—

5 (i) will not have any required Ex-
6 change operational by January 1, 2014; or

7 (ii) has not taken the actions the Sec-
8 retary determines necessary to implement—

9 (I) the other requirements set forth
10 in the standards under subsection (a);

11 or

12 (II) the requirements set forth in
13 subtitles A and C and the amendments
14 made by such subtitles;

15 the Secretary shall (directly or through agreement
16 with a not-for-profit entity) establish and operate
17 such Exchange within the State and the Secretary
18 shall take such actions as are necessary to implement
19 such other requirements.

20 (2) *ENFORCEMENT AUTHORITY.*—The provisions
21 of section 2736(b) of the Public Health Services Act
22 shall apply to the enforcement under paragraph (1)
23 of requirements of subsection (a)(1) (without regard to
24 any limitation on the application of those provisions
25 to group health plans).

1 (d) *NO INTERFERENCE WITH STATE REGULATORY*
2 *AUTHORITY.*—*Nothing in this title shall be construed to*
3 *preempt any State law that does not prevent the applica-*
4 *tion of the provisions of this title.*

5 (e) *PRESUMPTION FOR CERTAIN STATE-OPERATED*
6 *EXCHANGES.*—

7 (1) *IN GENERAL.*—*In the case of a State oper-*
8 *ating an Exchange before January 1, 2010, and*
9 *which has insured a percentage of its population not*
10 *less than the percentage of the population projected to*
11 *be covered nationally after the implementation of this*
12 *Act, that seeks to operate an Exchange under this sec-*
13 *tion, the Secretary shall presume that such Exchange*
14 *meets the standards under this section unless the Sec-*
15 *retary determines, after completion of the process es-*
16 *tablished under paragraph (2), that the Exchange*
17 *does not comply with such standards.*

18 (2) *PROCESS.*—*The Secretary shall establish a*
19 *process to work with a State described in paragraph*
20 *(1) to provide assistance necessary to assist the*
21 *State's Exchange in coming into compliance with the*
22 *standards for approval under this section.*

1 **SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT**
2 **AND OPERATION OF NONPROFIT, MEMBER-**
3 **RUN HEALTH INSURANCE ISSUERS.**

4 (a) *ESTABLISHMENT OF PROGRAM.—*

5 (1) *IN GENERAL.—The Secretary shall establish*
6 *a program to carry out the purposes of this section*
7 *to be known as the Consumer Operated and Oriented*
8 *Plan (CO–OP) program.*

9 (2) *PURPOSE.—It is the purpose of the CO–OP*
10 *program to foster the creation of qualified nonprofit*
11 *health insurance issuers to offer qualified health plans*
12 *in the individual and small group markets in the*
13 *States in which the issuers are licensed to offer such*
14 *plans.*

15 (b) *LOANS AND GRANTS UNDER THE CO–OP PRO-*
16 *GRAM.—*

17 (1) *IN GENERAL.—The Secretary shall provide*
18 *through the CO–OP program for the awarding to per-*
19 *sons applying to become qualified nonprofit health in-*
20 *surance issuers of—*

21 (A) *loans to provide assistance to such per-*
22 *son in meeting its start-up costs; and*

23 (B) *grants to provide assistance to such per-*
24 *son in meeting any solvency requirements of*
25 *States in which the person seeks to be licensed to*
26 *issue qualified health plans.*

1 (2) *REQUIREMENTS FOR AWARDING LOANS AND*
2 *GRANTS.*—

3 (A) *IN GENERAL.*—*In awarding loans and*
4 *grants under the CO-OP program, the Secretary*
5 *shall—*

6 (i) *take into account the recommenda-*
7 *tions of the advisory board established*
8 *under paragraph (3);*

9 (ii) *give priority to applicants that*
10 *will offer qualified health plans on a State-*
11 *wide basis, will utilize integrated care mod-*
12 *els, and have significant private support;*
13 *and*

14 (iii) *ensure that there is sufficient*
15 *funding to establish at least 1 qualified*
16 *nonprofit health insurance issuer in each*
17 *State, except that nothing in this clause*
18 *shall prohibit the Secretary from funding*
19 *the establishment of multiple qualified non-*
20 *profit health insurance issuers in any State*
21 *if the funding is sufficient to do so.*

22 (B) *STATES WITHOUT ISSUERS IN PRO-*
23 *GRAM.*—*If no health insurance issuer applies to*
24 *be a qualified nonprofit health insurance issuer*
25 *within a State, the Secretary may use amounts*

1 *appropriated under this section for the awarding*
2 *of grants to encourage the establishment of a*
3 *qualified nonprofit health insurance issuer with-*
4 *in the State or the expansion of a qualified non-*
5 *profit health insurance issuer from another State*
6 *to the State.*

7 (C) *AGREEMENT.—*

8 (i) *IN GENERAL.—The Secretary shall*
9 *require any person receiving a loan or*
10 *grant under the CO-OP program to enter*
11 *into an agreement with the Secretary which*
12 *requires such person to meet (and to con-*
13 *tinue to meet)—*

14 (i) *any requirement under this*
15 *section for such person to be treated as*
16 *a qualified nonprofit health insurance*
17 *issuer; and*

18 (ii) *any requirements contained*
19 *in the agreement for such person to re-*
20 *ceive such loan or grant.*

21 (ii) *RESTRICTIONS ON USE OF FED-*
22 *ERAL FUNDS.—The agreement shall include*
23 *a requirement that no portion of the funds*
24 *made available by any loan or grant under*
25 *this section may be used—*

1 (I) for carrying on propaganda,
2 or otherwise attempting, to influence
3 legislation; or

4 (II) for marketing.

5 Nothing in this clause shall be construed to
6 allow a person to take any action prohib-
7 ited by section 501(c)(29) of the Internal
8 Revenue Code of 1986.

9 (iii) *FAILURE TO MEET REQUIRE-*
10 *MENTS.—If the Secretary determines that a*
11 *person has failed to meet any requirement*
12 *described in clause (i) or (ii) and has failed*
13 *to correct such failure within a reasonable*
14 *period of time of when the person first*
15 *knows (or reasonably should have known) of*
16 *such failure, such person shall repay to the*
17 *Secretary an amount equal to the sum of—*

18 (I) 110 percent of the aggregate
19 amount of loans and grants received
20 under this section; plus

21 (II) interest on the aggregate
22 amount of loans and grants received
23 under this section for the period the
24 loans or grants were outstanding.

1 *The Secretary shall notify the Secretary of*
2 *the Treasury of any determination under*
3 *this section of a failure that results in the*
4 *termination of an issuer's tax-exempt status*
5 *under section 501(c)(29) of such Code.*

6 (D) *TIME FOR AWARDING LOANS AND*
7 *GRANTS.—The Secretary shall not later than*
8 *July 1, 2013, award the loans and grants under*
9 *the CO-OP program and begin the distribution*
10 *of amounts awarded under such loans and*
11 *grants.*

12 (3) *ADVISORY BOARD.—*

13 (A) *IN GENERAL.—The advisory board*
14 *under this paragraph shall consist of 15 mem-*
15 *bers appointed by the Comptroller General of the*
16 *United States from among individuals with*
17 *qualifications described in section 1805(c)(2) of*
18 *the Social Security Act.*

19 (B) *RULES RELATING TO APPOINTMENTS.—*

20 (i) *STANDARDS.—Any individual ap-*
21 *pointed under subparagraph (A) shall meet*
22 *ethics and conflict of interest standards pro-*
23 *tecting against insurance industry involve-*
24 *ment and interference.*

1 (ii) ORIGINAL APPOINTMENTS.—The
2 original appointment of board members
3 under subparagraph (A)(ii) shall be made
4 no later than 3 months after the date of en-
5 actment of this Act.

6 (C) VACANCY.—Any vacancy on the advi-
7 sory board shall be filled in the same manner as
8 the original appointment.

9 (D) PAY AND REIMBURSEMENT.—

10 (i) NO COMPENSATION FOR MEMBERS
11 OF ADVISORY BOARD.—Except as provided
12 in clause (ii), a member of the advisory
13 board may not receive pay, allowances, or
14 benefits by reason of their service on the
15 board.

16 (ii) TRAVEL EXPENSES.—Each mem-
17 ber shall receive travel expenses, including
18 per diem in lieu of subsistence under sub-
19 chapter I of chapter 57 of title 5, United
20 States Code.

21 (E) APPLICATION OF FACAs.—The Federal
22 Advisory Committee Act (5 U.S.C. App.) shall
23 apply to the advisory board, except that section
24 14 of such Act shall not apply.

1 (F) *TERMINATION.*—*The advisory board*
2 *shall terminate on the earlier of the date that it*
3 *completes its duties under this section or Decem-*
4 *ber 31, 2015.*

5 (c) *QUALIFIED NONPROFIT HEALTH INSURANCE*
6 *ISSUER.*—*For purposes of this section—*

7 (1) *IN GENERAL.*—*The term “qualified nonprofit*
8 *health insurance issuer” means a health insurance*
9 *issuer that is an organization—*

10 (A) *that is organized under State law as a*
11 *nonprofit, member corporation;*

12 (B) *substantially all of the activities of*
13 *which consist of the issuance of qualified health*
14 *plans in the individual and small group markets*
15 *in each State in which it is licensed to issue such*
16 *plans; and*

17 (C) *that meets the other requirements of this*
18 *subsection.*

19 (2) *CERTAIN ORGANIZATIONS PROHIBITED.*—*An*
20 *organization shall not be treated as a qualified non-*
21 *profit health insurance issuer if—*

22 (A) *the organization or a related entity (or*
23 *any predecessor of either) was a health insurance*
24 *issuer on July 16, 2009; or*

1 (B) *the organization is sponsored by a State*
2 *or local government, any political subdivision*
3 *thereof, or any instrumentality of such govern-*
4 *ment or political subdivision.*

5 (3) *GOVERNANCE REQUIREMENTS.—An organi-*
6 *zation shall not be treated as a qualified nonprofit*
7 *health insurance issuer unless—*

8 (A) *the governance of the organization is*
9 *subject to a majority vote of its members;*

10 (B) *its governing documents incorporate*
11 *ethics and conflict of interest standards pro-*
12 *tecting against insurance industry involvement*
13 *and interference; and*

14 (C) *as provided in regulations promulgated*
15 *by the Secretary, the organization is required to*
16 *operate with a strong consumer focus, including*
17 *timeliness, responsiveness, and accountability to*
18 *members.*

19 (4) *PROFITS INURE TO BENEFIT OF MEMBERS.—*
20 *An organization shall not be treated as a qualified*
21 *nonprofit health insurance issuer unless any profits*
22 *made by the organization are required to be used to*
23 *lower premiums, to improve benefits, or for other pro-*
24 *grams intended to improve the quality of health care*
25 *delivered to its members.*

1 (5) *COMPLIANCE WITH STATE INSURANCE*
2 *LAWS.—An organization shall not be treated as a*
3 *qualified nonprofit health insurance issuer unless the*
4 *organization meets all the requirements that other*
5 *issuers of qualified health plans are required to meet*
6 *in any State where the issuer offers a qualified health*
7 *plan, including solvency and licensure requirements,*
8 *rules on payments to providers, and compliance with*
9 *network adequacy rules, rate and form filing rules,*
10 *any applicable State premium assessments and any*
11 *other State law described in section 1324(b).*

12 (6) *COORDINATION WITH STATE INSURANCE RE-*
13 *FORMS.—An organization shall not be treated as a*
14 *qualified nonprofit health insurance issuer unless the*
15 *organization does not offer a health plan in a State*
16 *until that State has in effect (or the Secretary has*
17 *implemented for the State) the market reforms re-*
18 *quired by part A of title XXVII of the Public Health*
19 *Service Act (as amended by subtitles A and C of this*
20 *Act).*

21 (d) *ESTABLISHMENT OF PRIVATE PURCHASING COUN-*
22 *CIL.—*

23 (1) *IN GENERAL.—Qualified nonprofit health in-*
24 *surance issuers participating in the CO-OP program*
25 *under this section may establish a private purchasing*

1 *council to enter into collective purchasing arrange-*
2 *ments for items and services that increase adminis-*
3 *trative and other cost efficiencies, including claims*
4 *administration, administrative services, health infor-*
5 *mation technology, and actuarial services.*

6 (2) *COUNCIL MAY NOT SET PAYMENT RATES.—*

7 *The private purchasing council established under*
8 *paragraph (1) shall not set payment rates for health*
9 *care facilities or providers participating in health in-*
10 *surance coverage provided by qualified nonprofit*
11 *health insurance issuers.*

12 (3) *CONTINUED APPLICATION OF ANTITRUST*
13 *LAWS.—*

14 (A) *IN GENERAL.—Nothing in this section*
15 *shall be construed to limit the application of the*
16 *antitrust laws to any private purchasing council*
17 *(whether or not established under this subsection)*
18 *or to any qualified nonprofit health insurance*
19 *issuer participating in such a council.*

20 (B) *ANTITRUST LAWS.—For purposes of*
21 *this subparagraph, the term “antitrust laws” has*
22 *the meaning given the term in subsection (a) of*
23 *the first section of the Clayton Act (15 U.S.C.*
24 *12(a)). Such term also includes section 5 of the*
25 *Federal Trade Commission Act (15 U.S.C. 45) to*

1 *the extent that such section 5 applies to unfair*
2 *methods of competition.*

3 *(e) LIMITATION ON PARTICIPATION.—No representa-*
4 *tive of any Federal, State, or local government (or of any*
5 *political subdivision or instrumentality thereof), and no*
6 *representative of a person described in subsection (c)(2)(A),*
7 *may serve on the board of directors of a qualified nonprofit*
8 *health insurance issuer or with a private purchasing coun-*
9 *cil established under subsection (d).*

10 *(f) LIMITATIONS ON SECRETARY.—*

11 *(1) IN GENERAL.—The Secretary shall not—*

12 *(A) participate in any negotiations between*
13 *1 or more qualified nonprofit health insurance*
14 *issuers (or a private purchasing council estab-*
15 *lished under subsection (d)) and any health care*
16 *facilities or providers, including any drug man-*
17 *ufacturer, pharmacy, or hospital; and*

18 *(B) establish or maintain a price structure*
19 *for reimbursement of any health benefits covered*
20 *by such issuers.*

21 *(2) COMPETITION.—Nothing in this section shall*
22 *be construed as authorizing the Secretary to interfere*
23 *with the competitive nature of providing health bene-*
24 *fits through qualified nonprofit health insurance*
25 *issuers.*

1 (g) *APPROPRIATIONS.*—*There are hereby appropriated,*
2 *out of any funds in the Treasury not otherwise appro-*
3 *priated, \$6,000,000,000 to carry out this section.*

4 (h) *TAX EXEMPTION FOR QUALIFIED NONPROFIT*
5 *HEALTH INSURANCE ISSUER.*—

6 (1) *IN GENERAL.*—*Section 501(c) of the Internal*
7 *Revenue Code of 1986 (relating to list of exempt orga-*
8 *nizations) is amended by adding at the end the fol-*
9 *lowing:*

10 “(29) *CO–OP HEALTH INSURANCE ISSUERS.*—

11 “(A) *IN GENERAL.*—*A qualified nonprofit*
12 *health insurance issuer (within the meaning of*
13 *section 1322 of the Patient Protection and Af-*
14 *fordable Care Act) which has received a loan or*
15 *grant under the CO–OP program under such sec-*
16 *tion, but only with respect to periods for which*
17 *the issuer is in compliance with the requirements*
18 *of such section and any agreement with respect*
19 *to the loan or grant.*

20 “(B) *CONDITIONS FOR EXEMPTION.*—*Sub-*
21 *paragraph (A) shall apply to an organization*
22 *only if—*

23 “(i) *the organization has given notice*
24 *to the Secretary, in such manner as the Sec-*
25 *retary may by regulations prescribe, that it*

1 *is applying for recognition of its status*
2 *under this paragraph,*

3 *“(ii) except as provided in section*
4 *1322(c)(4) of the Patient Protection and Af-*
5 *fordable Care Act, no part of the net earn-*
6 *ings of which inures to the benefit of any*
7 *private shareholder or individual,*

8 *“(iii) no substantial part of the activi-*
9 *ties of which is carrying on propaganda, or*
10 *otherwise attempting, to influence legisla-*
11 *tion, and*

12 *“(iv) the organization does not partici-*
13 *pate in, or intervene in (including the pub-*
14 *lishing or distributing of statements), any*
15 *political campaign on behalf of (or in oppo-*
16 *sition to) any candidate for public office.”.*

17 (2) *ADDITIONAL REPORTING REQUIREMENT.—*
18 *Section 6033 of such Code (relating to returns by ex-*
19 *empt organizations) is amended by redesignating sub-*
20 *section (m) as subsection (n) and by inserting after*
21 *subsection (l) the following:*

22 *“(m) ADDITIONAL INFORMATION REQUIRED FROM*
23 *CO-OP INSURERS.—An organization described in section*
24 *501(c)(29) shall include on the return required under sub-*
25 *section (a) the following information:*

1 “(1) *The amount of the reserves required by each*
2 *State in which the organization is licensed to issue*
3 *qualified health plans.*”

4 “(2) *The amount of reserves on hand.*”.

5 (3) *APPLICATION OF TAX ON EXCESS BENEFIT*
6 *TRANSACTIONS.—Section 4958(e)(1) of such Code (de-*
7 *fining applicable tax-exempt organization) is amend-*
8 *ed by striking “paragraph (3) or (4)” and inserting*
9 *“paragraph (3), (4), or (29)”.*

10 (i) *GAO STUDY AND REPORT.—*

11 (1) *STUDY.—The Comptroller General of the*
12 *General Accountability Office shall conduct an ongo-*
13 *ing study on competition and market concentration*
14 *in the health insurance market in the United States*
15 *after the implementation of the reforms in such mar-*
16 *ket under the provisions of, and the amendments*
17 *made by, this Act. Such study shall include an anal-*
18 *ysis of new issuers of health insurance in such mar-*
19 *ket.*

20 (2) *REPORT.—The Comptroller General shall,*
21 *not later than December 31 of each even-numbered*
22 *year (beginning with 2014), report to the appropriate*
23 *committees of the Congress the results of the study*
24 *conducted under paragraph (1), including any rec-*
25 *ommendations for administrative or legislative*

1 *changes the Comptroller General determines necessary*
2 *or appropriate to increase competition in the health*
3 *insurance market.*

4 **SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.**

5 *(a) VOLUNTARY NATURE.—*

6 *(1) NO REQUIREMENT FOR HEALTH CARE PRO-*
7 *VIDERS TO PARTICIPATE.—Nothing in this section*
8 *shall be construed to require a health care provider to*
9 *participate in a community health insurance option,*
10 *or to impose any penalty for non-participation.*

11 *(2) NO REQUIREMENT FOR INDIVIDUALS TO*
12 *JOIN.—Nothing in this section shall be construed to*
13 *require an individual to participate in a community*
14 *health insurance option, or to impose any penalty for*
15 *non-participation.*

16 *(3) STATE OPT OUT.—*

17 *(A) IN GENERAL.—A State may elect to*
18 *prohibit Exchanges in such State from offering a*
19 *community health insurance option if such State*
20 *enacts a law to provide for such prohibition.*

21 *(B) TERMINATION OF OPT OUT.—A State*
22 *may repeal a law described in subparagraph (A)*
23 *and provide for the offering of such an option*
24 *through the Exchange.*

1 **(b) ESTABLISHMENT OF COMMUNITY HEALTH INSUR-**
2 **ANCE OPTION.—**

3 **(1) ESTABLISHMENT.—***The Secretary shall estab-*
4 *lish a community health insurance option to offer,*
5 *through the Exchanges established under this title*
6 *(other than Exchanges in States that elect to opt out*
7 *as provided for in subsection (a)(3)), health care cov-*
8 *erage that provides value, choice, competition, and*
9 *stability of affordable, high quality coverage through-*
10 *out the United States.*

11 **(2) COMMUNITY HEALTH INSURANCE OPTION.—**
12 *In this section, the term “community health insur-*
13 *ance option” means health insurance coverage that—*

14 **(A)** *except as specifically provided for in*
15 *this section, complies with the requirements for*
16 *being a qualified health plan;*

17 **(B)** *provides high value for the premium*
18 *charged;*

19 **(C)** *reduces administrative costs and pro-*
20 *motes administrative simplification for bene-*
21 *ficiaries;*

22 **(D)** *promotes high quality clinical care;*

23 **(E)** *provides high quality customer service*
24 *to beneficiaries;*

1 (F) offers a sufficient choice of providers;
2 and

3 (G) complies with State laws (if any), ex-
4 cept as otherwise provided for in this title, relat-
5 ing to the laws described in section 1324(b).

6 (3) *ESSENTIAL HEALTH BENEFITS.*—

7 (A) *GENERAL RULE.*—Except as provided
8 in subparagraph (B), a community health insur-
9 ance option offered under this section shall pro-
10 vide coverage only for the essential health bene-
11 fits described in section 1302(b).

12 (B) *STATES MAY OFFER ADDITIONAL BENE-*
13 *FITS.*—Nothing in this section shall preclude a
14 State from requiring that benefits in addition to
15 the essential health benefits required under sub-
16 paragraph (A) be provided to enrollees of a com-
17 munity health insurance option offered in such
18 State.

19 (C) *CREDITS.*—

20 (i) *IN GENERAL.*—An individual en-
21 rolled in a community health insurance op-
22 tion under this section shall be eligible for
23 credits under section 36B of the Internal
24 Revenue Code of 1986 in the same manner

1 *as an individual who is enrolled in a quali-*
2 *fied health plan.*

3 *(ii) NO ADDITIONAL FEDERAL COST.—*
4 *A requirement by a State under subpara-*
5 *graph (B) that benefits in addition to the*
6 *essential health benefits required under sub-*
7 *paragraph (A) be provided to enrollees of a*
8 *community health insurance option shall*
9 *not affect the amount of a premium tax*
10 *credit provided under section 36B of the In-*
11 *ternal Revenue Code of 1986 with respect to*
12 *such plan.*

13 *(D) STATE MUST ASSUME COST.—A State*
14 *shall make payments to or on behalf of an eligi-*
15 *ble individual to defray the cost of any addi-*
16 *tional benefits described in subparagraph (B).*

17 *(E) ENSURING ACCESS TO ALL SERVICES.—*
18 *Nothing in this Act shall prohibit an individual*
19 *enrolled in a community health insurance option*
20 *from paying out-of-pocket the full cost of any*
21 *item or service not included as an essential*
22 *health benefit or otherwise covered as a benefit by*
23 *a health plan. Nothing in subparagraph (B)*
24 *shall prohibit any type of medical provider from*
25 *accepting an out-of-pocket payment from an in-*

1 *dividual enrolled in a community health insur-*
2 *ance option for a service otherwise not included*
3 *as an essential health benefit.*

4 *(F) PROTECTING ACCESS TO END OF LIFE*
5 *CARE.—A community health insurance option*
6 *offered under this section shall be prohibited*
7 *from limiting access to end of life care.*

8 *(4) COST SHARING.—A community health insur-*
9 *ance option shall offer coverage at each of the levels*
10 *of coverage described in section 1302(d).*

11 *(5) PREMIUMS.—*

12 *(A) PREMIUMS SUFFICIENT TO COVER*
13 *COSTS.—The Secretary shall establish geographi-*
14 *cally adjusted premium rates in an amount suf-*
15 *ficient to cover expected costs (including claims*
16 *and administrative costs) using methods in gen-*
17 *eral use by qualified health plans.*

18 *(B) APPLICABLE RULES.—The provisions of*
19 *title XXVII of the Public Health Service Act re-*
20 *lating to premiums shall apply to community*
21 *health insurance options under this section, in-*
22 *cluding modified community rating provisions*
23 *under section 2701 of such Act.*

1 (C) *COLLECTION OF DATA.*—*The Secretary*
2 *shall collect data as necessary to set premium*
3 *rates under subparagraph (A).*

4 (D) *NATIONAL POOLING.*—*Notwithstanding*
5 *any other provision of law, the Secretary may*
6 *treat all enrollees in community health insur-*
7 *ance options as members of a single pool.*

8 (E) *CONTINGENCY MARGIN.*—*In establishing*
9 *premium rates under subparagraph (A), the Sec-*
10 *retary shall include an appropriate amount for*
11 *a contingency margin.*

12 (6) *REIMBURSEMENT RATES.*—

13 (A) *NEGOTIATED RATES.*—*The Secretary*
14 *shall negotiate rates for the reimbursement of*
15 *health care providers for benefits covered under*
16 *a community health insurance option.*

17 (B) *LIMITATION.*—*The rates described in*
18 *subparagraph (A) shall not be higher, in aggre-*
19 *gate, than the average reimbursement rates paid*
20 *by health insurance issuers offering qualified*
21 *health plans through the Exchange.*

22 (C) *INNOVATION.*—*Subject to the limits con-*
23 *tained in subparagraph (A), a State Advisory*
24 *Council established or designated under sub-*
25 *section (d) may develop or encourage the use of*

1 *innovative payment policies that promote qual-*
2 *ity, efficiency and savings to consumers.*

3 (7) *SOLVENCY AND CONSUMER PROTECTION.—*

4 (A) *SOLVENCY.—The Secretary shall estab-*
5 *lish a Federal solvency standard to be applied*
6 *with respect to a community health insurance*
7 *option. A community health insurance option*
8 *shall also be subject to the solvency standard of*
9 *each State in which such community health in-*
10 *surance option is offered.*

11 (B) *MINIMUM REQUIRED.—In establishing*
12 *the standard described under subparagraph (A),*
13 *the Secretary shall require a reserve fund that*
14 *shall be equal to at least the dollar value of the*
15 *incurred but not reported claims of a community*
16 *health insurance option.*

17 (C) *CONSUMER PROTECTIONS.—The con-*
18 *sumer protection laws of a State shall apply to*
19 *a community health insurance option.*

20 (8) *REQUIREMENTS ESTABLISHED IN PARTNER-*
21 *SHIP WITH INSURANCE COMMISSIONERS.—*

22 (A) *IN GENERAL.—The Secretary, in col-*
23 *laboration with the National Association of In-*
24 *surance Commissioners (in this paragraph re-*
25 *ferred to as the “NAIC”), may promulgate regu-*

1 *lations to establish additional requirements for a*
2 *community health insurance option.*

3 *(B) APPLICABILITY.—Any requirement pro-*
4 *mulgated under subparagraph (A) shall be appli-*
5 *cable to such option beginning 90 days after the*
6 *date on which the regulation involved becomes*
7 *final.*

8 *(c) START-UP FUND.—*

9 *(1) ESTABLISHMENT OF FUND.—*

10 *(A) IN GENERAL.—There is established in*
11 *the Treasury of the United States a trust fund*
12 *to be known as the “Health Benefit Plan Start-*
13 *Up Fund” (referred to in this section as the*
14 *“Start-Up Fund”), that shall consist of such*
15 *amounts as may be appropriated or credited to*
16 *the Start-Up Fund as provided for in this sub-*
17 *section to provide loans for the initial operations*
18 *of a community health insurance option. Such*
19 *amounts shall remain available until expended.*

20 *(B) FUNDING.—There is hereby appro-*
21 *priated to the Start-Up Fund, out of any mon-*
22 *neys in the Treasury not otherwise appropriated*
23 *an amount requested by the Secretary of Health*
24 *and Human Services as necessary to—*

1 (i) *pay the start-up costs associated*
2 *with the initial operations of a community*
3 *health insurance option; and*

4 (ii) *pay the costs of making payments*
5 *on claims submitted during the period that*
6 *is not more than 90 days from the date on*
7 *which such option is offered.*

8 (2) *USE OF START-UP FUND.—The Secretary*
9 *shall use amounts contained in the Start-Up Fund to*
10 *make payments (subject to the repayment require-*
11 *ments in paragraph (4)) for the purposes described in*
12 *paragraph (1)(B).*

13 (3) *PASS THROUGH OF REBATES.—The Sec-*
14 *retary may establish procedures for reducing the*
15 *amount of payments to a contracting administrator*
16 *to take into account any rebates or price concessions.*

17 (4) *REPAYMENT.—*

18 (A) *IN GENERAL.—A community health in-*
19 *surance option shall be required to repay the*
20 *Secretary of the Treasury (on such terms as the*
21 *Secretary may require) for any payments made*
22 *under paragraph (1)(B) by the date that is not*
23 *later than 9 years after the date on which the*
24 *payment is made. The Secretary may require the*
25 *payment of interest with respect to such repay-*

1 *ments at rates that do not exceed the market in-*
2 *terest rate (as determined by the Secretary).*

3 *(B) SANCTIONS IN CASE OF FOR-PROFIT*
4 *CONVERSION.—In any case in which the Sec-*
5 *retary enters into a contract with a qualified en-*
6 *tity for the offering of a community health in-*
7 *surance option and such entity is determined to*
8 *be a for-profit entity by the Secretary, such enti-*
9 *ty shall be—*

10 *(i) immediately liable to the Secretary*
11 *for any payments received by such entity*
12 *from the Start-Up Fund; and*

13 *(ii) permanently ineligible to offer a*
14 *qualified health plan.*

15 *(d) STATE ADVISORY COUNCIL.—*

16 *(1) ESTABLISHMENT.—A State (other than a*
17 *State that elects to opt out as provided for in sub-*
18 *section (a)(3)) shall establish or designate a public or*
19 *non-profit private entity to serve as the State Advi-*
20 *sory Council to provide recommendations to the Sec-*
21 *retary on the operations and policies of a community*
22 *health insurance option in the State. Such Council*
23 *shall provide recommendations on at least the fol-*
24 *lowing:*

1 (A) *policies and procedures to integrate*
2 *quality improvement and cost containment*
3 *mechanisms into the health care delivery system;*

4 (B) *mechanisms to facilitate public aware-*
5 *ness of the availability of a community health*
6 *insurance option; and*

7 (C) *alternative payment structures under a*
8 *community health insurance option for health*
9 *care providers that encourage quality improve-*
10 *ment and cost control.*

11 (2) *MEMBERS.*—*The members of the State Advi-*
12 *sory Council shall be representatives of the public and*
13 *shall include health care consumers and providers.*

14 (3) *APPLICABILITY OF RECOMMENDATIONS.*—*The*
15 *Secretary may apply the recommendations of a State*
16 *Advisory Council to a community health insurance*
17 *option in that State, in any other State, or in all*
18 *States.*

19 (e) *AUTHORITY TO CONTRACT; TERMS OF CON-*
20 *TRACT.*—

21 (1) *AUTHORITY.*—

22 (A) *IN GENERAL.*—*The Secretary may enter*
23 *into a contract or contracts with one or more*
24 *qualified entities for the purpose of performing*
25 *administrative functions (including functions de-*

1 scribed in subsection (a)(4) of section 1874A of
2 the Social Security Act) with respect to a com-
3 munity health insurance option in the same
4 manner as the Secretary may enter into con-
5 tracts under subsection (a)(1) of such section.
6 The Secretary shall have the same authority with
7 respect to a community health insurance option
8 under this section as the Secretary has under
9 subsections (a)(1) and (b) of section 1874A of the
10 Social Security Act with respect to title XVIII of
11 such Act.

12 (B) *REQUIREMENTS APPLY.*—If the Sec-
13 retary enters into a contract with a qualified en-
14 tity to offer a community health insurance op-
15 tion, under such contract such entity—

16 (i) shall meet the criteria established
17 under paragraph (2); and

18 (ii) shall receive an administrative fee
19 under paragraph (7).

20 (C) *LIMITATION.*—Contracts under this sub-
21 section shall not involve the transfer of insurance
22 risk to the contracting administrator.

23 (D) *REFERENCE.*—An entity with which
24 the Secretary has entered into a contract under

1 *this paragraph shall be referred to as a “con-*
2 *tracting administrator”.*

3 (2) *QUALIFIED ENTITY.—To be qualified to be*
4 *selected by the Secretary to offer a community health*
5 *insurance option, an entity shall—*

6 (A) *meet the criteria established under sec-*
7 *tion 1874A(a)(2) of the Social Security Act;*

8 (B) *be a nonprofit entity for purposes of of-*
9 *fering such option;*

10 (C) *meet the solvency standards applicable*
11 *under subsection (b)(7);*

12 (D) *be eligible to offer health insurance or*
13 *health benefits coverage;*

14 (E) *meet quality standards specified by the*
15 *Secretary;*

16 (F) *have in place effective procedures to*
17 *control fraud, abuse, and waste; and*

18 (G) *meet such other requirements as the*
19 *Secretary may impose.*

20 *Procedures described under subparagraph (F) shall*
21 *include the implementation of procedures to use bene-*
22 *ficiary identifiers to identify individuals entitled to*
23 *benefits so that such an individual’s social security*
24 *account number is not used, and shall also include*
25 *procedures for the use of technology (including front-*

1 *end, prepayment intelligent data-matching technology*
2 *similar to that used by hedge funds, investment funds,*
3 *and banks) to provide real-time data analysis of*
4 *claims for payment under this title to identify and*
5 *investigate unusual billing or order practices under*
6 *this title that could indicate fraud or abuse.*

7 (3) *TERM.—A contract provided for under para-*
8 *graph (1) shall be for a term of at least 5 years but*
9 *not more than 10 years, as determined by the Sec-*
10 *retary. At the end of each such term, the Secretary*
11 *shall conduct a competitive bidding process for the*
12 *purposes of renewing existing contracts or selecting*
13 *new qualified entities with which to enter into con-*
14 *tracts under such paragraph.*

15 (4) *LIMITATION.—A contract may not be re-*
16 *newed under this subsection unless the Secretary de-*
17 *termines that the contracting administrator has met*
18 *performance requirements established by the Secretary*
19 *in the areas described in paragraph (7)(B).*

20 (5) *AUDITS.—The Inspector General shall con-*
21 *duct periodic audits with respect to contracting ad-*
22 *ministrators under this subsection to ensure that the*
23 *administrator involved is in compliance with this sec-*
24 *tion.*

1 (6) *REVOCATION.*—*A contract awarded under*
2 *this subsection shall be revoked by the Secretary, upon*
3 *the recommendation of the Inspector General, only*
4 *after notice to the contracting administrator involved*
5 *and an opportunity for a hearing. The Secretary may*
6 *revoke such contract if the Secretary determines that*
7 *such administrator has engaged in fraud, deception,*
8 *waste, abuse of power, negligence, mismanagement of*
9 *taxpayer dollars, or gross mismanagement. An entity*
10 *that has had a contract revoked under this paragraph*
11 *shall not be qualified to enter into a subsequent con-*
12 *tract under this subsection.*

13 (7) *FEE FOR ADMINISTRATION.*—

14 (A) *IN GENERAL.*—*The Secretary shall pay*
15 *the contracting administrator a fee for the man-*
16 *agement, administration, and delivery of the*
17 *benefits under this section.*

18 (B) *REQUIREMENT FOR HIGH QUALITY AD-*
19 *MINISTRATION.*—*The Secretary may increase the*
20 *fee described in subparagraph (A) by not more*
21 *than 10 percent, or reduce the fee described in*
22 *subparagraph (A) by not more than 50 percent,*
23 *based on the extent to which the contracting ad-*
24 *ministrator, in the determination of the Sec-*
25 *retary, meets performance requirements estab-*

1 *lished by the Secretary, in at least the following*
2 *areas:*

3 *(i) Maintaining low premium costs*
4 *and low cost sharing requirements, provided*
5 *that such requirements are consistent with*
6 *section 1302.*

7 *(ii) Reducing administrative costs and*
8 *promoting administrative simplification for*
9 *beneficiaries.*

10 *(iii) Promoting high quality clinical*
11 *care.*

12 *(iv) Providing high quality customer*
13 *service to beneficiaries.*

14 *(C) NON-RENEWAL.—The Secretary may*
15 *not renew a contract to offer a community health*
16 *insurance option under this section with any*
17 *contracting entity that has been assessed more*
18 *than one reduction under subparagraph (B) dur-*
19 *ing the contract period.*

20 *(8) LIMITATION.—Notwithstanding the terms of*
21 *a contract under this subsection, the Secretary shall*
22 *negotiate the reimbursement rates for purposes of sub-*
23 *section (b)(6).*

24 *(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—*

1 (1) *IN GENERAL.*—*On an annual basis, the Sec-*
2 *retary shall conduct a study on the solvency of a com-*
3 *munity health insurance option and submit to Con-*
4 *gress a report describing the results of such study.*

5 (2) *RESULT.*—*If, in any year, the result of the*
6 *study under paragraph (1) is that a community*
7 *health insurance option is insolvent, such result shall*
8 *be treated as a community health insurance option*
9 *solvency warning.*

10 (3) *SUBMISSION OF PLAN AND PROCEDURE.*—

11 (A) *IN GENERAL.*—*If there is a community*
12 *health insurance option solvency warning under*
13 *paragraph (2) made in a year, the President*
14 *shall submit to Congress, within the 15-day pe-*
15 *riod beginning on the date of the budget submis-*
16 *sion to Congress under section 1105(a) of title*
17 *31, United States Code, for the succeeding year,*
18 *proposed legislation to respond to such warning.*

19 (B) *PROCEDURE.*—*In the case of a legisla-*
20 *tive proposal submitted by the President pursu-*
21 *ant to subparagraph (A), such proposal shall be*
22 *considered by Congress using the same proce-*
23 *dures described under sections 803 and 804 of*
24 *the Medicare Prescription Drug, Improvement,*

1 *and Modernization Act of 2003 that shall be used*
2 *for a medicare funding warning.*

3 *(g) MARKETING PARITY.—In a facility controlled by*
4 *the Federal Government, or by a State, where marketing*
5 *or promotional materials related to a community health in-*
6 *surance option are made available to the public, making*
7 *available marketing or promotional materials relating to*
8 *private health insurance plans shall not be prohibited. Such*
9 *materials include informational pamphlets, guidebooks, en-*
10 *rollment forms, or other materials determined reasonable*
11 *for display.*

12 *(h) AUTHORIZATION OF APPROPRIATIONS.—There is*
13 *authorized to be appropriated such sums as may be nec-*
14 *essary to carry out this section.*

15 **SEC. 1324. LEVEL PLAYING FIELD.**

16 *(a) IN GENERAL.—Notwithstanding any other provi-*
17 *sion of law, any health insurance coverage offered by a pri-*
18 *vate health insurance issuer shall not be subject to any Fed-*
19 *eral or State law described in subsection (b) if a qualified*
20 *health plan offered under the Consumer Operated and Ori-*
21 *ented Plan program under section 1322, a community*
22 *health insurance option under section 1323, or a nation-*
23 *wide qualified health plan under section 1333(b), is not sub-*
24 *ject to such law.*

1 **(b) LAWS DESCRIBED.**—*The Federal and State laws*
 2 *described in this subsection are those Federal and State*
 3 *laws relating to—*

- 4 (1) *guaranteed renewal;*
 5 (2) *rating;*
 6 (3) *preexisting conditions;*
 7 (4) *non-discrimination;*
 8 (5) *quality improvement and reporting;*
 9 (6) *fraud and abuse;*
 10 (7) *solvency and financial requirements;*
 11 (8) *market conduct;*
 12 (9) *prompt payment;*
 13 (10) *appeals and grievances;*
 14 (11) *privacy and confidentiality;*
 15 (12) *licensure; and*
 16 (13) *benefit plan material or information.*

17 **PART IV—STATE FLEXIBILITY TO ESTABLISH**

18 **ALTERNATIVE PROGRAMS**

19 **SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC**
 20 **HEALTH PROGRAMS FOR LOW-INCOME INDI-**
 21 **VIDUALS NOT ELIGIBLE FOR MEDICAID.**

22 **(a) ESTABLISHMENT OF PROGRAM.**—

23 (1) **IN GENERAL.**—*The Secretary shall establish*
 24 *a basic health program meeting the requirements of*
 25 *this section under which a State may enter into con-*

1 *tracts to offer 1 or more standard health plans pro-*
2 *viding at least the essential health benefits described*
3 *in section 1302(b) to eligible individuals in lieu of of-*
4 *fering such individuals coverage through an Ex-*
5 *change.*

6 (2) *CERTIFICATIONS AS TO BENEFIT COVERAGE*
7 *AND COSTS.*—*Such program shall provide that a*
8 *State may not establish a basic health program under*
9 *this section unless the State establishes to the satisfac-*
10 *tion of the Secretary, and the Secretary certifies,*
11 *that—*

12 (A) *in the case of an eligible individual en-*
13 *rolled in a standard health plan offered through*
14 *the program, the State provides—*

15 (i) *that the amount of the monthly pre-*
16 *mium an eligible individual is required to*
17 *pay for coverage under the standard health*
18 *plan for the individual and the individual's*
19 *dependents does not exceed the amount of*
20 *the monthly premium that the eligible indi-*
21 *vidual would have been required to pay (in*
22 *the rating area in which the individual re-*
23 *sides) if the individual had enrolled in the*
24 *applicable second lowest cost silver plan (as*
25 *defined in section 36B(b)(3)(B) of the Inter-*

1 *nal Revenue Code of 1986) offered to the in-*
2 *dividual through an Exchange; and*

3 *(ii) that the cost-sharing an eligible in-*
4 *dividual is required to pay under the stand-*
5 *ard health plan does not exceed—*

6 *(I) the cost-sharing required*
7 *under a platinum plan in the case of*
8 *an eligible individual with household*
9 *income not in excess of 150 percent of*
10 *the poverty line for the size of the fam-*
11 *ily involved; and*

12 *(II) the cost-sharing required*
13 *under a gold plan in the case of an eli-*
14 *gible individual not described in sub-*
15 *clause (I); and*

16 *(B) the benefits provided under the stand-*
17 *ard health plans offered through the program*
18 *cover at least the essential health benefits de-*
19 *scribed in section 1302(b).*

20 *For purposes of subparagraph (A)(i), the amount of*
21 *the monthly premium an individual is required to*
22 *pay under either the standard health plan or the ap-*
23 *plicable second lowest cost silver plan shall be deter-*
24 *mined after reduction for any premium tax credits*

1 *and cost-sharing reductions allowable with respect to*
2 *either plan.*

3 **(b) STANDARD HEALTH PLAN.**—*In this section, the*
4 *term “standard health plan” means a health benefits plan*
5 *that the State contracts with under this section—*

6 *(1) under which the only individuals eligible to*
7 *enroll are eligible individuals;*

8 *(2) that provides at least the essential health ben-*
9 *efits described in section 1302(b); and*

10 *(3) in the case of a plan that provides health in-*
11 *surance coverage offered by a health insurance issuer,*
12 *that has a medical loss ratio of at least 85 percent.*

13 **(c) CONTRACTING PROCESS.**—

14 **(1) IN GENERAL.**—*A State basic health program*
15 *shall establish a competitive process for entering into*
16 *contracts with standard health plans under subsection*
17 *(a), including negotiation of premiums and cost-shar-*
18 *ing and negotiation of benefits in addition to the es-*
19 *sential health benefits described in section 1302(b).*

20 **(2) SPECIFIC ITEMS TO BE CONSIDERED.**—*A*
21 *State shall, as part of its competitive process under*
22 *paragraph (1), include at least the following:*

23 **(A) INNOVATION.**—*Negotiation with offerors*
24 *of a standard health plan for the inclusion of in-*
25 *novative features in the plan, including—*

1 (i) care coordination and care manage-
2 ment for enrollees, especially for those with
3 chronic health conditions;

4 (ii) incentives for use of preventive
5 services; and

6 (iii) the establishment of relationships
7 between providers and patients that maxi-
8 mize patient involvement in health care de-
9 cision-making, including providing incen-
10 tives for appropriate utilization under the
11 plan.

12 (B) *HEALTH AND RESOURCE DIF-*
13 *FERENCES.*—Consideration of, and the making
14 of suitable allowances for, differences in health
15 care needs of enrollees and differences in local
16 availability of, and access to, health care pro-
17 viders. Nothing in this subparagraph shall be
18 construed as allowing discrimination on the
19 basis of pre-existing conditions or other health
20 status-related factors.

21 (C) *MANAGED CARE.*—Contracting with
22 managed care systems, or with systems that offer
23 as many of the attributes of managed care as are
24 feasible in the local health care market.

1 (D) *PERFORMANCE MEASURES.*—*Estab-*
2 *lishing specific performance measures and stand-*
3 *ards for issuers of standard health plans that*
4 *focus on quality of care and improved health*
5 *outcomes, requiring such plans to report to the*
6 *State with respect to the measures and stand-*
7 *ards, and making the performance and quality*
8 *information available to enrollees in a useful*
9 *form.*

10 (3) *ENHANCED AVAILABILITY.*—

11 (A) *MULTIPLE PLANS.*—*A State shall, to the*
12 *maximum extent feasible, seek to make multiple*
13 *standard health plans available to eligible indi-*
14 *viduals within a State to ensure individuals*
15 *have a choice of such plans.*

16 (B) *REGIONAL COMPACTS.*—*A State may*
17 *negotiate a regional compact with other States to*
18 *include coverage of eligible individuals in all*
19 *such States in agreements with issuers of stand-*
20 *ard health plans.*

21 (4) *COORDINATION WITH OTHER STATE PRO-*
22 *GRAMS.*—*A State shall seek to coordinate the admin-*
23 *istration of, and provision of benefits under, its pro-*
24 *gram under this section with the State medicaid pro-*
25 *gram under title XIX of the Social Security Act, the*

1 *State child health plan under title XXI of such Act,*
2 *and other State-administered health programs to*
3 *maximize the efficiency of such programs and to im-*
4 *prove the continuity of care.*

5 *(d) TRANSFER OF FUNDS TO STATES.—*

6 *(1) IN GENERAL.—If the Secretary determines*
7 *that a State electing the application of this section*
8 *meets the requirements of the program established*
9 *under subsection (a), the Secretary shall transfer to*
10 *the State for each fiscal year for which 1 or more*
11 *standard health plans are operating within the State*
12 *the amount determined under paragraph (3).*

13 *(2) USE OF FUNDS.—A State shall establish a*
14 *trust for the deposit of the amounts received under*
15 *paragraph (1) and amounts in the trust fund shall*
16 *only be used to reduce the premiums and cost-sharing*
17 *of, or to provide additional benefits for, eligible indi-*
18 *viduals enrolled in standard health plans within the*
19 *State. Amounts in the trust fund, and expenditures of*
20 *such amounts, shall not be included in determining*
21 *the amount of any non-Federal funds for purposes of*
22 *meeting any matching or expenditure requirement of*
23 *any federally-funded program.*

24 *(3) AMOUNT OF PAYMENT.—*

25 *(A) SECRETARIAL DETERMINATION.—*

1 (i) *IN GENERAL.*—*The amount deter-*
2 *mined under this paragraph for any fiscal*
3 *year is the amount the Secretary determines*
4 *is equal to 85 percent of the premium tax*
5 *credits under section 36B of the Internal*
6 *Revenue Code of 1986, and the cost-sharing*
7 *reductions under section 1402, that would*
8 *have been provided for the fiscal year to eli-*
9 *gible individuals enrolled in standard*
10 *health plans in the State if such eligible in-*
11 *dividuals were allowed to enroll in qualified*
12 *health plans through an Exchange estab-*
13 *lished under this subtitle.*

14 (ii) *SPECIFIC REQUIREMENTS.*—*The*
15 *Secretary shall make the determination*
16 *under clause (i) on a per enrollee basis and*
17 *shall take into account all relevant factors*
18 *necessary to determine the value of the pre-*
19 *mium tax credits and cost-sharing reduc-*
20 *tions that would have been provided to eli-*
21 *gible individuals described in clause (i), in-*
22 *cluding the age and income of the enrollee,*
23 *whether the enrollment is for self-only or*
24 *family coverage, geographic differences in*
25 *average spending for health care across rat-*

1 *ing areas, the health status of the enrollee*
2 *for purposes of determining risk adjustment*
3 *payments and reinsurance payments that*
4 *would have been made if the enrollee had*
5 *enrolled in a qualified health plan through*
6 *an Exchange, and whether any reconcili-*
7 *ation of the credit or cost-sharing reductions*
8 *would have occurred if the enrollee had been*
9 *so enrolled. This determination shall take*
10 *into consideration the experience of other*
11 *States with respect to participation in an*
12 *Exchange and such credits and reductions*
13 *provided to residents of the other States,*
14 *with a special focus on enrollees with in-*
15 *come below 200 percent of poverty.*

16 *(iii) CERTIFICATION.—The Chief Actua-*
17 *ry of the Centers for Medicare & Medicaid*
18 *Services, in consultation with the Office of*
19 *Tax Analysis of the Department of the*
20 *Treasury, shall certify whether the method-*
21 *ology used to make determinations under*
22 *this subparagraph, and such determina-*
23 *tions, meet the requirements of clause (ii).*
24 *Such certifications shall be based on suffi-*
25 *cient data from the State and from com-*

1 *parable States about their experience with*
2 *programs created by this Act.*

3 (B) *CORRECTIONS.*—*The Secretary shall ad-*
4 *just the payment for any fiscal year to reflect*
5 *any error in the determinations under subpara-*
6 *graph (A) for any preceding fiscal year.*

7 (4) *APPLICATION OF SPECIAL RULES.*—*The pro-*
8 *visions of section 1303 shall apply to a State basic*
9 *health program, and to standard health plans offered*
10 *through such program, in the same manner as such*
11 *rules apply to qualified health plans.*

12 (e) *ELIGIBLE INDIVIDUAL.*—

13 (1) *IN GENERAL.*—*In this section, the term “eli-*
14 *gible individual” means, with respect to any State,*
15 *an individual—*

16 (A) *who a resident of the State who is not*
17 *eligible to enroll in the State’s medicaid program*
18 *under title XIX of the Social Security Act for*
19 *benefits that at a minimum consist of the essen-*
20 *tial health benefits described in section 1302(b);*

21 (B) *whose household income exceeds 133*
22 *percent but does not exceed 200 percent of the*
23 *poverty line for the size of the family involved;*

24 (C) *who is not eligible for minimum essen-*
25 *tial coverage (as defined in section 5000A(f) of*

1 *the Internal Revenue Code of 1986) or is eligible*
2 *for an employer-sponsored plan that is not af-*
3 *fordable coverage (as determined under section*
4 *5000A(e)(2) of such Code); and*

5 *(D) who has not attained age 65 as of the*
6 *beginning of the plan year.*

7 *Such term shall not include any individual who is*
8 *not a qualified individual under section 1312 who is*
9 *eligible to be covered by a qualified health plan of-*
10 *fered through an Exchange.*

11 *(2) ELIGIBLE INDIVIDUALS MAY NOT USE EX-*
12 *CHANGE.—An eligible individual shall not be treated*
13 *as a qualified individual under section 1312 eligible*
14 *for enrollment in a qualified health plan offered*
15 *through an Exchange established under section 1311.*

16 *(f) SECRETARIAL OVERSIGHT.—The Secretary shall*
17 *each year conduct a review of each State program to ensure*
18 *compliance with the requirements of this section, including*
19 *ensuring that the State program meets—*

20 *(1) eligibility verification requirements for par-*
21 *ticipation in the program;*

22 *(2) the requirements for use of Federal funds re-*
23 *ceived by the program; and*

24 *(3) the quality and performance standards under*
25 *this section.*

1 (g) *STANDARD HEALTH PLAN OFFERORS.*—A State
2 may provide that persons eligible to offer standard health
3 plans under a basic health program established under this
4 section may include a licensed health maintenance organi-
5 zation, a licensed health insurance insurer, or a network
6 of health care providers established to offer services under
7 the program.

8 (h) *DEFINITIONS.*—Any term used in this section
9 which is also used in section 36B of the Internal Revenue
10 Code of 1986 shall have the meaning given such term by
11 such section.

12 **SEC. 1332. WAIVER FOR STATE INNOVATION.**

13 (a) *APPLICATION.*—

14 (1) *IN GENERAL.*—A State may apply to the
15 Secretary for the waiver of all or any requirements
16 described in paragraph (2) with respect to health in-
17 surance coverage within that State for plan years be-
18 ginning on or after January 1, 2017. Such applica-
19 tion shall—

20 (A) be filed at such time and in such man-
21 ner as the Secretary may require;

22 (B) contain such information as the Sec-
23 retary may require, including—

24 (i) a comprehensive description of the
25 State legislation and program to implement

1 *a plan meeting the requirements for a waiver*
2 *under this section; and*

3 *(ii) a 10-year budget plan for such*
4 *plan that is budget neutral for the Federal*
5 *Government; and*

6 *(C) provide an assurance that the State has*
7 *enacted the law described in subsection (b)(2).*

8 (2) *REQUIREMENTS.—The requirements de-*
9 *scribed in this paragraph with respect to health in-*
10 *surance coverage within the State for plan years be-*
11 *ginning on or after January 1, 2014, are as follows:*

12 *(A) Part I of subtitle D.*

13 *(B) Part II of subtitle D.*

14 *(C) Section 1402.*

15 *(D) Sections 36B, 4980H, and 5000A of the*
16 *Internal Revenue Code of 1986.*

17 (3) *PASS THROUGH OF FUNDING.—With respect*
18 *to a State waiver under paragraph (1), under which,*
19 *due to the structure of the State plan, individuals and*
20 *small employers in the State would not qualify for the*
21 *premium tax credits, cost-sharing reductions, or small*
22 *business credits under sections 36B of the Internal*
23 *Revenue Code of 1986 or under part I of subtitle E*
24 *for which they would otherwise be eligible, the Sec-*
25 *retary shall provide for an alternative means by*

1 *which the aggregate amount of such credits or reduc-*
2 *tions that would have been paid on behalf of partici-*
3 *pants in the Exchanges established under this title*
4 *had the State not received such waiver, shall be paid*
5 *to the State for purposes of implementing the State*
6 *plan under the waiver. Such amount shall be deter-*
7 *mined annually by the Secretary, taking into consid-*
8 *eration the experience of other States with respect to*
9 *participation in an Exchange and credits and reduc-*
10 *tions provided under such provisions to residents of*
11 *the other States.*

12 (4) *WAIVER CONSIDERATION AND TRANS-*
13 *PARENCY.—*

14 (A) *IN GENERAL.—An application for a*
15 *waiver under this section shall be considered by*
16 *the Secretary in accordance with the regulations*
17 *described in subparagraph (B).*

18 (B) *REGULATIONS.—Not later than 180*
19 *days after the date of enactment of this Act, the*
20 *Secretary shall promulgate regulations relating*
21 *to waivers under this section that provide—*

22 (i) *a process for public notice and com-*
23 *ment at the State level, including public*
24 *hearings, sufficient to ensure a meaningful*
25 *level of public input;*

1 (ii) a process for the submission of an
2 application that ensures the disclosure of—

3 (I) the provisions of law that the
4 State involved seeks to waive; and

5 (II) the specific plans of the State
6 to ensure that the waiver will be in
7 compliance with subsection (b);

8 (iii) a process for providing public no-
9 tice and comment after the application is
10 received by the Secretary, that is sufficient
11 to ensure a meaningful level of public input
12 and that does not impose requirements that
13 are in addition to, or duplicative of, re-
14 quirements imposed under the Administra-
15 tive Procedures Act, or requirements that
16 are unreasonable or unnecessarily burden-
17 some with respect to State compliance;

18 (iv) a process for the submission to the
19 Secretary of periodic reports by the State
20 concerning the implementation of the pro-
21 gram under the waiver; and

22 (v) a process for the periodic evalua-
23 tion by the Secretary of the program under
24 the waiver.

1 (C) *REPORT.*—*The Secretary shall annually*
2 *report to Congress concerning actions taken by*
3 *the Secretary with respect to applications for*
4 *waivers under this section.*

5 (5) *COORDINATED WAIVER PROCESS.*—*The Sec-*
6 *retary shall develop a process for coordinating and*
7 *consolidating the State waiver processes applicable*
8 *under the provisions of this section, and the existing*
9 *waiver processes applicable under titles XVIII, XIX,*
10 *and XXI of the Social Security Act, and any other*
11 *Federal law relating to the provision of health care*
12 *items or services. Such process shall permit a State*
13 *to submit a single application for a waiver under any*
14 *or all of such provisions.*

15 (6) *DEFINITION.*—*In this section, the term “Sec-*
16 *retary” means—*

17 (A) *the Secretary of Health and Human*
18 *Services with respect to waivers relating to the*
19 *provisions described in subparagraph (A)*
20 *through (C) of paragraph (2); and*

21 (B) *the Secretary of the Treasury with re-*
22 *spect to waivers relating to the provisions de-*
23 *scribed in paragraph (2)(D).*

24 (b) *GRANTING OF WAIVERS.*—

1 (1) *IN GENERAL.*—*The Secretary may grant a*
2 *request for a waiver under subsection (a)(1) only if*
3 *the Secretary determines that the State plan—*

4 (A) *will provide coverage that is at least as*
5 *comprehensive as the coverage defined in section*
6 *1302(b) and offered through Exchanges estab-*
7 *lished under this title as certified by Office of the*
8 *Actuary of the Centers for Medicare & Medicaid*
9 *Services based on sufficient data from the State*
10 *and from comparable States about their experi-*
11 *ence with programs created by this Act and the*
12 *provisions of this Act that would be waived;*

13 (B) *will provide coverage and cost sharing*
14 *protections against excessive out-of-pocket spend-*
15 *ing that are at least as affordable as the provi-*
16 *sions of this title would provide;*

17 (C) *will provide coverage to at least a com-*
18 *parable number of its residents as the provisions*
19 *of this title would provide; and*

20 (D) *will not increase the Federal deficit.*

21 (2) *REQUIREMENT TO ENACT A LAW.*—

22 (A) *IN GENERAL.*—*A law described in this*
23 *paragraph is a State law that provides for State*
24 *actions under a waiver under this section, in-*

1 *cluding the implementation of the State plan*
2 *under subsection (a)(1)(B).*

3 *(B) TERMINATION OF OPT OUT.—A State*
4 *may repeal a law described in subparagraph (A)*
5 *and terminate the authority provided under the*
6 *waiver with respect to the State.*

7 *(c) SCOPE OF WAIVER.—*

8 *(1) IN GENERAL.—The Secretary shall determine*
9 *the scope of a waiver of a requirement described in*
10 *subsection (a)(2) granted to a State under subsection*
11 *(a)(1).*

12 *(2) LIMITATION.—The Secretary may not waive*
13 *under this section any Federal law or requirement*
14 *that is not within the authority of the Secretary.*

15 *(d) DETERMINATIONS BY SECRETARY.—*

16 *(1) TIME FOR DETERMINATION.—The Secretary*
17 *shall make a determination under subsection (a)(1)*
18 *not later than 180 days after the receipt of an appli-*
19 *cation from a State under such subsection.*

20 *(2) EFFECT OF DETERMINATION.—*

21 *(A) GRANTING OF WAIVERS.—If the Sec-*
22 *retary determines to grant a waiver under sub-*
23 *section (a)(1), the Secretary shall notify the*
24 *State involved of such determination and the*
25 *terms and effectiveness of such waiver.*

1 (B) *DENIAL OF WAIVER.*—*If the Secretary*
2 *determines a waiver should not be granted under*
3 *subsection (a)(1), the Secretary shall notify the*
4 *State involved, and the appropriate committees*
5 *of Congress of such determination and the rea-*
6 *sons therefore.*

7 (e) *TERM OF WAIVER.*—*No waiver under this section*
8 *may extend over a period of longer than 5 years unless the*
9 *State requests continuation of such waiver, and such request*
10 *shall be deemed granted unless the Secretary, within 90*
11 *days after the date of its submission to the Secretary, either*
12 *denies such request in writing or informs the State in writ-*
13 *ing with respect to any additional information which is*
14 *needed in order to make a final determination with respect*
15 *to the request.*

16 **SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS**
17 **IN MORE THAN ONE STATE.**

18 (a) *HEALTH CARE CHOICE COMPACTS.*—

19 (1) *IN GENERAL.*—*Not later than July 1, 2013,*
20 *the Secretary shall, in consultation with the National*
21 *Association of Insurance Commissioners, issue regula-*
22 *tions for the creation of health care choice compacts*
23 *under which 2 or more States may enter into an*
24 *agreement under which—*

1 (A) 1 or more qualified health plans could
2 be offered in the individual markets in all such
3 States but, except as provided in subparagraph
4 (B), only be subject to the laws and regulations
5 of the State in which the plan was written or
6 issued;

7 (B) the issuer of any qualified health plan
8 to which the compact applies—

9 (i) would continue to be subject to
10 market conduct, unfair trade practices, net-
11 work adequacy, and consumer protection
12 standards (including standards relating to
13 rating), including addressing disputes as to
14 the performance of the contract, of the State
15 in which the purchaser resides;

16 (ii) would be required to be licensed in
17 each State in which it offers the plan under
18 the compact or to submit to the jurisdiction
19 of each such State with regard to the stand-
20 ards described in clause (i) (including al-
21 lowing access to records as if the insurer
22 were licensed in the State); and

23 (iii) must clearly notify consumers
24 that the policy may not be subject to all the

1 *laws and regulations of the State in which*
2 *the purchaser resides.*

3 (2) *STATE AUTHORITY.—A State may not enter*
4 *into an agreement under this subsection unless the*
5 *State enacts a law after the date of the enactment of*
6 *this title that specifically authorizes the State to enter*
7 *into such agreements.*

8 (3) *APPROVAL OF COMPACTS.—The Secretary*
9 *may approve interstate health care choice compacts*
10 *under paragraph (1) only if the Secretary determines*
11 *that such health care choice compact—*

12 *(A) will provide coverage that is at least as*
13 *comprehensive as the coverage defined in section*
14 *1302(b) and offered through Exchanges estab-*
15 *lished under this title;*

16 *(B) will provide coverage and cost sharing*
17 *protections against excessive out-of-pocket spend-*
18 *ing that are at least as affordable as the provi-*
19 *sions of this title would provide;*

20 *(C) will provide coverage to at least a com-*
21 *parable number of its residents as the provisions*
22 *of this title would provide;*

23 *(D) will not increase the Federal deficit;*
24 *and*

1 (E) will not weaken enforcement of laws
2 and regulations described in paragraph (1)(B)(i)
3 in any State that is included in such compact.

4 (4) *EFFECTIVE DATE.*—A health care choice com-
5 pact described in paragraph (1) shall not take effect
6 before January 1, 2016.

7 (b) *AUTHORITY FOR NATIONWIDE PLANS.*—

8 (1) *IN GENERAL.*—Except as provided in para-
9 graph (2), if an issuer (including a group of health
10 insurance issuers affiliated either by common owner-
11 ship and control or by the common use of a nation-
12 ally licensed service mark) of a qualified health plan
13 in the individual or small group market meets the re-
14 quirements of this subsection (in this subsection a
15 “nationwide qualified health plan”)—

16 (A) the issuer of the plan may offer the na-
17 tionwide qualified health plan in the individual
18 or small group market in more than 1 State;
19 and

20 (B) with respect to State laws mandating
21 benefit coverage by a health plan, only the State
22 laws of the State in which such plan is written
23 or issued shall apply to the nationwide qualified
24 health plan.

1 (2) *STATE OPT-OUT.*—A State may, by specific
2 reference in a law enacted after the date of enactment
3 of this title, provide that this subsection shall not
4 apply to that State. Such opt-out shall be effective
5 until such time as the State by law revokes it.

6 (3) *PLAN REQUIREMENTS.*—An issuer meets the
7 requirements of this subsection with respect to a na-
8 tionwide qualified health plan if, in the determina-
9 tion of the Secretary—

10 (A) the plan offers a benefits package that
11 is uniform in each State in which the plan is of-
12 fered and meets the requirements set forth in
13 paragraphs (4) through (6);

14 (B) the issuer is licensed in each State in
15 which it offers the plan and is subject to all re-
16 quirements of State law not inconsistent with
17 this section, including but not limited to, the
18 standards and requirements that a State imposes
19 that do not prevent the application of a require-
20 ment of part A of title XXVII of the Public
21 Health Service Act or a requirement of this title;

22 (C) the issuer meets all requirements of this
23 title with respect to a qualified health plan, in-
24 cluding the requirement to offer the silver and

1 *gold levels of the plan in each Exchange in the*
2 *State for the market in which the plan is offered;*

3 *(D) the issuer determines the premiums for*
4 *the plan in any State on the basis of the rating*
5 *rules in effect in that State for the rating areas*
6 *in which it is offered;*

7 *(E) the issuer offers the nationwide quali-*
8 *fied health plan in at least 60 percent of the par-*
9 *ticipating States in the first year in which the*
10 *plan is offered, 65 percent of such States in the*
11 *second year, 70 percent of such States in the*
12 *third year, 75 percent of such States in the*
13 *fourth year, and 80 percent of such States in the*
14 *fifth and subsequent years;*

15 *(F) the issuer shall offer the plan in partici-*
16 *pating States across the country, in all geo-*
17 *graphic regions, and in all States that have*
18 *adopted adjusted community rating before the*
19 *date of enactment of this Act; and*

20 *(G) the issuer clearly notifies consumers*
21 *that the policy may not contain some benefits*
22 *otherwise mandated for plans in the State in*
23 *which the purchaser resides and provides a de-*
24 *tailed statement of the benefits offered and the*

1 *benefit differences in that State, in accordance*
2 *with rules promulgated by the Secretary.*

3 (4) *FORM REVIEW FOR NATIONWIDE PLANS.—*
4 *Notwithstanding any contrary provision of State law,*
5 *at least 3 months before any nationwide qualified*
6 *health plan is offered, the issuer shall file all nation-*
7 *wide qualified health plan forms with the regulator in*
8 *each participating State in which the plan will be of-*
9 *fered. An issuer may appeal the disapproval of a na-*
10 *tionwide qualified health plan form to the Secretary.*

11 (5) *APPLICABLE RULES.—The Secretary shall, in*
12 *consultation with the National Association of Insur-*
13 *ance Commissioners, issue rules for the offering of na-*
14 *tionwide qualified health plans under this subsection.*
15 *Nationwide qualified health plans may be offered only*
16 *after such rules have taken effect.*

17 (6) *COVERAGE.—The Secretary shall provide*
18 *that the health benefits coverage provided to an indi-*
19 *vidual through a nationwide qualified health plan*
20 *under this subsection shall include at least the essen-*
21 *tial benefits package described in section 1302.*

22 (7) *STATE LAW MANDATING BENEFIT COVERAGE*
23 *BY A HEALTH BENEFITS PLAN.—For the purposes of*
24 *this subsection, a State law mandating benefit cov-*
25 *erage by a health plan is a law that mandates health*

1 *insurance coverage or the offer of health insurance*
2 *coverage for specific health services or specific dis-*
3 *eases. A law that mandates health insurance coverage*
4 *or reimbursement for services provided by certain*
5 *classes of providers of health care services, or a law*
6 *that mandates that certain classes of individuals must*
7 *be covered as a group or as dependents, is not a State*
8 *law mandating benefit coverage by a health benefits*
9 *plan.*

10 **PART V—REINSURANCE AND RISK ADJUSTMENT**

11 **SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR IN-**
12 **DIVIDUAL AND SMALL GROUP MARKETS IN**
13 **EACH STATE.**

14 *(a) IN GENERAL.—Each State shall, not later than*
15 *January 1, 2014—*

16 *(1) include in the Federal standards or State*
17 *law or regulation the State adopts and has in effect*
18 *under section 1321(b) the provisions described in sub-*
19 *section (b); and*

20 *(2) establish (or enter into a contract with) 1 or*
21 *more applicable reinsurance entities to carry out the*
22 *reinsurance program under this section.*

23 *(b) MODEL REGULATION.—*

24 *(1) IN GENERAL.—In establishing the Federal*
25 *standards under section 1321(a), the Secretary, in*

1 *consultation with the National Association of Insur-*
2 *ance Commissioners (the “NAIC”), shall include pro-*
3 *visions that enable States to establish and maintain*
4 *a program under which—*

5 *(A) health insurance issuers, and third*
6 *party administrators on behalf of group health*
7 *plans, are required to make payments to an ap-*
8 *plicable reinsurance entity for any plan year be-*
9 *ginning in the 3-year period beginning January*
10 *1, 2014 (as specified in paragraph (3)); and*

11 *(B) the applicable reinsurance entity col-*
12 *lects payments under subparagraph (A) and uses*
13 *amounts so collected to make reinsurance pay-*
14 *ments to health insurance issuers described in*
15 *subparagraph (A) that cover high risk individ-*
16 *uals in the individual market (excluding grand-*
17 *fathered health plans) for any plan year begin-*
18 *ning in such 3-year period.*

19 *(2) HIGH-RISK INDIVIDUAL; PAYMENT*
20 *AMOUNTS.—The Secretary shall include the following*
21 *in the provisions under paragraph (1):*

22 *(A) DETERMINATION OF HIGH-RISK INDI-*
23 *VIDUALS.—The method by which individuals will*
24 *be identified as high risk individuals for pur-*
25 *poses of the reinsurance program established*

1 *under this section. Such method shall provide for*
2 *identification of individuals as high-risk indi-*
3 *viduals on the basis of—*

4 *(i) a list of at least 50 but not more*
5 *than 100 medical conditions that are iden-*
6 *tified as high-risk conditions and that may*
7 *be based on the identification of diagnostic*
8 *and procedure codes that are indicative of*
9 *individuals with pre-existing, high-risk con-*
10 *ditions; or*

11 *(ii) any other comparable objective*
12 *method of identification recommended by*
13 *the American Academy of Actuaries.*

14 *(B) PAYMENT AMOUNT.—The formula for*
15 *determining the amount of payments that will be*
16 *paid to health insurance issuers described in*
17 *paragraph (1)(A) that insure high-risk individ-*
18 *uals. Such formula shall provide for the equitable*
19 *allocation of available funds through reconcili-*
20 *ation and may be designed—*

21 *(i) to provide a schedule of payments*
22 *that specifies the amount that will be paid*
23 *for each of the conditions identified under*
24 *subparagraph (A); or*

1 (ii) to use any other comparable meth-
2 od for determining payment amounts that
3 is recommended by the American Academy
4 of Actuaries and that encourages the use of
5 care coordination and care management
6 programs for high risk conditions.

7 (3) DETERMINATION OF REQUIRED CONTRIBU-
8 TIONS.—

9 (A) IN GENERAL.—The Secretary shall in-
10 clude in the provisions under paragraph (1) the
11 method for determining the amount each health
12 insurance issuer and group health plan described
13 in paragraph (1)(A) contributing to the reinsur-
14 ance program under this section is required to
15 contribute under such paragraph for each plan
16 year beginning in the 36-month period beginning
17 January 1, 2014. The contribution amount for
18 any plan year may be based on the percentage
19 of revenue of each issuer and the total costs of
20 providing benefits to enrollees in self-insured
21 plans or on a specified amount per enrollee and
22 may be required to be paid in advance or peri-
23 odically throughout the plan year.

24 (B) SPECIFIC REQUIREMENTS.—The method
25 under this paragraph shall be designed so that—

1 (i) *the contribution amount for each*
2 *issuer proportionally reflects each issuer's*
3 *fully insured commercial book of business*
4 *for all major medical products and the total*
5 *value of all fees charged by the issuer and*
6 *the costs of coverage administered by the*
7 *issuer as a third party administrator;*

8 (ii) *the contribution amount can in-*
9 *clude an additional amount to fund the ad-*
10 *ministrative expenses of the applicable rein-*
11 *surance entity;*

12 (iii) *the aggregate contribution*
13 *amounts for all States shall, based on the*
14 *best estimates of the NAIC and without re-*
15 *gard to amounts described in clause (ii),*
16 *equal \$10,000,000,000 for plan years begin-*
17 *ning in 2014, \$6,000,000,000 for plan years*
18 *beginning 2015, and \$4,000,000,000 for*
19 *plan years beginning in 2016; and*

20 (iv) *in addition to the aggregate con-*
21 *tribution amounts under clause (iii), each*
22 *issuer's contribution amount for any cal-*
23 *endar year under clause (iii) reflects its*
24 *proportionate share of an additional*
25 *\$2,000,000,000 for 2014, an additional*

1 \$2,000,000,000 for 2015, and an additional
2 \$1,000,000,000 for 2016.

3 *Nothing in this subparagraph shall be construed*
4 *to preclude a State from collecting additional*
5 *amounts from issuers on a voluntary basis.*

6 (4) *EXPENDITURE OF FUNDS.—The provisions*
7 *under paragraph (1) shall provide that—*

8 (A) *the contribution amounts collected for*
9 *any calendar year may be allocated and used in*
10 *any of the three calendar years for which*
11 *amounts are collected based on the reinsurance*
12 *needs of a particular period or to reflect experi-*
13 *ence in a prior period; and*

14 (B) *amounts remaining unexpended as of*
15 *December, 2016, may be used to make payments*
16 *under any reinsurance program of a State in the*
17 *individual market in effect in the 2-year period*
18 *beginning on January 1, 2017.*

19 *Notwithstanding the preceding sentence, any con-*
20 *tribution amounts described in paragraph (3)(B)(iv)*
21 *shall be deposited into the general fund of the Treas-*
22 *ury of the United States and may not be used for the*
23 *program established under this section.*

24 (c) *APPLICABLE REINSURANCE ENTITY.—For pur-*
25 *poses of this section—*

1 (1) *IN GENERAL.*—*The term “applicable reinsur-*
2 *ance entity” means a not-for-profit organization—*

3 *(A) the purpose of which is to help stabilize*
4 *premiums for coverage in the individual and*
5 *small group markets in a State during the first*
6 *3 years of operation of an Exchange for such*
7 *markets within the State when the risk of ad-*
8 *verse selection related to new rating rules and*
9 *market changes is greatest; and*

10 *(B) the duties of which shall be to carry out*
11 *the reinsurance program under this section by*
12 *coordinating the funding and operation of the*
13 *risk-spreading mechanisms designed to imple-*
14 *ment the reinsurance program.*

15 (2) *STATE DISCRETION.*—*A State may have*
16 *more than 1 applicable reinsurance entity to carry*
17 *out the reinsurance program under this section with-*
18 *in the State and 2 or more States may enter into*
19 *agreements to provide for an applicable reinsurance*
20 *entity to carry out such program in all such States.*

21 (3) *ENTITIES ARE TAX-EXEMPT.*—*An applicable*
22 *reinsurance entity established under this section shall*
23 *be exempt from taxation under chapter 1 of the Inter-*
24 *nal Revenue Code of 1986. The preceding sentence*
25 *shall not apply to the tax imposed by section 511*

1 *such Code (relating to tax on unrelated business tax-*
 2 *able income of an exempt organization).*

3 *(d) COORDINATION WITH STATE HIGH-RISK POOLS.—*
 4 *The State shall eliminate or modify any State high-risk*
 5 *pool to the extent necessary to carry out the reinsurance*
 6 *program established under this section. The State may co-*
 7 *ordinate the State high-risk pool with such program to the*
 8 *extent not inconsistent with the provisions of this section.*

9 **SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR**
 10 **PLANS IN INDIVIDUAL AND SMALL GROUP**
 11 **MARKETS.**

12 *(a) IN GENERAL.—The Secretary shall establish and*
 13 *administer a program of risk corridors for calendar years*
 14 *2014, 2015, and 2016 under which a qualified health plan*
 15 *offered in the individual or small group market shall par-*
 16 *ticipate in a payment adjustment system based on the ratio*
 17 *of the allowable costs of the plan to the plan's aggregate*
 18 *premiums. Such program shall be based on the program*
 19 *for regional participating provider organizations under*
 20 *part D of title XVIII of the Social Security Act.*

21 *(b) PAYMENT METHODOLOGY.—*

22 *(1) PAYMENTS OUT.—The Secretary shall pro-*
 23 *vide under the program established under subsection*
 24 *(a) that if—*

1 (A) a participating plan's allowable costs
2 for any plan year are more than 103 percent but
3 not more than 108 percent of the target amount,
4 the Secretary shall pay to the plan an amount
5 equal to 50 percent of the target amount in ex-
6 cess of 103 percent of the target amount; and

7 (B) a participating plan's allowable costs
8 for any plan year are more than 108 percent of
9 the target amount, the Secretary shall pay to the
10 plan an amount equal to the sum of 2.5 percent
11 of the target amount plus 80 percent of allowable
12 costs in excess of 108 percent of the target
13 amount.

14 (2) *PAYMENTS IN.*—The Secretary shall provide
15 under the program established under subsection (a)
16 that if—

17 (A) a participating plan's allowable costs
18 for any plan year are less than 97 percent but
19 not less than 92 percent of the target amount, the
20 plan shall pay to the Secretary an amount equal
21 to 50 percent of the excess of 97 percent of the
22 target amount over the allowable costs; and

23 (B) a participating plan's allowable costs
24 for any plan year are less than 92 percent of the
25 target amount, the plan shall pay to the Sec-

1 retary an amount equal to the sum of 2.5 per-
2 cent of the target amount plus 80 percent of the
3 excess of 92 percent of the target amount over the
4 allowable costs.

5 (c) *DEFINITIONS.*—*In this section:*

6 (1) *ALLOWABLE COSTS.*—

7 (A) *IN GENERAL.*—*The amount of allowable*
8 *costs of a plan for any year is an amount equal*
9 *to the total costs (other than administrative*
10 *costs) of the plan in providing benefits covered*
11 *by the plan.*

12 (B) *REDUCTION FOR RISK ADJUSTMENT*
13 *AND REINSURANCE PAYMENTS.*—*Allowable costs*
14 *shall reduced by any risk adjustment and rein-*
15 *surance payments received under section 1341*
16 *and 1343.*

17 (2) *TARGET AMOUNT.*—*The target amount of a*
18 *plan for any year is an amount equal to the total*
19 *premiums (including any premium subsidies under*
20 *any governmental program), reduced by the adminis-*
21 *trative costs of the plan.*

22 **SEC. 1343. RISK ADJUSTMENT.**

23 (a) *IN GENERAL.*—

24 (1) *LOW ACTUARIAL RISK PLANS.*—*Using the cri-*
25 *teria and methods developed under subsection (b),*

1 *each State shall assess a charge on health plans and*
2 *health insurance issuers (with respect to health insur-*
3 *ance coverage) described in subsection (c) if the actu-*
4 *arial risk of the enrollees of such plans or coverage for*
5 *a year is less than the average actuarial risk of all*
6 *enrollees in all plans or coverage in such State for*
7 *such year that are not self-insured group health plans*
8 *(which are subject to the provisions of the Employee*
9 *Retirement Income Security Act of 1974).*

10 (2) *HIGH ACTUARIAL RISK PLANS.*—*Using the*
11 *criteria and methods developed under subsection (b),*
12 *each State shall provide a payment to health plans*
13 *and health insurance issuers (with respect to health*
14 *insurance coverage) described in subsection (c) if the*
15 *actuarial risk of the enrollees of such plans or cov-*
16 *erage for a year is greater than the average actuarial*
17 *risk of all enrollees in all plans and coverage in such*
18 *State for such year that are not self-insured group*
19 *health plans (which are subject to the provisions of*
20 *the Employee Retirement Income Security Act of*
21 *1974).*

22 (b) *CRITERIA AND METHODS.*—*The Secretary, in con-*
23 *sultation with States, shall establish criteria and methods*
24 *to be used in carrying out the risk adjustment activities*
25 *under this section. The Secretary may utilize criteria and*

1 *methods similar to the criteria and methods utilized under*
 2 *part C or D of title XVIII of the Social Security Act. Such*
 3 *criteria and methods shall be included in the standards and*
 4 *requirements the Secretary prescribes under section 1321.*

5 (c) *SCOPE.*—*A health plan or a health insurance issuer*
 6 *is described in this subsection if such health plan or health*
 7 *insurance issuer provides coverage in the individual or*
 8 *small group market within the State. This subsection shall*
 9 *not apply to a grandfathered health plan or the issuer of*
 10 *a grandfathered health plan with respect to that plan.*

11 ***Subtitle E—Affordable Coverage***
 12 ***Choices for All Americans***

13 ***PART I—PREMIUM TAX CREDITS AND COST-***
 14 ***SHARING REDUCTIONS***

15 ***Subpart A—Premium Tax Credits and Cost-sharing***
 16 ***Reductions***

17 ***SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM***
 18 ***ASSISTANCE FOR COVERAGE UNDER A QUALI-***
 19 ***FIED HEALTH PLAN.***

20 (a) *IN GENERAL.*—*Subpart C of part IV of subchapter*
 21 *A of chapter 1 of the Internal Revenue Code of 1986 (relat-*
 22 *ing to refundable credits) is amended by inserting after sec-*
 23 *tion 36A the following new section:*

1 **“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A**
2 **QUALIFIED HEALTH PLAN.**

3 “(a) *IN GENERAL.*—*In the case of an applicable tax-*
4 *payer, there shall be allowed as a credit against the tax*
5 *imposed by this subtitle for any taxable year an amount*
6 *equal to the premium assistance credit amount of the tax-*
7 *payer for the taxable year.*

8 “(b) *PREMIUM ASSISTANCE CREDIT AMOUNT.*—*For*
9 *purposes of this section—*

10 “(1) *IN GENERAL.*—*The term ‘premium assist-*
11 *ance credit amount’ means, with respect to any tax-*
12 *able year, the sum of the premium assistance amounts*
13 *determined under paragraph (2) with respect to all*
14 *coverage months of the taxpayer occurring during the*
15 *taxable year.*

16 “(2) *PREMIUM ASSISTANCE AMOUNT.*—*The pre-*
17 *mium assistance amount determined under this sub-*
18 *section with respect to any coverage month is the*
19 *amount equal to the lesser of—*

20 “(A) *the monthly premiums for such month*
21 *for 1 or more qualified health plans offered in*
22 *the individual market within a State which*
23 *cover the taxpayer, the taxpayer’s spouse, or any*
24 *dependent (as defined in section 152) of the tax-*
25 *payer and which were enrolled in through an*
26 *Exchange established by the State under 1311 of*

1 *the Patient Protection and Affordable Care Act,*
2 *or*

3 “(B) *the excess (if any) of—*

4 “(i) *the adjusted monthly premium for*
5 *such month for the applicable second lowest*
6 *cost silver plan with respect to the taxpayer,*
7 *over*

8 “(ii) *an amount equal to 1/12 of the*
9 *product of the applicable percentage and the*
10 *taxpayer’s household income for the taxable*
11 *year.*

12 “(3) *OTHER TERMS AND RULES RELATING TO*
13 *PREMIUM ASSISTANCE AMOUNTS.—For purposes of*
14 *paragraph (2)—*

15 “(A) *APPLICABLE PERCENTAGE.—*

16 “(i) *IN GENERAL.—Except as provided*
17 *in clause (ii), the applicable percentage*
18 *with respect to any taxpayer for any tax-*
19 *able year is equal to 2.8 percent, increased*
20 *by the number of percentage points (not*
21 *greater than 7) which bears the same ratio*
22 *to 7 percentage points as—*

23 “(I) *the taxpayer’s household in-*
24 *come for the taxable year in excess of*

1 100 percent of the poverty line for a
2 family of the size involved, bears to

3 “(II) an amount equal to 200 per-
4 cent of the poverty line for a family of
5 the size involved.

6 “(ii) *SPECIAL RULE FOR TAXPAYERS*
7 *UNDER 133 PERCENT OF POVERTY LINE.*—If
8 a taxpayer’s household income for the tax-
9 able year is in excess of 100 percent, but not
10 more than 133 percent, of the poverty line
11 for a family of the size involved, the tax-
12 payer’s applicable percentage shall be 2 per-
13 cent.

14 “(iii) *INDEXING.*—In the case of tax-
15 able years beginning in any calendar year
16 after 2014, the Secretary shall adjust the
17 initial and final applicable percentages
18 under clause (i), and the 2 percent under
19 clause (ii), for the calendar year to reflect
20 the excess of the rate of premium growth be-
21 tween the preceding calendar year and 2013
22 over the rate of income growth for such pe-
23 riod.

24 “(B) *APPLICABLE SECOND LOWEST COST*
25 *SILVER PLAN.*—The applicable second lowest cost

1 *silver plan with respect to any applicable tax-*
2 *payer is the second lowest cost silver plan of the*
3 *individual market in the rating area in which*
4 *the taxpayer resides which—*

5 *“(i) is offered through the same Ex-*
6 *change through which the qualified health*
7 *plans taken into account under paragraph*
8 *(2)(A) were offered, and*

9 *“(ii) provides—*

10 *“(I) self-only coverage in the case*
11 *of an applicable taxpayer—*

12 *“(aa) whose tax for the tax-*
13 *able year is determined under sec-*
14 *tion 1(c) (relating to unmarried*
15 *individuals other than surviving*
16 *spouses and heads of households)*
17 *and who is not allowed a deduc-*
18 *tion under section 151 for the tax-*
19 *able year with respect to a de-*
20 *pendent, or*

21 *“(bb) who is not described in*
22 *item (aa) but who purchases only*
23 *self-only coverage, and*

24 *“(II) family coverage in the case*
25 *of any other applicable taxpayer.*

1 *If a taxpayer files a joint return and no credit*
2 *is allowed under this section with respect to 1 of*
3 *the spouses by reason of subsection (e), the tax-*
4 *payer shall be treated as described in clause*
5 *(ii)(I) unless a deduction is allowed under sec-*
6 *tion 151 for the taxable year with respect to a*
7 *dependent other than either spouse and sub-*
8 *section (e) does not apply to the dependent.*

9 *“(C) ADJUSTED MONTHLY PREMIUM.—The*
10 *adjusted monthly premium for an applicable sec-*
11 *ond lowest cost silver plan is the monthly pre-*
12 *mium which would have been charged (for the*
13 *rating area with respect to which the premiums*
14 *under paragraph (2)(A) were determined) for the*
15 *plan if each individual covered under a qualified*
16 *health plan taken into account under paragraph*
17 *(2)(A) were covered by such silver plan and the*
18 *premium was adjusted only for the age of each*
19 *such individual in the manner allowed under*
20 *section 2701 of the Public Health Service Act. In*
21 *the case of a State participating in the wellness*
22 *discount demonstration project under section*
23 *2705(d) of the Public Health Service Act, the ad-*
24 *justed monthly premium shall be determined*

1 *without regard to any premium discount or re-*
2 *bate under such project.*

3 “(D) *ADDITIONAL BENEFITS.—If—*

4 “(i) *a qualified health plan under sec-*
5 *tion 1302(b)(5) of the Patient Protection*
6 *and Affordable Care Act offers benefits in*
7 *addition to the essential health benefits re-*
8 *quired to be provided by the plan, or*

9 “(ii) *a State requires a qualified health*
10 *plan under section 1311(d)(3)(B) of such*
11 *Act to cover benefits in addition to the es-*
12 *sential health benefits required to be pro-*
13 *vided by the plan,*

14 *the portion of the premium for the plan properly*
15 *allocable (under rules prescribed by the Secretary*
16 *of Health and Human Services) to such addi-*
17 *tional benefits shall not be taken into account in*
18 *determining either the monthly premium or the*
19 *adjusted monthly premium under paragraph (2).*

20 “(E) *SPECIAL RULE FOR PEDIATRIC DEN-*
21 *TAL COVERAGE.—For purposes of determining*
22 *the amount of any monthly premium, if an indi-*
23 *vidual enrolls in both a qualified health plan*
24 *and a plan described in section*
25 *1311(d)(2)(B)(ii)(I) of the Patient Protection*

1 *and Affordable Care Act for any plan year, the*
2 *portion of the premium for the plan described in*
3 *such section that (under regulations prescribed*
4 *by the Secretary) is properly allocable to pedi-*
5 *atric dental benefits which are included in the*
6 *essential health benefits required to be provided*
7 *by a qualified health plan under section*
8 *1302(b)(1)(J) of such Act shall be treated as a*
9 *premium payable for a qualified health plan.*

10 “(c) *DEFINITION AND RULES RELATING TO APPLICA-*
11 *BLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED*
12 *HEALTH PLAN.—For purposes of this section—*

13 “(1) *APPLICABLE TAXPAYER.—*

14 “(A) *IN GENERAL.—The term ‘applicable*
15 *taxpayer’ means, with respect to any taxable*
16 *year, a taxpayer whose household income for the*
17 *taxable year exceeds 100 percent but does not ex-*
18 *ceed 400 percent of an amount equal to the pov-*
19 *erty line for a family of the size involved.*

20 “(B) *SPECIAL RULE FOR CERTAIN INDIVID-*
21 *UALS LAWFULLY PRESENT IN THE UNITED*
22 *STATES.—If—*

23 “(i) *a taxpayer has a household income*
24 *which is not greater than 100 percent of an*

1 *amount equal to the poverty line for a fam-*
2 *ily of the size involved, and*

3 *“(ii) the taxpayer is an alien lawfully*
4 *present in the United States, but is not eli-*
5 *gible for the medicaid program under title*
6 *XIX of the Social Security Act by reason of*
7 *such alien status,*

8 *the taxpayer shall, for purposes of the credit*
9 *under this section, be treated as an applicable*
10 *taxpayer with a household income which is equal*
11 *to 100 percent of the poverty line for a family*
12 *of the size involved.*

13 “(C) *MARRIED COUPLES MUST FILE JOINT*
14 *RETURN.—If the taxpayer is married (within the*
15 *meaning of section 7703) at the close of the tax-*
16 *able year, the taxpayer shall be treated as an ap-*
17 *plicable taxpayer only if the taxpayer and the*
18 *taxpayer’s spouse file a joint return for the tax-*
19 *able year.*

20 “(D) *DENIAL OF CREDIT TO DEPEND-*
21 *ENTS.—No credit shall be allowed under this sec-*
22 *tion to any individual with respect to whom a*
23 *deduction under section 151 is allowable to an-*
24 *other taxpayer for a taxable year beginning in*

1 *the calendar year in which such individual's*
2 *taxable year begins.*

3 “(2) *COVERAGE MONTH.*—*For purposes of this*
4 *subsection—*

5 “(A) *IN GENERAL.*—*The term ‘coverage*
6 *month’ means, with respect to an applicable tax-*
7 *payer, any month if—*

8 “(i) *as of the first day of such month*
9 *the taxpayer, the taxpayer’s spouse, or any*
10 *dependent of the taxpayer is covered by a*
11 *qualified health plan described in subsection*
12 *(b)(2)(A) that was enrolled in through an*
13 *Exchange established by the State under*
14 *section 1311 of the Patient Protection and*
15 *Affordable Care Act, and*

16 “(ii) *the premium for coverage under*
17 *such plan for such month is paid by the*
18 *taxpayer (or through advance payment of*
19 *the credit under subsection (a) under section*
20 *1412 of the Patient Protection and Afford-*
21 *able Care Act).*

22 “(B) *EXCEPTION FOR MINIMUM ESSENTIAL*
23 *COVERAGE.*—

24 “(i) *IN GENERAL.*—*The term ‘coverage*
25 *month’ shall not include any month with*

1 *respect to an individual if for such month*
2 *the individual is eligible for minimum es-*
3 *sential coverage other than eligibility for*
4 *coverage described in section 5000A(f)(1)(C)*
5 *(relating to coverage in the individual mar-*
6 *ket).*

7 “(ii) *MINIMUM ESSENTIAL COV-*
8 *ERAGE.—The term ‘minimum essential cov-*
9 *erage’ has the meaning given such term by*
10 *section 5000A(f).*

11 “(C) *SPECIAL RULE FOR EMPLOYER-SPON-*
12 *SORED MINIMUM ESSENTIAL COVERAGE.—For*
13 *purposes of subparagraph (B)—*

14 “(i) *COVERAGE MUST BE AFFORD-*
15 *ABLE.—Except as provided in clause (iii),*
16 *an employee shall not be treated as eligible*
17 *for minimum essential coverage if such cov-*
18 *erage—*

19 “(I) *consists of an eligible em-*
20 *ployer-sponsored plan (as defined in*
21 *section 5000A(f)(2)), and*

22 “(II) *the employee’s required con-*
23 *tribution (within the meaning of sec-*
24 *tion 5000A(e)(1)(B)) with respect to*

1 *the plan exceeds 9.8 percent of the ap-*
2 *plicable taxpayer's household income.*

3 *This clause shall also apply to an indi-*
4 *vidual who is eligible to enroll in the plan*
5 *by reason of a relationship the individual*
6 *bears to the employee.*

7 “(ii) *COVERAGE MUST PROVIDE MIN-*
8 *IMUM VALUE.—Except as provided in clause*
9 *(iii), an employee shall not be treated as el-*
10 *igible for minimum essential coverage if*
11 *such coverage consists of an eligible em-*
12 *ployer-sponsored plan (as defined in section*
13 *5000A(f)(2)) and the plan's share of the*
14 *total allowed costs of benefits provided*
15 *under the plan is less than 60 percent of*
16 *such costs.*

17 “(iii) *EMPLOYEE OR FAMILY MUST NOT*
18 *BE COVERED UNDER EMPLOYER PLAN.—*
19 *Clauses (i) and (ii) shall not apply if the*
20 *employee (or any individual described in*
21 *the last sentence of clause (i)) is covered*
22 *under the eligible employer-sponsored plan*
23 *or the grandfathered health plan.*

24 “(iv) *INDEXING.—In the case of plan*
25 *years beginning in any calendar year after*

1 2014, the Secretary shall adjust the 9.8 per-
2 cent under clause (i)(II) in the same man-
3 ner as the percentages are adjusted under
4 subsection (b)(3)(A)(ii).

5 “(3) DEFINITIONS AND OTHER RULES.—

6 “(A) QUALIFIED HEALTH PLAN.—The term
7 ‘qualified health plan’ has the meaning given
8 such term by section 1301(a) of the Patient Pro-
9 tection and Affordable Care Act, except that such
10 term shall not include a qualified health plan
11 which is a catastrophic plan described in section
12 1302(e) of such Act.

13 “(B) GRANDFATHERED HEALTH PLAN.—
14 The term ‘grandfathered health plan’ has the
15 meaning given such term by section 1251 of the
16 Patient Protection and Affordable Care Act.

17 “(d) TERMS RELATING TO INCOME AND FAMILIES.—

18 For purposes of this section—

19 “(1) FAMILY SIZE.—The family size involved
20 with respect to any taxpayer shall be equal to the
21 number of individuals for whom the taxpayer is al-
22 lowed a deduction under section 151 (relating to al-
23 lowance of deduction for personal exemptions) for the
24 taxable year.

25 “(2) HOUSEHOLD INCOME.—

1 “(A) *HOUSEHOLD INCOME.*—*The term*
2 *‘household income’ means, with respect to any*
3 *taxpayer, an amount equal to the sum of—*

4 “(i) *the modified gross income of the*
5 *taxpayer, plus*

6 “(ii) *the aggregate modified gross in-*
7 *comes of all other individuals who—*

8 “(I) *were taken into account in*
9 *determining the taxpayer’s family size*
10 *under paragraph (1), and*

11 “(II) *were required to file a re-*
12 *turn of tax imposed by section 1 for*
13 *the taxable year.*

14 “(B) *MODIFIED GROSS INCOME.*—*The term*
15 *‘modified gross income’ means gross income—*

16 “(i) *decreased by the amount of any*
17 *deduction allowable under paragraph (1),*
18 *(3), (4), or (10) of section 62(a),*

19 “(ii) *increased by the amount of inter-*
20 *est received or accrued during the taxable*
21 *year which is exempt from tax imposed by*
22 *this chapter, and*

23 “(iii) *determined without regard to*
24 *sections 911, 931, and 933.*

25 “(3) *POVERTY LINE.*—

1 “(A) *IN GENERAL.*—*The term ‘poverty line’*
2 *has the meaning given that term in section*
3 *2110(c)(5) of the Social Security Act (42 U.S.C.*
4 *1397jj(c)(5)).*

5 “(B) *POVERTY LINE USED.*—*In the case of*
6 *any qualified health plan offered through an Ex-*
7 *change for coverage during a taxable year begin-*
8 *ning in a calendar year, the poverty line used*
9 *shall be the most recently published poverty line*
10 *as of the 1st day of the regular enrollment period*
11 *for coverage during such calendar year.*

12 “(e) *RULES FOR INDIVIDUALS NOT LAWFULLY*
13 *PRESENT.*—

14 “(1) *IN GENERAL.*—*If 1 or more individuals for*
15 *whom a taxpayer is allowed a deduction under sec-*
16 *tion 151 (relating to allowance of deduction for per-*
17 *sonal exemptions) for the taxable year (including the*
18 *taxpayer or his spouse) are individuals who are not*
19 *lawfully present—*

20 “(A) *the aggregate amount of premiums*
21 *otherwise taken into account under clauses (i)*
22 *and (ii) of subsection (b)(2)(A) shall be reduced*
23 *by the portion (if any) of such premiums which*
24 *is attributable to such individuals, and*

1 “(B) for purposes of applying this section,
2 the determination as to what percentage a tax-
3 payer’s household income bears to the poverty
4 level for a family of the size involved shall be
5 made under one of the following methods:

6 “(i) A method under which—

7 “(I) the taxpayer’s family size is
8 determined by not taking such individ-
9 uals into account, and

10 “(II) the taxpayer’s household in-
11 come is equal to the product of the tax-
12 payer’s household income (determined
13 without regard to this subsection) and
14 a fraction—

15 “(aa) the numerator of which
16 is the poverty line for the tax-
17 payer’s family size determined
18 after application of subclause (I),
19 and

20 “(bb) the denominator of
21 which is the poverty line for the
22 taxpayer’s family size determined
23 without regard to subclause (I).

1 “(ii) *A comparable method reaching*
2 *the same result as the method under clause*
3 *(i).*

4 “(2) *LAWFULLY PRESENT.*—*For purposes of this*
5 *section, an individual shall be treated as lawfully*
6 *present only if the individual is, and is reasonably*
7 *expected to be for the entire period of enrollment for*
8 *which the credit under this section is being claimed,*
9 *a citizen or national of the United States or an alien*
10 *lawfully present in the United States.*

11 “(3) *SECRETARIAL AUTHORITY.*—*The Secretary*
12 *of Health and Human Services, in consultation with*
13 *the Secretary, shall prescribe rules setting forth the*
14 *methods by which calculations of family size and*
15 *household income are made for purposes of this sub-*
16 *section. Such rules shall be designed to ensure that the*
17 *least burden is placed on individuals enrolling in*
18 *qualified health plans through an Exchange and tax-*
19 *payers eligible for the credit allowable under this sec-*
20 *tion.*

21 “(f) *RECONCILIATION OF CREDIT AND ADVANCE CRED-*
22 *IT.*—

23 “(1) *IN GENERAL.*—*The amount of the credit al-*
24 *lowed under this section for any taxable year shall be*
25 *reduced (but not below zero) by the amount of any*

1 *advance payment of such credit under section 1412 of*
2 *the Patient Protection and Affordable Care Act.*

3 “(2) *EXCESS ADVANCE PAYMENTS.—*

4 “(A) *IN GENERAL.—If the advance pay-*
5 *ments to a taxpayer under section 1412 of the*
6 *Patient Protection and Affordable Care Act for a*
7 *taxable year exceed the credit allowed by this sec-*
8 *tion (determined without regard to paragraph*
9 *(1)), the tax imposed by this chapter for the tax-*
10 *able year shall be increased by the amount of*
11 *such excess.*

12 “(B) *LIMITATION ON INCREASE WHERE IN-*
13 *COME LESS THAN 400 PERCENT OF POVERTY*
14 *LINE.—*

15 “(i) *IN GENERAL.—In the case of an*
16 *applicable taxpayer whose household income*
17 *is less than 400 percent of the poverty line*
18 *for the size of the family involved for the*
19 *taxable year, the amount of the increase*
20 *under subparagraph (A) shall in no event*
21 *exceed \$400 (\$250 in the case of a taxpayer*
22 *whose tax is determined under section 1(c)*
23 *for the taxable year).*

24 “(ii) *INDEXING OF AMOUNT.—In the*
25 *case of any calendar year beginning after*

1 2014, each of the dollar amounts under
2 clause (i) shall be increased by an amount
3 equal to—

4 “(I) such dollar amount, multi-
5 plied by

6 “(II) the cost-of-living adjustment
7 determined under section 1(f)(3) for
8 the calendar year, determined by sub-
9 stituting ‘calendar year 2013’ for ‘cal-
10 endar year 1992’ in subparagraph (B)
11 thereof.

12 If the amount of any increase under clause
13 (i) is not a multiple of \$50, such increase
14 shall be rounded to the next lowest multiple
15 of \$50.

16 “(g) REGULATIONS.—The Secretary shall prescribe
17 such regulations as may be necessary to carry out the provi-
18 sions of this section, including regulations which provide
19 for—

20 “(1) the coordination of the credit allowed under
21 this section with the program for advance payment of
22 the credit under section 1412 of the Patient Protec-
23 tion and Affordable Care Act, and

24 “(2) the application of subsection (f) where the
25 filing status of the taxpayer for a taxable year is dif-

1 ferent from such status used for determining the ad-
2 vance payment of the credit.”.

3 (b) *DISALLOWANCE OF DEDUCTION.*—Section 280C of
4 the Internal Revenue Code of 1986 is amended by adding
5 at the end the following new subsection:

6 “(g) *CREDIT FOR HEALTH INSURANCE PREMIUMS.*—
7 No deduction shall be allowed for the portion of the pre-
8 miums paid by the taxpayer for coverage of 1 or more indi-
9 viduals under a qualified health plan which is equal to the
10 amount of the credit determined for the taxable year under
11 section 36B(a) with respect to such premiums.”.

12 (c) *STUDY ON AFFORDABLE COVERAGE.*—

13 (1) *STUDY AND REPORT.*—

14 (A) *IN GENERAL.*—Not later than 5 years
15 after the date of the enactment of this Act, the
16 Comptroller General shall conduct a study on the
17 affordability of health insurance coverage, in-
18 cluding—

19 (i) the impact of the tax credit for
20 qualified health insurance coverage of indi-
21 viduals under section 36B of the Internal
22 Revenue Code of 1986 and the tax credit for
23 employee health insurance expenses of small
24 employers under section 45R of such Code

1 *on maintaining and expanding the health*
2 *insurance coverage of individuals;*

3 *(ii) the availability of affordable health*
4 *benefits plans, including a study of whether*
5 *the percentage of household income used for*
6 *purposes of section 36B(c)(2)(C) of the In-*
7 *ternal Revenue Code of 1986 (as added by*
8 *this section) is the appropriate level for de-*
9 *termining whether employer-provided cov-*
10 *erage is affordable for an employee and*
11 *whether such level may be lowered without*
12 *significantly increasing the costs to the Fed-*
13 *eral Government and reducing employer-*
14 *provided coverage; and*

15 *(iii) the ability of individuals to main-*
16 *tain essential health benefits coverage (as*
17 *defined in section 5000A(f) of the Internal*
18 *Revenue Code of 1986).*

19 *(B) REPORT.—The Comptroller General*
20 *shall submit to the appropriate committees of*
21 *Congress a report on the study conducted under*
22 *subparagraph (A), together with legislative rec-*
23 *ommendations relating to the matters studied*
24 *under such subparagraph.*

1 (2) *APPROPRIATE COMMITTEES OF CONGRESS.*—

2 *In this subsection, the term “appropriate committees*
3 *of Congress” means the Committee on Ways and*
4 *Means, the Committee on Education and Labor, and*
5 *the Committee on Energy and Commerce of the House*
6 *of Representatives and the Committee on Finance and*
7 *the Committee on Health, Education, Labor and Pen-*
8 *sions of the Senate.*

9 (d) *CONFORMING AMENDMENTS.*—

10 (1) *Paragraph (2) of section 1324(b) of title 31,*
11 *United States Code, is amended by inserting “36B,”*
12 *after “36A.”*

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

“Sec. 36B. Refundable credit for coverage under a qualified health plan.”.

17 (e) *EFFECTIVE DATE.*—*The amendments made by this*
18 *section shall apply to taxable years ending after December*
19 *31, 2013.*

20 **SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS EN-**
21 **ROLLING IN QUALIFIED HEALTH PLANS.**

22 (a) *IN GENERAL.*—*In the case of an eligible insured*
23 *enrolled in a qualified health plan—*

24 (1) *the Secretary shall notify the issuer of the*
25 *plan of such eligibility; and*

1 (2) *the issuer shall reduce the cost-sharing under*
2 *the plan at the level and in the manner specified in*
3 *subsection (c).*

4 (b) *ELIGIBLE INSURED.—In this section, the term “eli-*
5 *gible insured” means an individual—*

6 (1) *who enrolls in a qualified health plan in the*
7 *silver level of coverage in the individual market of-*
8 *fered through an Exchange; and*

9 (2) *whose household income exceeds 100 percent*
10 *but does not exceed 400 percent of the poverty line for*
11 *a family of the size involved.*

12 *In the case of an individual described in section*
13 *36B(c)(1)(B) of the Internal Revenue Code of 1986, the in-*
14 *dividual shall be treated as having household income equal*
15 *to 100 percent for purposes of applying this section.*

16 (c) *DETERMINATION OF REDUCTION IN COST-SHAR-*
17 *ING.—*

18 (1) *REDUCTION IN OUT-OF-POCKET LIMIT.—*

19 (A) *IN GENERAL.—The reduction in cost-*
20 *sharing under this subsection shall first be*
21 *achieved by reducing the applicable out-of-pocket*
22 *limit under section 1302(c)(1) in the case of—*

23 (i) *an eligible insured whose household*
24 *income is more than 100 percent but not*
25 *more than 200 percent of the poverty line*

1 *for a family of the size involved, by two-*
2 *thirds;*

3 (ii) *an eligible insured whose household*
4 *income is more than 200 percent but not*
5 *more than 300 percent of the poverty line*
6 *for a family of the size involved, by one-*
7 *half; and*

8 (iii) *an eligible insured whose house-*
9 *hold income is more than 300 percent but*
10 *not more than 400 percent of the poverty*
11 *line for a family of the size involved, by*
12 *one-third.*

13 (B) *COORDINATION WITH ACTUARIAL VALUE*
14 *LIMITS.—*

15 (i) *IN GENERAL.—The Secretary shall*
16 *ensure the reduction under this paragraph*
17 *shall not result in an increase in the plan's*
18 *share of the total allowed costs of benefits*
19 *provided under the plan above—*

20 (I) *90 percent in the case of an el-*
21 *igible insured described in paragraph*
22 *(2)(A);*

23 (II) *80 percent in the case of an*
24 *eligible insured described in paragraph*
25 *(2)(B); and*

1 (III) 70 percent in the case of an
2 eligible insured described in clause (ii)
3 or (iii) of subparagraph (A).

4 (ii) ADJUSTMENT.—The Secretary
5 shall adjust the out-of pocket limits under
6 paragraph (1) if necessary to ensure that
7 such limits do not cause the respective actu-
8 arial values to exceed the levels specified in
9 clause (i).

10 (2) ADDITIONAL REDUCTION FOR LOWER INCOME
11 INSUREDS.—The Secretary shall establish procedures
12 under which the issuer of a qualified health plan to
13 which this section applies shall further reduce cost-
14 sharing under the plan in a manner sufficient to—

15 (A) in the case of an eligible insured whose
16 household income is not less than 100 percent
17 but not more than 150 percent of the poverty
18 line for a family of the size involved, increase the
19 plan's share of the total allowed costs of benefits
20 provided under the plan to 90 percent of such
21 costs; and

22 (B) in the case of an eligible insured whose
23 household income is more than 150 percent but
24 not more than 200 percent of the poverty line for
25 a family of the size involved, increase the plan's

1 *share of the total allowed costs of benefits pro-*
2 *vided under the plan to 80 percent of such costs.*

3 (3) *METHODS FOR REDUCING COST-SHARING.*—

4 (A) *IN GENERAL.*—*An issuer of a qualified*
5 *health plan making reductions under this sub-*
6 *section shall notify the Secretary of such reduc-*
7 *tions and the Secretary shall make periodic and*
8 *timely payments to the issuer equal to the value*
9 *of the reductions.*

10 (B) *CAPITATED PAYMENTS.*—*The Secretary*
11 *may establish a capitated payment system to*
12 *carry out the payment of cost-sharing reductions*
13 *under this section. Any such system shall take*
14 *into account the value of the reductions and*
15 *make appropriate risk adjustments to such pay-*
16 *ments.*

17 (4) *ADDITIONAL BENEFITS.*—*If a qualified*
18 *health plan under section 1302(b)(5) offers benefits in*
19 *addition to the essential health benefits required to be*
20 *provided by the plan, or a State requires a qualified*
21 *health plan under section 1311(d)(3)(B) to cover ben-*
22 *efits in addition to the essential health benefits re-*
23 *quired to be provided by the plan, the reductions in*
24 *cost-sharing under this section shall not apply to such*
25 *additional benefits.*

1 (5) *SPECIAL RULE FOR PEDIATRIC DENTAL*
2 *PLANS.—If an individual enrolls in both a qualified*
3 *health plan and a plan described in section*
4 *1311(d)(2)(B)(ii)(I) for any plan year, subsection (a)*
5 *shall not apply to that portion of any reduction in*
6 *cost-sharing under subsection (c) that (under regula-*
7 *tions prescribed by the Secretary) is properly allo-*
8 *cable to pediatric dental benefits which are included*
9 *in the essential health benefits required to be provided*
10 *by a qualified health plan under section*
11 *1302(b)(1)(J).*

12 *(d) SPECIAL RULES FOR INDIANS.—*

13 (1) *INDIANS UNDER 300 PERCENT OF POVERTY.—*
14 *If an individual enrolled in any qualified health plan*
15 *in the individual market through an Exchange is an*
16 *Indian (as defined in section 4(d) of the Indian Self-*
17 *Determination and Education Assistance Act (25*
18 *U.S.C. 450b(d))) whose household income is not more*
19 *than 300 percent of the poverty line for a family of*
20 *the size involved, then, for purposes of this section—*

21 (A) *such individual shall be treated as an*
22 *eligible insured; and*

23 (B) *the issuer of the plan shall eliminate*
24 *any cost-sharing under the plan.*

1 (2) *ITEMS OR SERVICES FURNISHED THROUGH*
2 *INDIAN HEALTH PROVIDERS.—If an Indian (as so de-*
3 *finied) enrolled in a qualified health plan is furnished*
4 *an item or service directly by the Indian Health*
5 *Service, an Indian Tribe, Tribal Organization, or*
6 *Urban Indian Organization or through referral under*
7 *contract health services—*

8 (A) *no cost-sharing under the plan shall be*
9 *imposed under the plan for such item or service;*
10 *and*

11 (B) *the issuer of the plan shall not reduce*
12 *the payment to any such entity for such item or*
13 *service by the amount of any cost-sharing that*
14 *would be due from the Indian but for subpara-*
15 *graph (A).*

16 (3) *PAYMENT.—The Secretary shall pay to the*
17 *issuer of a qualified health plan the amount necessary*
18 *to reflect the increase in actuarial value of the plan*
19 *required by reason of this subsection.*

20 (e) *RULES FOR INDIVIDUALS NOT LAWFULLY*
21 *PRESENT.—*

22 (1) *IN GENERAL.—If an individual who is an el-*
23 *igible insured is not lawfully present—*

1 (A) *no cost-sharing reduction under this*
2 *section shall apply with respect to the indi-*
3 *vidual; and*

4 (B) *for purposes of applying this section,*
5 *the determination as to what percentage a tax-*
6 *payer's household income bears to the poverty*
7 *level for a family of the size involved shall be*
8 *made under one of the following methods:*

9 (i) *A method under which—*

10 (I) *the taxpayer's family size is*
11 *determined by not taking such individ-*
12 *uals into account, and*

13 (II) *the taxpayer's household in-*
14 *come is equal to the product of the tax-*
15 *payer's household income (determined*
16 *without regard to this subsection) and*
17 *a fraction—*

18 (aa) *the numerator of which*
19 *is the poverty line for the tax-*
20 *payer's family size determined*
21 *after application of subclause (I),*
22 *and*

23 (bb) *the denominator of*
24 *which is the poverty line for the*

1 *taxpayer's family size determined*
2 *without regard to subclause (I).*

3 *(ii) A comparable method reaching the*
4 *same result as the method under clause (i).*

5 *(2) LAWFULLY PRESENT.—For purposes of this*
6 *section, an individual shall be treated as lawfully*
7 *present only if the individual is, and is reasonably*
8 *expected to be for the entire period of enrollment for*
9 *which the cost-sharing reduction under this section is*
10 *being claimed, a citizen or national of the United*
11 *States or an alien lawfully present in the United*
12 *States.*

13 *(3) SECRETARIAL AUTHORITY.—The Secretary,*
14 *in consultation with the Secretary of the Treasury,*
15 *shall prescribe rules setting forth the methods by*
16 *which calculations of family size and household in-*
17 *come are made for purposes of this subsection. Such*
18 *rules shall be designed to ensure that the least burden*
19 *is placed on individuals enrolling in qualified health*
20 *plans through an Exchange and taxpayers eligible for*
21 *the credit allowable under this section.*

22 *(f) DEFINITIONS AND SPECIAL RULES.—In this sec-*
23 *tion:*

24 *(1) IN GENERAL.—Any term used in this section*
25 *which is also used in section 36B of the Internal Rev-*

1 *enue Code of 1986 shall have the meaning given such*
2 *term by such section.*

3 (2) *LIMITATIONS ON REDUCTION.—No cost-shar-*
4 *ing reduction shall be allowed under this section with*
5 *respect to coverage for any month unless the month is*
6 *a coverage month with respect to which a credit is al-*
7 *lowed to the insured (or an applicable taxpayer on*
8 *behalf of the insured) under section 36B of such Code.*

9 (3) *DATA USED FOR ELIGIBILITY.—Any deter-*
10 *mination under this section shall be made on the*
11 *basis of the taxable year for which the advance deter-*
12 *mination is made under section 1412 and not the tax-*
13 *able year for which the credit under section 36B of*
14 *such Code is allowed.*

15 ***Subpart B—Eligibility Determinations***

16 ***SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY***
17 ***FOR EXCHANGE PARTICIPATION, PREMIUM***
18 ***TAX CREDITS AND REDUCED COST-SHARING,***
19 ***AND INDIVIDUAL RESPONSIBILITY EXEMP-***
20 ***TIONS.***

21 (a) *ESTABLISHMENT OF PROGRAM.—The Secretary*
22 *shall establish a program meeting the requirements of this*
23 *section for determining—*

24 (1) *whether an individual who is to be covered*
25 *in the individual market by a qualified health plan*

1 *offered through an Exchange, or who is claiming a*
2 *premium tax credit or reduced cost-sharing, meets the*
3 *requirements of sections 1312(f)(3), 1402(e), and*
4 *1412(d) of this title and section 36B(e) of the Internal*
5 *Revenue Code of 1986 that the individual be a citizen*
6 *or national of the United States or an alien lawfully*
7 *present in the United States;*

8 *(2) in the case of an individual claiming a pre-*
9 *mium tax credit or reduced cost-sharing under section*
10 *36B of such Code or section 1402—*

11 *(A) whether the individual meets the income*
12 *and coverage requirements of such sections; and*

13 *(B) the amount of the tax credit or reduced*
14 *cost-sharing;*

15 *(3) whether an individual's coverage under an*
16 *employer-sponsored health benefits plan is treated as*
17 *unaffordable under sections 36B(c)(2)(C) and*
18 *5000A(e)(2); and*

19 *(4) whether to grant a certification under section*
20 *1311(d)(4)(H) attesting that, for purposes of the indi-*
21 *vidual responsibility requirement under section*
22 *5000A of the Internal Revenue Code of 1986, an indi-*
23 *vidual is entitled to an exemption from either the in-*
24 *dividual responsibility requirement or the penalty*
25 *imposed by such section.*

1 **(b) INFORMATION REQUIRED TO BE PROVIDED BY AP-**
2 **PLICANTS.—**

3 **(1) IN GENERAL.—***An applicant for enrollment*
4 *in a qualified health plan offered through an Ex-*
5 *change in the individual market shall provide—*

6 **(A)** *the name, address, and date of birth of*
7 *each individual who is to be covered by the plan*
8 *(in this subsection referred to as an “enrollee”);*
9 *and*

10 **(B)** *the information required by any of the*
11 *following paragraphs that is applicable to an en-*
12 *rollee.*

13 **(2) CITIZENSHIP OR IMMIGRATION STATUS.—***The*
14 *following information shall be provided with respect*
15 *to every enrollee:*

16 **(A)** *In the case of an enrollee whose eligi-*
17 *bility is based on an attestation of citizenship of*
18 *the enrollee, the enrollee’s social security number.*

19 **(B)** *In the case of an individual whose eligi-*
20 *bility is based on an attestation of the enrollee’s*
21 *immigration status, the enrollee’s social security*
22 *number (if applicable) and such identifying in-*
23 *formation with respect to the enrollee’s immigra-*
24 *tion status as the Secretary, after consultation*

1 with the Secretary of Homeland Security, deter-
2 mines appropriate.

3 (3) *ELIGIBILITY AND AMOUNT OF TAX CREDIT OR*
4 *REDUCED COST-SHARING.*—*In the case of an enrollee*
5 *with respect to whom a premium tax credit or re-*
6 *duced cost-sharing under section 36B of such Code or*
7 *section 1402 is being claimed, the following informa-*
8 *tion:*

9 (A) *INFORMATION REGARDING INCOME AND*
10 *FAMILY SIZE.*—*The information described in sec-*
11 *tion 6103(l)(21) for the taxable year ending with*
12 *or within the second calendar year preceding the*
13 *calendar year in which the plan year begins.*

14 (B) *CHANGES IN CIRCUMSTANCES.*—*The in-*
15 *formation described in section 1412(b)(2), in-*
16 *cluding information with respect to individuals*
17 *who were not required to file an income tax re-*
18 *turn for the taxable year described in subpara-*
19 *graph (A) or individuals who experienced*
20 *changes in marital status or family size or sig-*
21 *nificant reductions in income.*

22 (4) *EMPLOYER-SPONSORED COVERAGE.*—*In the*
23 *case of an enrollee with respect to whom eligibility for*
24 *a premium tax credit under section 36B of such Code*
25 *or cost-sharing reduction under section 1402 is being*

1 *established on the basis that the enrollee's (or related*
2 *individual's) employer is not treated under section*
3 *36B(c)(2)(C) of such Code as providing minimum es-*
4 *sential coverage or affordable minimum essential cov-*
5 *erage, the following information:*

6 (A) *The name, address, and employer iden-*
7 *tification number (if available) of the employer.*

8 (B) *Whether the enrollee or individual is a*
9 *full-time employee and whether the employer*
10 *provides such minimum essential coverage.*

11 (C) *If the employer provides such minimum*
12 *essential coverage, the lowest cost option for the*
13 *enrollee's or individual's enrollment status and*
14 *the enrollee's or individual's required contribu-*
15 *tion (within the meaning of section*
16 *5000A(e)(1)(B) of such Code) under the em-*
17 *ployer-sponsored plan.*

18 (D) *If an enrollee claims an employer's*
19 *minimum essential coverage is unaffordable, the*
20 *information described in paragraph (3).*

21 *If an enrollee changes employment or obtains addi-*
22 *tional employment while enrolled in a qualified*
23 *health plan for which such credit or reduction is al-*
24 *lowed, the enrollee shall notify the Exchange of such*
25 *change or additional employment and provide the in-*

1 *formation described in this paragraph with respect to*
2 *the new employer.*

3 (5) *EXEMPTIONS FROM INDIVIDUAL RESPONSIB-*
4 *BILITY REQUIREMENTS.—In the case of an individual*
5 *who is seeking an exemption certificate under section*
6 *1311(d)(4)(H) from any requirement or penalty im-*
7 *posed by section 5000A, the following information:*

8 (A) *In the case of an individual seeking ex-*
9 *emption based on the individual’s status as a*
10 *member of an exempt religious sect or division,*
11 *as a member of a health care sharing ministry,*
12 *as an Indian, or as an individual eligible for a*
13 *hardship exemption, such information as the*
14 *Secretary shall prescribe.*

15 (B) *In the case of an individual seeking ex-*
16 *emption based on the lack of affordable coverage*
17 *or the individual’s status as a taxpayer with*
18 *household income less than 100 percent of the*
19 *poverty line, the information described in para-*
20 *graphs (3) and (4), as applicable.*

21 (c) *VERIFICATION OF INFORMATION CONTAINED IN*
22 *RECORDS OF SPECIFIC FEDERAL OFFICIALS.—*

23 (1) *INFORMATION TRANSFERRED TO SEC-*
24 *RETARY.—An Exchange shall submit the information*
25 *provided by an applicant under subsection (b) to the*

1 *Secretary for verification in accordance with the re-*
2 *quirements of this subsection and subsection (d).*

3 (2) *CITIZENSHIP OR IMMIGRATION STATUS.—*

4 (A) *COMMISSIONER OF SOCIAL SECURITY.—*

5 *The Secretary shall submit to the Commissioner*
6 *of Social Security the following information for*
7 *a determination as to whether the information*
8 *provided is consistent with the information in*
9 *the records of the Commissioner:*

10 (i) *The name, date of birth, and social*
11 *security number of each individual for*
12 *whom such information was provided under*
13 *subsection (b)(2).*

14 (ii) *The attestation of an individual*
15 *that the individual is a citizen.*

16 (B) *SECRETARY OF HOMELAND SECUR-*
17 *ITY.—*

18 (i) *IN GENERAL.—In the case of an in-*
19 *dividual—*

20 (I) *who attests that the individual*
21 *is an alien lawfully present in the*
22 *United States; or*

23 (II) *who attests that the indi-*
24 *vidual is a citizen but with respect to*
25 *whom the Commissioner of Social Se-*

1 curity has notified the Secretary under
2 subsection (e)(3) that the attestation is
3 inconsistent with information in the
4 records maintained by the Commis-
5 sioner;

6 the Secretary shall submit to the Secretary
7 of Homeland Security the information de-
8 scribed in clause (ii) for a determination as
9 to whether the information provided is con-
10 sistent with the information in the records
11 of the Secretary of Homeland Security.

12 (ii) *INFORMATION.*—The information
13 described in clause (ii) is the following:

14 (I) The name, date of birth, and
15 any identifying information with re-
16 spect to the individual's immigration
17 status provided under subsection
18 (b)(2).

19 (II) The attestation that the indi-
20 vidual is an alien lawfully present in
21 the United States or in the case of an
22 individual described in clause (i)(II),
23 the attestation that the individual is a
24 citizen.

1 (3) *ELIGIBILITY FOR TAX CREDIT AND COST-*
2 *SHARING REDUCTION.*—*The Secretary shall submit*
3 *the information described in subsection (b)(3)(A) pro-*
4 *vided under paragraph (3), (4), or (5) of subsection*
5 *(b) to the Secretary of the Treasury for verification*
6 *of household income and family size for purposes of*
7 *eligibility.*

8 (4) *METHODS.*—

9 (A) *IN GENERAL.*—*The Secretary, in con-*
10 *sultation with the Secretary of the Treasury, the*
11 *Secretary of Homeland Security, and the Com-*
12 *missioner of Social Security, shall provide that*
13 *verifications and determinations under this sub-*
14 *section shall be done—*

15 (i) *through use of an on-line system or*
16 *otherwise for the electronic submission of,*
17 *and response to, the information submitted*
18 *under this subsection with respect to an ap-*
19 *plicant; or*

20 (ii) *by determining the consistency of*
21 *the information submitted with the infor-*
22 *mation maintained in the records of the*
23 *Secretary of the Treasury, the Secretary of*
24 *Homeland Security, or the Commissioner of*

1 *Social Security through such other method*
2 *as is approved by the Secretary.*

3 (B) *FLEXIBILITY.*—*The Secretary may*
4 *modify the methods used under the program es-*
5 *tablished by this section for the Exchange and*
6 *verification of information if the Secretary deter-*
7 *mines such modifications would reduce the ad-*
8 *ministrative costs and burdens on the applicant,*
9 *including allowing an applicant to request the*
10 *Secretary of the Treasury to provide the infor-*
11 *mation described in paragraph (3) directly to*
12 *the Exchange or to the Secretary. The Secretary*
13 *shall not make any such modification unless the*
14 *Secretary determines that any applicable re-*
15 *quirements under this section and section 6103*
16 *of the Internal Revenue Code of 1986 with re-*
17 *spect to the confidentiality, disclosure, mainte-*
18 *nance, or use of information will be met.*

19 (d) *VERIFICATION BY SECRETARY.*—*In the case of in-*
20 *formation provided under subsection (b) that is not required*
21 *under subsection (c) to be submitted to another person for*
22 *verification, the Secretary shall verify the accuracy of such*
23 *information in such manner as the Secretary determines*
24 *appropriate, including delegating responsibility for*
25 *verification to the Exchange.*

1 (e) *ACTIONS RELATING TO VERIFICATION.*—

2 (1) *IN GENERAL.*—Each person to whom the Sec-
3 retary provided information under subsection (c)
4 shall report to the Secretary under the method estab-
5 lished under subsection (c)(4) the results of its
6 verification and the Secretary shall notify the Ex-
7 change of such results. Each person to whom the Sec-
8 retary provided information under subsection (d)
9 shall report to the Secretary in such manner as the
10 Secretary determines appropriate.

11 (2) *VERIFICATION.*—

12 (A) *ELIGIBILITY FOR ENROLLMENT AND*
13 *PREMIUM TAX CREDITS AND COST-SHARING RE-*
14 *DUCTIONS.*—If information provided by an ap-
15 plicant under paragraphs (1), (2), (3), and (4)
16 of subsection (b) is verified under subsections (c)
17 and (d)—

18 (i) *the individual's eligibility to enroll*
19 *through the Exchange and to apply for pre-*
20 *mium tax credits and cost-sharing reduc-*
21 *tions shall be satisfied; and*

22 (ii) *the Secretary shall, if applicable,*
23 *notify the Secretary of the Treasury under*
24 *section 1412(c) of the amount of any ad-*
25 *vance payment to be made.*

1 (B) *EXEMPTION FROM INDIVIDUAL RESPON-*
2 *SIBILITY.—If information provided by an appli-*
3 *cant under subsection (b)(5) is verified under*
4 *subsections (c) and (d), the Secretary shall issue*
5 *the certification of exemption described in section*
6 *1311(d)(4)(H).*

7 (3) *INCONSISTENCIES INVOLVING ATTESTATION*
8 *OF CITIZENSHIP OR LAWFUL PRESENCE.—If the infor-*
9 *mation provided by any applicant under subsection*
10 *(b)(2) is inconsistent with information in the records*
11 *maintained by the Commissioner of Social Security*
12 *or Secretary of Homeland Security, whichever is ap-*
13 *licable, the applicant’s eligibility will be determined*
14 *in the same manner as an individual’s eligibility*
15 *under the medicaid program is determined under sec-*
16 *tion 1902(ee) of the Social Security Act (as in effect*
17 *on January 1, 2010).*

18 (4) *INCONSISTENCIES INVOLVING OTHER INFOR-*
19 *MATION.—*

20 (A) *IN GENERAL.—If the information pro-*
21 *vided by an applicant under subsection (b)*
22 *(other than subsection (b)(2)) is inconsistent*
23 *with information in the records maintained by*
24 *persons under subsection (c) or is not verified*
25 *under subsection (d), the Secretary shall notify*

1 *the Exchange and the Exchange shall take the*
2 *following actions:*

3 *(i) REASONABLE EFFORT.—The Ex-*
4 *change shall make a reasonable effort to*
5 *identify and address the causes of such in-*
6 *consistency, including through typo-*
7 *graphical or other clerical errors, by con-*
8 *tacting the applicant to confirm the accu-*
9 *racy of the information, and by taking such*
10 *additional actions as the Secretary, through*
11 *regulation or other guidance, may identify.*

12 *(ii) NOTICE AND OPPORTUNITY TO*
13 *CORRECT.—In the case the inconsistency or*
14 *inability to verify is not resolved under sub-*
15 *paragraph (A), the Exchange shall—*

16 *(I) notify the applicant of such*
17 *fact;*

18 *(II) provide the applicant an op-*
19 *portunity to either present satisfactory*
20 *documentary evidence or resolve the in-*
21 *consistency with the person verifying*
22 *the information under subsection (c) or*
23 *(d) during the 90-day period beginning*
24 *the date on which the notice required*

1 *under subclause (I) is sent to the ap-*
2 *plicant.*

3 *The Secretary may extend the 90-day pe-*
4 *riod under subclause (II) for enrollments oc-*
5 *curring during 2014.*

6 *(B) SPECIFIC ACTIONS NOT INVOLVING CITI-*
7 *ZENSHIP OR LAWFUL PRESENCE.—*

8 *(i) IN GENERAL.—Except as provided*
9 *in paragraph (3), the Exchange shall, dur-*
10 *ing any period before the close of the period*
11 *under subparagraph (A)(i)(II), make any*
12 *determination under paragraphs (2), (3),*
13 *and (4) of subsection (a) on the basis of the*
14 *information contained on the application.*

15 *(ii) ELIGIBILITY OR AMOUNT OF CRED-*
16 *IT OR REDUCTION.—If an inconsistency in-*
17 *volving the eligibility for, or amount of, any*
18 *premium tax credit or cost-sharing reduc-*
19 *tion is unresolved under this subsection as*
20 *of the close of the period under subpara-*
21 *graph (A)(i)(II), the Exchange shall notify*
22 *the applicant of the amount (if any) of the*
23 *credit or reduction that is determined on*
24 *the basis of the records maintained by per-*
25 *sons under subsection (c).*

1 (iii) *EMPLOYER AFFORDABILITY.*—If
2 the Secretary notifies an Exchange that an
3 enrollee is eligible for a premium tax credit
4 under section 36B of such Code or cost-shar-
5 ing reduction under section 1402 because
6 the enrollee’s (or related individual’s) em-
7 ployer does not provide minimum essential
8 coverage through an employer-sponsored
9 plan or that the employer does provide that
10 coverage but it is not affordable coverage,
11 the Exchange shall notify the employer of
12 such fact and that the employer may be lia-
13 ble for the payment assessed under section
14 4980H of such Code.

15 (iv) *EXEMPTION.*—In any case where
16 the inconsistency involving, or inability to
17 verify, information provided under sub-
18 section (b)(5) is not resolved as of the close
19 of the period under subparagraph
20 (A)(ii)(II), the Exchange shall notify an ap-
21 plicant that no certification of exemption
22 from any requirement or payment under
23 section 5000A of such Code will be issued.

24 (C) *APPEALS PROCESS.*—The Exchange
25 shall also notify each person receiving notice

1 *under this paragraph of the appeals processes es-*
2 *tablished under subsection (f).*

3 *(f) APPEALS AND REDETERMINATIONS.—*

4 *(1) IN GENERAL.—The Secretary, in consultation*
5 *with the Secretary of the Treasury, the Secretary of*
6 *Homeland Security, and the Commissioner of Social*
7 *Security, shall establish procedures by which the Sec-*
8 *retary or one of such other Federal officers—*

9 *(A) hears and makes decisions with respect*
10 *to appeals of any determination under subsection*
11 *(e); and*

12 *(B) redetermines eligibility on a periodic*
13 *basis in appropriate circumstances.*

14 *(2) EMPLOYER LIABILITY.—*

15 *(A) IN GENERAL.—The Secretary shall es-*
16 *tablish a separate appeals process for employers*
17 *who are notified under subsection (e)(4)(C) that*
18 *the employer may be liable for a tax imposed by*
19 *section 4980H of the Internal Revenue Code of*
20 *1986 with respect to an employee because of a*
21 *determination that the employer does not provide*
22 *minimum essential coverage through an em-*
23 *ployer-sponsored plan or that the employer does*
24 *provide that coverage but it is not affordable cov-*

1 *erage with respect to an employee. Such process*
2 *shall provide an employer the opportunity to—*

3 *(i) present information to the Ex-*
4 *change for review of the determination ei-*
5 *ther by the Exchange or the person making*
6 *the determination, including evidence of the*
7 *employer-sponsored plan and employer con-*
8 *tributions to the plan; and*

9 *(ii) have access to the data used to*
10 *make the determination to the extent allow-*
11 *able by law.*

12 *Such process shall be in addition to any rights*
13 *of appeal the employer may have under subtitle*
14 *F of such Code.*

15 *(B) CONFIDENTIALITY.—Notwithstanding*
16 *any provision of this title (or the amendments*
17 *made by this title) or section 6103 of the Inter-*
18 *nal Revenue Code of 1986, an employer shall not*
19 *be entitled to any taxpayer return information*
20 *with respect to an employee for purposes of de-*
21 *termining whether the employer is subject to the*
22 *penalty under section 4980H of such Code with*
23 *respect to the employee, except that—*

24 *(i) the employer may be notified as to*
25 *the name of an employee and whether or*

1 *not the employee's income is above or below*
2 *the threshold by which the affordability of*
3 *an employer's health insurance coverage is*
4 *measured; and*

5 *(ii) this subparagraph shall not apply*
6 *to an employee who provides a waiver (at*
7 *such time and in such manner as the Sec-*
8 *retary may prescribe) authorizing an em-*
9 *ployer to have access to the employee's tax-*
10 *payer return information.*

11 *(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—*

12 *(1) IN GENERAL.—An applicant for insurance*
13 *coverage or for a premium tax credit or cost-sharing*
14 *reduction shall be required to provide only the infor-*
15 *mation strictly necessary to authenticate identity, de-*
16 *termine eligibility, and determine the amount of the*
17 *credit or reduction.*

18 *(2) RECEIPT OF INFORMATION.—Any person who*
19 *receives information provided by an applicant under*
20 *subsection (b) (whether directly or by another person*
21 *at the request of the applicant), or receives informa-*
22 *tion from a Federal agency under subsection (c), (d),*
23 *or (e), shall—*

24 *(A) use the information only for the pur-*
25 *poses of, and to the extent necessary in, ensuring*

1 *the efficient operation of the Exchange, including*
2 *verifying the eligibility of an individual to enroll*
3 *through an Exchange or to claim a premium tax*
4 *credit or cost-sharing reduction or the amount of*
5 *the credit or reduction; and*

6 *(B) not disclose the information to any*
7 *other person except as provided in this section.*

8 *(h) PENALTIES.—*

9 *(1) FALSE OR FRAUDULENT INFORMATION.—*

10 *(A) CIVIL PENALTY.—*

11 *(i) IN GENERAL.—If—*

12 *(I) any person fails to provides*
13 *correct information under subsection*
14 *(b); and*

15 *(II) such failure is attributable to*
16 *negligence or disregard of any rules or*
17 *regulations of the Secretary,*

18 *such person shall be subject, in addition to*
19 *any other penalties that may be prescribed*
20 *by law, to a civil penalty of not more than*
21 *\$25,000 with respect to any failures involv-*
22 *ing an application for a plan year. For*
23 *purposes of this subparagraph, the terms*
24 *“negligence” and “disregard” shall have the*

1 *same meanings as when used in section*
2 *6662 of the Internal Revenue Code of 1986.*

3 *(ii) REASONABLE CAUSE EXCEPTION.—*
4 *No penalty shall be imposed under clause*
5 *(i) if the Secretary determines that there*
6 *was a reasonable cause for the failure and*
7 *that the person acted in good faith.*

8 *(B) KNOWING AND WILLFUL VIOLATIONS.—*
9 *Any person who knowingly and willfully pro-*
10 *vides false or fraudulent information under sub-*
11 *section (b) shall be subject, in addition to any*
12 *other penalties that may be prescribed by law, to*
13 *a civil penalty of not more than \$250,000.*

14 *(2) IMPROPER USE OR DISCLOSURE OF INFORMA-*
15 *TION.—Any person who knowingly and willfully uses*
16 *or discloses information in violation of subsection (g)*
17 *shall be subject, in addition to any other penalties*
18 *that may be prescribed by law, to a civil penalty of*
19 *not more than \$25,000.*

20 *(3) LIMITATIONS ON LIENS AND LEVIES.—The*
21 *Secretary (or, if applicable, the Attorney General of*
22 *the United States) shall not—*

23 *(A) file notice of lien with respect to any*
24 *property of a person by reason of any failure to*
25 *pay the penalty imposed by this subsection; or*

1 (B) *levy on any such property with respect*
2 *to such failure.*

3 (i) *STUDY OF ADMINISTRATION OF EMPLOYER RE-*
4 *SPONSIBILITY.—*

5 (1) *IN GENERAL.—The Secretary of Health and*
6 *Human Services shall, in consultation with the Sec-*
7 *retary of the Treasury, conduct a study of the proce-*
8 *dures that are necessary to ensure that in the admin-*
9 *istration of this title and section 4980H of the Inter-*
10 *nal Revenue Code of 1986 (as added by section 1513)*
11 *that the following rights are protected:*

12 (A) *The rights of employees to preserve their*
13 *right to confidentiality of their taxpayer return*
14 *information and their right to enroll in a quali-*
15 *fied health plan through an Exchange if an em-*
16 *ployer does not provide affordable coverage.*

17 (B) *The rights of employers to adequate due*
18 *process and access to information necessary to*
19 *accurately determine any payment assessed on*
20 *employers.*

21 (2) *REPORT.—Not later than January 1, 2013,*
22 *the Secretary of Health and Human Services shall re-*
23 *port the results of the study conducted under para-*
24 *graph (1), including any recommendations for legisla-*
25 *tive changes, to the Committees on Finance and*

1 *Health, Education, Labor and Pensions of the Senate*
2 *and the Committees of Education and Labor and*
3 *Ways and Means of the House of Representatives.*

4 **SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF**
5 **PREMIUM TAX CREDITS AND COST-SHARING**
6 **REDUCTIONS.**

7 *(a) IN GENERAL.—The Secretary, in consultation with*
8 *the Secretary of the Treasury, shall establish a program*
9 *under which—*

10 *(1) upon request of an Exchange, advance deter-*
11 *minations are made under section 1411 with respect*
12 *to the income eligibility of individuals enrolling in a*
13 *qualified health plan in the individual market*
14 *through the Exchange for the premium tax credit al-*
15 *lowable under section 36B of the Internal Revenue*
16 *Code of 1986 and the cost-sharing reductions under*
17 *section 1402;*

18 *(2) the Secretary notifies—*

19 *(A) the Exchange and the Secretary of the*
20 *Treasury of the advance determinations; and*

21 *(B) the Secretary of the Treasury of the*
22 *name and employer identification number of*
23 *each employer with respect to whom 1 or more*
24 *employee of the employer were determined to be*
25 *eligible for the premium tax credit under section*

1 *36B of the Internal Revenue Code of 1986 and*
2 *the cost-sharing reductions under section 1402*
3 *because—*

4 *(i) the employer did not provide min-*
5 *imum essential coverage; or*

6 *(ii) the employer provided such min-*
7 *imum essential coverage but it was deter-*
8 *mined under section 36B(c)(2)(C) of such*
9 *Code to either be unaffordable to the em-*
10 *ployee or not provide the required min-*
11 *imum actuarial value; and*

12 *(3) the Secretary of the Treasury makes advance*
13 *payments of such credit or reductions to the issuers*
14 *of the qualified health plans in order to reduce the*
15 *premiums payable by individuals eligible for such*
16 *credit.*

17 *(b) ADVANCE DETERMINATIONS.—*

18 *(1) IN GENERAL.—The Secretary shall provide*
19 *under the program established under subsection (a)*
20 *that advance determination of eligibility with respect*
21 *to any individual shall be made—*

22 *(A) during the annual open enrollment pe-*
23 *riod applicable to the individual (or such other*
24 *enrollment period as may be specified by the*
25 *Secretary); and*

1 (B) on the basis of the individual's house-
2 hold income for the most recent taxable year for
3 which the Secretary, after consultation with the
4 Secretary of the Treasury, determines informa-
5 tion is available.

6 (2) *CHANGES IN CIRCUMSTANCES.*—The Sec-
7 retary shall provide procedures for making advance
8 determinations on the basis of information other than
9 that described in paragraph (1)(B) in cases where in-
10 formation included with an application form dem-
11 onstrates substantial changes in income, changes in
12 family size or other household circumstances, change
13 in filing status, the filing of an application for unem-
14 ployment benefits, or other significant changes affect-
15 ing eligibility, including—

16 (A) allowing an individual claiming a de-
17 crease of 20 percent or more in income, or filing
18 an application for unemployment benefits, to
19 have eligibility for the credit determined on the
20 basis of household income for a later period or
21 on the basis of the individual's estimate of such
22 income for the taxable year; and

23 (B) the determination of household income
24 in cases where the taxpayer was not required to

1 *file a return of tax imposed by this chapter for*
2 *the second preceding taxable year.*

3 (c) *PAYMENT OF PREMIUM TAX CREDITS AND COST-*
4 *SHARING REDUCTIONS.—*

5 (1) *IN GENERAL.—The Secretary shall notify the*
6 *Secretary of the Treasury and the Exchange through*
7 *which the individual is enrolling of the advance deter-*
8 *mination under section 1411.*

9 (2) *PREMIUM TAX CREDIT.—*

10 (A) *IN GENERAL.—The Secretary of the*
11 *Treasury shall make the advance payment under*
12 *this section of any premium tax credit allowed*
13 *under section 36B of the Internal Revenue Code*
14 *of 1986 to the issuer of a qualified health plan*
15 *on a monthly basis (or such other periodic basis*
16 *as the Secretary may provide).*

17 (B) *ISSUER RESPONSIBILITIES.—An issuer*
18 *of a qualified health plan receiving an advance*
19 *payment with respect to an individual enrolled*
20 *in the plan shall—*

21 (i) *reduce the premium charged the in-*
22 *sured for any period by the amount of the*
23 *advance payment for the period;*

24 (ii) *notify the Exchange and the Sec-*
25 *retary of such reduction;*

1 (iii) include with each billing state-
2 ment the amount by which the premium for
3 the plan has been reduced by reason of the
4 advance payment; and

5 (iv) in the case of any nonpayment of
6 premiums by the insured—

7 (I) notify the Secretary of such
8 nonpayment; and

9 (II) allow a 3-month grace period
10 for nonpayment of premiums before
11 discontinuing coverage.

12 (3) *COST-SHARING REDUCTIONS.*—The Secretary
13 shall also notify the Secretary of the Treasury and the
14 Exchange under paragraph (1) if an advance pay-
15 ment of the cost-sharing reductions under section
16 1402 is to be made to the issuer of any qualified
17 health plan with respect to any individual enrolled in
18 the plan. The Secretary of the Treasury shall make
19 such advance payment at such time and in such
20 amount as the Secretary specifies in the notice.

21 (d) *NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT*
22 *LAWFULLY PRESENT.*—Nothing in this subtitle or the
23 amendments made by this subtitle allows Federal payments,
24 credits, or cost-sharing reductions for individuals who are
25 not lawfully present in the United States.

1 (e) *STATE FLEXIBILITY.*—Nothing in this subtitle or
2 the amendments made by this subtitle shall be construed
3 to prohibit a State from making payments to or on behalf
4 of an individual for coverage under a qualified health plan
5 offered through an Exchange that are in addition to any
6 credits or cost-sharing reductions allowable to the indi-
7 vidual under this subtitle and such amendments.

8 **SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLL-**
9 **MENT THROUGH AN EXCHANGE AND STATE**
10 **MEDICAID, CHIP, AND HEALTH SUBSIDY PRO-**
11 **GRAMS.**

12 (a) *IN GENERAL.*—The Secretary shall establish a sys-
13 tem meeting the requirements of this section under which
14 residents of each State may apply for enrollment in, receive
15 a determination of eligibility for participation in, and con-
16 tinue participation in, applicable State health subsidy pro-
17 grams. Such system shall ensure that if an individual ap-
18 plying to an Exchange is found through screening to be eli-
19 gible for medical assistance under the State medicaid plan
20 under title XIX, or eligible for enrollment under a State
21 children’s health insurance program (CHIP) under title
22 XXI of such Act, the individual is enrolled for assistance
23 under such plan or program.

24 (b) *REQUIREMENTS RELATING TO FORMS AND NO-*
25 *TICE.*—

1 (1) *REQUIREMENTS RELATING TO FORMS.*—

2 (A) *IN GENERAL.*—*The Secretary shall de-*
3 *velop and provide to each State a single, stream-*
4 *lined form that—*

5 (i) *may be used to apply for all appli-*
6 *cable State health subsidy programs within*
7 *the State;*

8 (ii) *may be filed online, in person, by*
9 *mail, or by telephone;*

10 (iii) *may be filed with an Exchange or*
11 *with State officials operating one of the*
12 *other applicable State health subsidy pro-*
13 *grams; and*

14 (iv) *is structured to maximize an ap-*
15 *plicant's ability to complete the form satis-*
16 *factorily, taking into account the character-*
17 *istics of individuals who qualify for appli-*
18 *cable State health subsidy programs.*

19 (B) *STATE AUTHORITY TO ESTABLISH*
20 *FORM.*—*A State may develop and use its own*
21 *single, streamlined form as an alternative to the*
22 *form developed under subparagraph (A) if the al-*
23 *ternative form is consistent with standards pro-*
24 *mulgated by the Secretary under this section.*

1 (C) *SUPPLEMENTAL ELIGIBILITY FORMS.*—

2 *The Secretary may allow a State to use a sup-*
3 *plemental or alternative form in the case of indi-*
4 *viduals who apply for eligibility that is not de-*
5 *termined on the basis of the household income (as*
6 *defined in section 36B of the Internal Revenue*
7 *Code of 1986).*

8 (2) *NOTICE.*—*The Secretary shall provide that*
9 *an applicant filing a form under paragraph (1) shall*
10 *receive notice of eligibility for an applicable State*
11 *health subsidy program without any need to provide*
12 *additional information or paperwork unless such in-*
13 *formation or paperwork is specifically required by*
14 *law when information provided on the form is incon-*
15 *sistent with data used for the electronic verification*
16 *under paragraph (3) or is otherwise insufficient to*
17 *determine eligibility.*

18 (c) *REQUIREMENTS RELATING TO ELIGIBILITY BASED*
19 *ON DATA EXCHANGES.*—

20 (1) *DEVELOPMENT OF SECURE INTERFACES.*—
21 *Each State shall develop for all applicable State*
22 *health subsidy programs a secure, electronic interface*
23 *allowing an exchange of data (including information*
24 *contained in the application forms described in sub-*
25 *section (b)) that allows a determination of eligibility*

1 *for all such programs based on a single application.*
2 *Such interface shall be compatible with the method es-*
3 *tablished for data verification under section*
4 *1411(c)(4).*

5 (2) *DATA MATCHING PROGRAM.—Each applica-*
6 *ble State health subsidy program shall participate in*
7 *a data matching arrangement for determining eligi-*
8 *bility for participation in the program under para-*
9 *graph (3) that—*

10 (A) *provides access to data described in*
11 *paragraph (3);*

12 (B) *applies only to individuals who—*

13 (i) *receive assistance from an applica-*
14 *ble State health subsidy program; or*

15 (ii) *apply for such assistance—*

16 (I) *by filing a form described in*
17 *subsection (b); or*

18 (II) *by requesting a determination*
19 *of eligibility and authorizing disclosure*
20 *of the information described in para-*
21 *graph (3) to applicable State health*
22 *coverage subsidy programs for purposes*
23 *of determining and establishing eligi-*
24 *bility; and*

1 (C) *consistent with standards promulgated*
2 *by the Secretary, including the privacy and data*
3 *security safeguards described in section 1942 of*
4 *the Social Security Act or that are otherwise ap-*
5 *plicable to such programs.*

6 (3) *DETERMINATION OF ELIGIBILITY.—*

7 (A) *IN GENERAL.—Each applicable State*
8 *health subsidy program shall, to the maximum*
9 *extent practicable—*

10 (i) *establish, verify, and update eligi-*
11 *bility for participation in the program*
12 *using the data matching arrangement under*
13 *paragraph (2); and*

14 (ii) *determine such eligibility on the*
15 *basis of reliable, third party data, including*
16 *information described in sections 1137,*
17 *453(i), and 1942(a) of the Social Security*
18 *Act, obtained through such arrangement.*

19 (B) *EXCEPTION.—This paragraph shall not*
20 *apply in circumstances with respect to which the*
21 *Secretary determines that the administrative*
22 *and other costs of use of the data matching ar-*
23 *rangement under paragraph (2) outweigh its ex-*
24 *pected gains in accuracy, efficiency, and pro-*
25 *gram participation.*

1 (4) *SECRETARIAL STANDARDS.*—*The Secretary*
2 *shall, after consultation with persons in possession of*
3 *the data to be matched and representatives of applica-*
4 *ble State health subsidy programs, promulgate stand-*
5 *ards governing the timing, contents, and procedures*
6 *for data matching described in this subsection. Such*
7 *standards shall take into account administrative and*
8 *other costs and the value of data matching to the es-*
9 *tablishment, verification, and updating of eligibility*
10 *for applicable State health subsidy programs.*

11 (d) *ADMINISTRATIVE AUTHORITY.*—

12 (1) *AGREEMENTS.*—*Subject to section 1411 and*
13 *section 6103(l)(21) of the Internal Revenue Code of*
14 *1986 and any other requirement providing safeguards*
15 *of privacy and data integrity, the Secretary may es-*
16 *tablish model agreements, and enter into agreements,*
17 *for the sharing of data under this section.*

18 (2) *AUTHORITY OF EXCHANGE TO CONTRACT*
19 *OUT.*—*Nothing in this section shall be construed to—*

20 (A) *prohibit contractual arrangements*
21 *through which a State medicaid agency deter-*
22 *mines eligibility for all applicable State health*
23 *subsidy programs, but only if such agency com-*
24 *plies with the Secretary's requirements ensuring*

1 *reduced administrative costs, eligibility errors,*
 2 *and disruptions in coverage; or*

3 *(B) change any requirement under title XIX*
 4 *that eligibility for participation in a State’s*
 5 *medicaid program must be determined by a pub-*
 6 *lic agency.*

7 *(e) APPLICABLE STATE HEALTH SUBSIDY PRO-*
 8 *GRAM.—In this section, the term “applicable State health*
 9 *subsidy program” means—*

10 *(1) the program under this title for the enroll-*
 11 *ment in qualified health plans offered through an Ex-*
 12 *change, including the premium tax credits under sec-*
 13 *tion 36B of the Internal Revenue Code of 1986 and*
 14 *cost-sharing reductions under section 1402;*

15 *(2) a State medicaid program under title XIX of*
 16 *the Social Security Act;*

17 *(3) a State children’s health insurance program*
 18 *(CHIP) under title XXI of such Act; and*

19 *(4) a State program under section 1331 estab-*
 20 *lishing qualified basic health plans.*

21 **SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY RE-**
 22 **QUIREMENTS FOR CERTAIN PROGRAMS.**

23 *(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION*
 24 *AND SOCIAL SECURITY NUMBERS.—*

1 (1) *TAXPAYER RETURN INFORMATION.*—Sub-
2 *section (l) of section 6103 of the Internal Revenue*
3 *Code of 1986 is amended by adding at the end the fol-*
4 *lowing new paragraph:*

5 “(21) *DISCLOSURE OF RETURN INFORMATION TO*
6 *CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN*
7 *PROGRAMS.*—

8 “(A) *IN GENERAL.*—*The Secretary, upon*
9 *written request from the Secretary of Health and*
10 *Human Services, shall disclose to officers, em-*
11 *ployees, and contractors of the Department of*
12 *Health and Human Services return information*
13 *of any taxpayer whose income is relevant in de-*
14 *termining any premium tax credit under section*
15 *36B or any cost-sharing reduction under section*
16 *1402 of the Patient Protection and Affordable*
17 *Care Act or eligibility for participation in a*
18 *State medicaid program under title XIX of the*
19 *Social Security Act, a State’s children’s health*
20 *insurance program under title XXI of the Social*
21 *Security Act, or a basic health program under*
22 *section 1331 of Patient Protection and Affordable*
23 *Care Act. Such return information shall be lim-*
24 *ited to—*

1 “(i) taxpayer identity information
2 with respect to such taxpayer,

3 “(ii) the filing status of such taxpayer,

4 “(iii) the number of individuals for
5 whom a deduction is allowed under section
6 151 with respect to the taxpayer (including
7 the taxpayer and the taxpayer’s spouse),

8 “(iv) the modified gross income (as de-
9 fined in section 36B) of such taxpayer and
10 each of the other individuals included under
11 clause (iii) who are required to file a return
12 of tax imposed by chapter 1 for the taxable
13 year,

14 “(v) such other information as is pre-
15 scribed by the Secretary by regulation as
16 might indicate whether the taxpayer is eli-
17 gible for such credit or reduction (and the
18 amount thereof), and

19 “(vi) the taxable year with respect to
20 which the preceding information relates or,
21 if applicable, the fact that such information
22 is not available.

23 “(B) INFORMATION TO EXCHANGE AND
24 STATE AGENCIES.—The Secretary of Health and
25 Human Services may disclose to an Exchange

1 *established under the Patient Protection and Af-*
2 *fordable Care Act or its contractors, or to a State*
3 *agency administering a State program described*
4 *in subparagraph (A) or its contractors, any in-*
5 *consistency between the information provided by*
6 *the Exchange or State agency to the Secretary*
7 *and the information provided to the Secretary*
8 *under subparagraph (A).*

9 “(C) *RESTRICTION ON USE OF DISCLOSED*
10 *INFORMATION.—Return information disclosed*
11 *under subparagraph (A) or (B) may be used by*
12 *officers, employees, and contractors of the De-*
13 *partment of Health and Human Services, an*
14 *Exchange, or a State agency only for the pur-*
15 *poses of, and to the extent necessary in—*

16 “(i) *establishing eligibility for partici-*
17 *ipation in the Exchange, and verifying the*
18 *appropriate amount of, any credit or reduc-*
19 *tion described in subparagraph (A),*

20 “(ii) *determining eligibility for par-*
21 *ticipation in the State programs described*
22 *in subparagraph (A).”.*

23 (2) *SOCIAL SECURITY NUMBERS.—Section*
24 *205(c)(2)(C) of the Social Security Act is amended by*
25 *adding at the end the following new clause:*

1 “(x) *The Secretary of Health and*
2 *Human Services, and the Exchanges estab-*
3 *lished under section 1311 of the Patient*
4 *Protection and Affordable Care Act, are au-*
5 *thorized to collect and use the names and*
6 *social security account numbers of individ-*
7 *uals as required to administer the provi-*
8 *sions of, and the amendments made by, the*
9 *such Act.”.*

10 (b) *CONFIDENTIALITY AND DISCLOSURE.—Paragraph*
11 *(3) of section 6103(a) of such Code is amended by striking*
12 *“or (20)” and inserting “(20), or (21)”.*

13 (c) *PROCEDURES AND RECORDKEEPING RELATED TO*
14 *DISCLOSURES.—Paragraph (4) of section 6103(p) of such*
15 *Code is amended—*

16 (1) *by inserting “, or any entity described in*
17 *subsection (l)(21),” after “or (20)” in the matter pre-*
18 *ceding subparagraph (A),*

19 (2) *by inserting “or any entity described in sub-*
20 *section (l)(21),” after “or (o)(1)(A)” in subparagraph*
21 *(F)(ii), and*

22 (3) *by inserting “or any entity described in sub-*
23 *section (l)(21),” after “or (20)” both places it appears*
24 *in the matter after subparagraph (F).*

1 (d) *UNAUTHORIZED DISCLOSURE OR INSPECTION.*—
2 *Paragraph (2) of section 7213(a) of such Code is amended*
3 *by striking “or (20)” and inserting “(20), or (21)”.*

4 **SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING RE-**
5 **DUCTION PAYMENTS DISREGARDED FOR FED-**
6 **ERAL AND FEDERALLY-ASSISTED PROGRAMS.**

7 *For purposes of determining the eligibility of any indi-*
8 *vidual for benefits or assistance, or the amount or extent*
9 *of benefits or assistance, under any Federal program or*
10 *under any State or local program financed in whole or in*
11 *part with Federal funds—*

12 (1) *any credit or refund allowed or made to any*
13 *individual by reason of section 36B of the Internal*
14 *Revenue Code of 1986 (as added by section 1401)*
15 *shall not be taken into account as income and shall*
16 *not be taken into account as resources for the month*
17 *of receipt and the following 2 months; and*

18 (2) *any cost-sharing reduction payment or ad-*
19 *vance payment of the credit allowed under such sec-*
20 *tion 36B that is made under section 1402 or 1412*
21 *shall be treated as made to the qualified health plan*
22 *in which an individual is enrolled and not to that in-*
23 *dividual.*

1 **PART II—SMALL BUSINESS TAX CREDIT**

2 **SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EX-**
3 **PENSES OF SMALL BUSINESSES.**

4 (a) *IN GENERAL.*—Subpart D of part IV of subchapter
5 *A* of chapter 1 of the Internal Revenue Code of 1986 (relat-
6 *ing to business-related credits*) is amended by inserting
7 *after section 45Q the following:*

8 **“SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF**
9 **SMALL EMPLOYERS.**

10 “(a) *GENERAL RULE.*—For purposes of section 38, in
11 *the case of an eligible small employer, the small employer*
12 *health insurance credit determined under this section for*
13 *any taxable year in the credit period is the amount deter-*
14 *mined under subsection (b).*

15 “(b) *HEALTH INSURANCE CREDIT AMOUNT.*—Subject
16 *to subsection (c), the amount determined under this sub-*
17 *section with respect to any eligible small employer is equal*
18 *to 50 percent (35 percent in the case of a tax-exempt eligible*
19 *small employer) of the lesser of—*

20 “(1) *the aggregate amount of nonelective con-*
21 *tributions the employer made on behalf of its employ-*
22 *ees during the taxable year under the arrangement de-*
23 *scribed in subsection (d)(4) for premiums for quali-*
24 *fied health plans offered by the employer to its em-*
25 *ployees through an Exchange, or*

1 “(2) *the aggregate amount of nonelective con-*
2 *tributions which the employer would have made dur-*
3 *ing the taxable year under the arrangement if each*
4 *employee taken into account under paragraph (1) had*
5 *enrolled in a qualified health plan which had a pre-*
6 *mium equal to the average premium (as determined*
7 *by the Secretary of Health and Human Services) for*
8 *the small group market in the rating area in which*
9 *the employee enrolls for coverage.*

10 “(c) *PHASEOUT OF CREDIT AMOUNT BASED ON NUM-*
11 *BER OF EMPLOYEES AND AVERAGE WAGES.—The amount*
12 *of the credit determined under subsection (b) without regard*
13 *to this subsection shall be reduced (but not below zero) by*
14 *the sum of the following amounts:*

15 “(1) *Such amount multiplied by a fraction the*
16 *numerator of which is the total number of full-time*
17 *equivalent employees of the employer in excess of 10*
18 *and the denominator of which is 15.*

19 “(2) *Such amount multiplied by a fraction the*
20 *numerator of which is the average annual wages of*
21 *the employer in excess of the dollar amount in effect*
22 *under subsection (d)(3)(B) and the denominator of*
23 *which is such dollar amount.*

24 “(d) *ELIGIBLE SMALL EMPLOYER.—For purposes of*
25 *this section—*

1 “(1) *IN GENERAL.*—*The term ‘eligible small em-*
2 *ployer’ means, with respect to any taxable year, an*
3 *employer—*

4 “(A) *which has no more than 25 full-time*
5 *equivalent employees for the taxable year,*

6 “(B) *the average annual wages of which do*
7 *not exceed an amount equal to twice the dollar*
8 *amount in effect under paragraph (3)(B) for the*
9 *taxable year, and*

10 “(C) *which has in effect an arrangement de-*
11 *scribed in paragraph (4).*

12 “(2) *FULL-TIME EQUIVALENT EMPLOYEES.*—

13 “(A) *IN GENERAL.*—*The term ‘full-time*
14 *equivalent employees’ means a number of em-*
15 *ployees equal to the number determined by divid-*
16 *ing—*

17 “(i) *the total number of hours of serv-*
18 *ice for which wages were paid by the em-*
19 *ployer to employees during the taxable year,*
20 *by*

21 “(ii) *2,080.*

22 *Such number shall be rounded to the next lowest*
23 *whole number if not otherwise a whole number.*

24 “(B) *EXCESS HOURS NOT COUNTED.*—*If an*
25 *employee works in excess of 2,080 hours of serv-*

1 *ice during any taxable year, such excess shall not*
2 *be taken into account under subparagraph (A).*

3 “(C) *HOURS OF SERVICE.*—*The Secretary,*
4 *in consultation with the Secretary of Labor,*
5 *shall prescribe such regulations, rules, and guid-*
6 *ance as may be necessary to determine the hours*
7 *of service of an employee, including rules for the*
8 *application of this paragraph to employees who*
9 *are not compensated on an hourly basis.*

10 “(3) *AVERAGE ANNUAL WAGES.*—

11 “(A) *IN GENERAL.*—*The average annual*
12 *wages of an eligible small employer for any tax-*
13 *able year is the amount determined by divid-*
14 *ing—*

15 “(i) *the aggregate amount of wages*
16 *which were paid by the employer to employ-*
17 *ees during the taxable year, by*

18 “(ii) *the number of full-time equivalent*
19 *employees of the employee determined under*
20 *paragraph (2) for the taxable year.*

21 *Such amount shall be rounded to the next lowest*
22 *multiple of \$1,000 if not otherwise such a mul-*
23 *tiple.*

24 “(B) *DOLLAR AMOUNT.*—*For purposes of*
25 *paragraph (1)(B)—*

1 “(i) 2011, 2012, AND 2013.—The dollar
2 amount in effect under this paragraph for
3 taxable years beginning in 2011, 2012, or
4 2013 is \$20,000.

5 “(ii) SUBSEQUENT YEARS.—In the
6 case of a taxable year beginning in a cal-
7 endar year after 2013, the dollar amount in
8 effect under this paragraph shall be equal to
9 \$20,000, multiplied by the cost-of-living ad-
10 justment determined under section 1(f)(3)
11 for the calendar year, determined by sub-
12 stituting ‘calendar year 2012’ for ‘calendar
13 year 1992’ in subparagraph (B) thereof.

14 “(4) CONTRIBUTION ARRANGEMENT.—An ar-
15 rangement is described in this paragraph if it re-
16 quires an eligible small employer to make a nonelec-
17 tive contribution on behalf of each employee who en-
18 rolls in a qualified health plan offered to employees
19 by the employer through an exchange in an amount
20 equal to a uniform percentage (not less than 50 per-
21 cent) of the premium cost of the qualified health plan.

22 “(5) SEASONAL WORKER HOURS AND WAGES NOT
23 COUNTED.—For purposes of this subsection—

24 “(A) IN GENERAL.—The number of hours of
25 service worked by, and wages paid to, a seasonal

1 *worker of an employer shall not be taken into ac-*
2 *count in determining the full-time equivalent*
3 *employees and average annual wages of the em-*
4 *ployer unless the worker works for the employer*
5 *on more than 120 days during the taxable year.*

6 “(B) *DEFINITION OF SEASONAL WORKER.—*

7 *The term ‘seasonal worker’ means a worker who*
8 *performs labor or services on a seasonal basis as*
9 *defined by the Secretary of Labor, including*
10 *workers covered by section 500.20(s)(1) of title*
11 *29, Code of Federal Regulations and retail work-*
12 *ers employed exclusively during holiday seasons.*

13 “(e) *OTHER RULES AND DEFINITIONS.—For purposes*
14 *of this section—*

15 “(1) *EMPLOYEE.—*

16 “(A) *CERTAIN EMPLOYEES EXCLUDED.—*

17 *The term ‘employee’ shall not include—*

18 “(i) *an employee within the meaning*
19 *of section 401(c)(1),*

20 “(ii) *any 2-percent shareholder (as de-*
21 *defined in section 1372(b)) of an eligible small*
22 *business which is an S corporation,*

23 “(iii) *any 5-percent owner (as defined*
24 *in section 416(i)(1)(B)(i)) of an eligible*
25 *small business, or*

1 “(iv) any individual who bears any of
2 the relationships described in subpara-
3 graphs (A) through (G) of section 152(d)(2)
4 to, or is a dependent described in section
5 152(d)(2)(H) of, an individual described in
6 clause (i), (ii), or (iii).

7 “(B) LEASED EMPLOYEES.—The term ‘em-
8 ployee’ shall include a leased employee within
9 the meaning of section 414(n).

10 “(2) CREDIT PERIOD.—The term ‘credit period’
11 means, with respect to any eligible small employer,
12 the 2-consecutive-taxable year period beginning with
13 the 1st taxable year in which the employer (or any
14 predecessor) offers 1 or more qualified health plans to
15 its employees through an Exchange.

16 “(3) NONELECTIVE CONTRIBUTION.—The term
17 ‘nonelective contribution’ means an employer con-
18 tribution other than an employer contribution pursu-
19 ant to a salary reduction arrangement.

20 “(4) WAGES.—The term ‘wages’ has the meaning
21 given such term by section 3121(a) (determined with-
22 out regard to any dollar limitation contained in such
23 section).

24 “(5) AGGREGATION AND OTHER RULES MADE AP-
25 PLICABLE.—

1 “(A) *AGGREGATION RULES.*—All employers
2 *treated as a single employer under subsection*
3 *(b), (c), (m), or (o) of section 414 shall be treated*
4 *as a single employer for purposes of this section.*

5 “(B) *OTHER RULES.*—Rules similar to the
6 *rules of subsections (c), (d), and (e) of section 52*
7 *shall apply.*

8 “(f) *CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGI-*
9 *BLE SMALL EMPLOYERS.*—

10 “(1) *IN GENERAL.*—In the case of a tax-exempt
11 *eligible small employer, there shall be treated as a*
12 *credit allowable under subpart C (and not allowable*
13 *under this subpart) the lesser of—*

14 “(A) *the amount of the credit determined*
15 *under this section with respect to such employer,*
16 *or*

17 “(B) *the amount of the payroll taxes of the*
18 *employer during the calendar year in which the*
19 *taxable year begins.*

20 “(2) *TAX-EXEMPT ELIGIBLE SMALL EM-*
21 *PLOYER.*—For purposes of this section, the term ‘tax-
22 *exempt eligible small employer’ means an eligible*
23 *small employer which is any organization described*
24 *in section 501(c) which is exempt from taxation*
25 *under section 501(a).*

1 “(3) *PAYROLL TAXES.*—*For purposes of this sub-*
2 *section—*

3 “(A) *IN GENERAL.*—*The term ‘payroll taxes’*
4 *means—*

5 “(i) *amounts required to be withheld*
6 *from the employees of the tax-exempt eligi-*
7 *ble small employer under section 3401(a),*

8 “(ii) *amounts required to be withheld*
9 *from such employees under section 3101(b),*
10 *and*

11 “(iii) *amounts of the taxes imposed on*
12 *the tax-exempt eligible small employer*
13 *under section 3111(b).*

14 “(B) *SPECIAL RULE.*—*A rule similar to the*
15 *rule of section 24(d)(2)(C) shall apply for pur-*
16 *poses of subparagraph (A).*

17 “(g) *APPLICATION OF SECTION FOR CALENDAR YEARS*
18 *2011, 2012, AND 2013.*—*In the case of any taxable year*
19 *beginning in 2011, 2012, or 2013, the following modifica-*
20 *tions to this section shall apply in determining the amount*
21 *of the credit under subsection (a):*

22 “(1) *NO CREDIT PERIOD REQUIRED.*—*The credit*
23 *shall be determined without regard to whether the tax-*
24 *able year is in a credit period and for purposes of ap-*
25 *plying this section to taxable years beginning after*

1 *2013, no credit period shall be treated as beginning*
2 *with a taxable year beginning before 2014.*

3 “(2) *AMOUNT OF CREDIT.*—*The amount of the*
4 *credit determined under subsection (b) shall be deter-*
5 *mined—*

6 “(A) *by substituting ‘35 percent (25 percent*
7 *in the case of a tax-exempt eligible small em-*
8 *ployer)’ for ‘50 percent (35 percent in the case*
9 *of a tax-exempt eligible small employer),’*

10 “(B) *by reference to an eligible small em-*
11 *ployer’s nonelective contributions for premiums*
12 *paid for health insurance coverage (within the*
13 *meaning of section 9832(b)(1)) of an employee,*
14 *and*

15 “(C) *by substituting for the average pre-*
16 *mium determined under subsection (b)(2) the*
17 *amount the Secretary of Health and Human*
18 *Services determines is the average premium for*
19 *the small group market in the State in which the*
20 *employer is offering health insurance coverage*
21 *(or for such area within the State as is specified*
22 *by the Secretary).*

23 “(3) *CONTRIBUTION ARRANGEMENT.*—*An ar-*
24 *rangement shall not fail to meet the requirements of*

1 *subsection (d)(4) solely because it provides for the of-*
2 *fering of insurance outside of an Exchange.*

3 “(h) *INSURANCE DEFINITIONS.*—*Any term used in this*
4 *section which is also used in the Public Health Service Act*
5 *or subtitle A of title I of the Patient Protection and Afford-*
6 *able Care Act shall have the meaning given such term by*
7 *such Act or subtitle.*

8 “(i) *REGULATIONS.*—*The Secretary shall prescribe*
9 *such regulations as may be necessary to carry out the provi-*
10 *sions of this section, including regulations to prevent the*
11 *avoidance of the 2-year limit on the credit period through*
12 *the use of successor entities and the avoidance of the limita-*
13 *tions under subsection (c) through the use of multiple enti-*
14 *ties.”.*

15 (b) *CREDIT TO BE PART OF GENERAL BUSINESS*
16 *CREDIT.*—*Section 38(b) of the Internal Revenue Code of*
17 *1986 (relating to current year business credit) is amended*
18 *by striking “plus” at the end of paragraph (34), by striking*
19 *the period at the end of paragraph (35) and inserting “,*
20 *plus”, and by inserting after paragraph (35) the following:*

21 *“(36) the small employer health insurance credit*
22 *determined under section 45R.”.*

23 (c) *CREDIT ALLOWED AGAINST ALTERNATIVE MIN-*
24 *IMUM TAX.*—*Section 38(c)(4)(B) of the Internal Revenue*
25 *Code of 1986 (defining specified credits) is amended by re-*

1 *designating clauses (vi), (vii), and (viii) as clauses (vii),*
2 *(viii), and (ix), respectively, and by inserting after clause*
3 *(v) the following new clause:*

4 *“(vi) the credit determined under sec-*
5 *tion 45R.”.*

6 *(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EX-*
7 *PENSES FOR WHICH CREDIT ALLOWED.—*

8 *(1) IN GENERAL.—Section 280C of the Internal*
9 *Revenue Code of 1986 (relating to disallowance of de-*
10 *duction for certain expenses for which credit allowed),*
11 *as amended by section 1401(b), is amended by adding*
12 *at the end the following new subsection:*

13 *“(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EX-*
14 *PENSES OF SMALL EMPLOYERS.—No deduction shall be al-*
15 *lowed for that portion of the premiums for qualified health*
16 *plans (as defined in section 1301(a) of the Patient Protec-*
17 *tion and Affordable Care Act), or for health insurance cov-*
18 *erage in the case of taxable years beginning in 2011, 2012,*
19 *or 2013, paid by an employer which is equal to the amount*
20 *of the credit determined under section 45R(a) with respect*
21 *to the premiums.”.*

22 *(2) DEDUCTION FOR EXPIRING CREDITS.—Sec-*
23 *tion 196(c) of such Code is amended by striking*
24 *“and” at the end of paragraph (12), by striking the*
25 *period at the end of paragraph (13) and inserting “,*

1 *and*”, and by adding at the end the following new
2 paragraph:

3 “(14) the small employer health insurance credit
4 determined under section 45R(a).”.

5 (e) *CLERICAL AMENDMENT*.—The table of sections for
6 subpart D of part IV of subchapter A of chapter 1 of the
7 Internal Revenue Code of 1986 is amended by adding at
8 the end the following:

 “Sec. 45R. *Employee health insurance expenses of small employers*.”.

9 (f) *EFFECTIVE DATES*.—

10 (1) *IN GENERAL*.—The amendments made by
11 this section shall apply to amounts paid or incurred
12 in taxable years beginning after December 31, 2010.

13 (2) *MINIMUM TAX*.—The amendments made by
14 subsection (c) shall apply to credits determined under
15 section 45R of the Internal Revenue Code of 1986 in
16 taxable years beginning after December 31, 2010, and
17 to carrybacks of such credits.

18 ***Subtitle F—Shared Responsibility***
19 ***for Health Care***

20 ***PART I—INDIVIDUAL RESPONSIBILITY***

21 ***SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSEN-***
22 ***TIAL COVERAGE.***

23 (a) *FINDINGS*.—Congress makes the following findings:

24 (1) *IN GENERAL*.—The individual responsibility
25 requirement provided for in this section (in this sub-

1 *section referred to as the “requirement”) is commer-*
2 *cial and economic in nature, and substantially affects*
3 *interstate commerce, as a result of the effects described*
4 *in paragraph (2).*

5 (2) *EFFECTS ON THE NATIONAL ECONOMY AND*
6 *INTERSTATE COMMERCE.—The effects described in*
7 *this paragraph are the following:*

8 (A) *The requirement regulates activity that*
9 *is commercial and economic in nature: economic*
10 *and financial decisions about how and when*
11 *health care is paid for, and when health insur-*
12 *ance is purchased.*

13 (B) *Health insurance and health care serv-*
14 *ices are a significant part of the national econ-*
15 *omy. National health spending is projected to in-*
16 *crease from \$2,500,000,000,000, or 17.6 percent*
17 *of the economy, in 2009 to \$4,700,000,000,000 in*
18 *2019. Private health insurance spending is pro-*
19 *jected to be \$854,000,000,000 in 2009, and pays*
20 *for medical supplies, drugs, and equipment that*
21 *are shipped in interstate commerce. Since most*
22 *health insurance is sold by national or regional*
23 *health insurance companies, health insurance is*
24 *sold in interstate commerce and claims pay-*
25 *ments flow through interstate commerce.*

1 (C) *The requirement, together with the other*
2 *provisions of this Act, will add millions of new*
3 *consumers to the health insurance market, in-*
4 *creasing the supply of, and demand for, health*
5 *care services. According to the Congressional*
6 *Budget Office, the requirement will increase the*
7 *number and share of Americans who are insured.*

8 (D) *The requirement achieves near-uni-*
9 *versal coverage by building upon and strength-*
10 *ening the private employer-based health insur-*
11 *ance system, which covers 176,000,000 Ameri-*
12 *cans nationwide. In Massachusetts, a similar re-*
13 *quirement has strengthened private employer-*
14 *based coverage: despite the economic downturn,*
15 *the number of workers offered employer-based*
16 *coverage has actually increased.*

17 (E) *Half of all personal bankruptcies are*
18 *caused in part by medical expenses. By signifi-*
19 *cantly increasing health insurance coverage, the*
20 *requirement, together with the other provisions of*
21 *this Act, will improve financial security for fam-*
22 *ilies.*

23 (F) *Under the Employee Retirement Income*
24 *Security Act of 1974 (29 U.S.C. 1001 et seq.),*
25 *the Public Health Service Act (42 U.S.C. 201 et*

1 *seq.), and this Act, the Federal Government has*
2 *a significant role in regulating health insurance*
3 *which is in interstate commerce.*

4 *(G) Under sections 2704 and 2705 of the*
5 *Public Health Service Act (as added by section*
6 *1201 of this Act), if there were no requirement,*
7 *many individuals would wait to purchase health*
8 *insurance until they needed care. By signifi-*
9 *cantly increasing health insurance coverage, the*
10 *requirement, together with the other provisions of*
11 *this Act, will minimize this adverse selection and*
12 *broaden the health insurance risk pool to include*
13 *healthy individuals, which will lower health in-*
14 *surance premiums. The requirement is essential*
15 *to creating effective health insurance markets in*
16 *which improved health insurance products that*
17 *are guaranteed issue and do not exclude coverage*
18 *of pre-existing conditions can be sold.*

19 *(H) Administrative costs for private health*
20 *insurance, which were \$90,000,000,000 in 2006,*
21 *are 26 to 30 percent of premiums in the current*
22 *individual and small group markets. By signifi-*
23 *cantly increasing health insurance coverage and*
24 *the size of purchasing pools, which will increase*
25 *economies of scale, the requirement, together with*

1 *the other provisions of this Act, will significantly*
 2 *reduce administrative costs and lower health in-*
 3 *surance premiums. The requirement is essential*
 4 *to creating effective health insurance markets*
 5 *that do not require underwriting and eliminate*
 6 *its associated administrative costs.*

7 (3) *SUPREME COURT RULING.—In United States*
 8 *v. South-Eastern Underwriters Association (322 U.S.*
 9 *533 (1944)), the Supreme Court of the United States*
 10 *ruled that insurance is interstate commerce subject to*
 11 *Federal regulation.*

12 (b) *IN GENERAL.—Subtitle D of the Internal Revenue*
 13 *Code of 1986 is amended by adding at the end the following*
 14 *new chapter:*

15 **“CHAPTER 48—MAINTENANCE OF**
 16 **MINIMUM ESSENTIAL COVERAGE**

“Sec. 5000A. Requirement to maintain minimum essential coverage.

17 **“SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSEN-**
 18 **TIAL COVERAGE.**

19 “(a) *REQUIREMENT TO MAINTAIN MINIMUM ESSEN-*
 20 *TIAL COVERAGE.—An applicable individual shall for each*
 21 *month beginning after 2013 ensure that the individual, and*
 22 *any dependent of the individual who is an applicable indi-*
 23 *vidual, is covered under minimum essential coverage for*
 24 *such month.*

1 “(b) *SHARED RESPONSIBILITY PAYMENT.*—

2 “(1) *IN GENERAL.*—*If an applicable individual*
3 *fails to meet the requirement of subsection (a) for 1*
4 *or more months during any calendar year beginning*
5 *after 2013, then, except as provided in subsection (d),*
6 *there is hereby imposed a penalty with respect to the*
7 *individual in the amount determined under sub-*
8 *section (c).*

9 “(2) *INCLUSION WITH RETURN.*—*Any penalty*
10 *imposed by this section with respect to any month*
11 *shall be included with a taxpayer’s return under*
12 *chapter 1 for the taxable year which includes such*
13 *month.*

14 “(3) *PAYMENT OF PENALTY.*—*If an individual*
15 *with respect to whom a penalty is imposed by this*
16 *section for any month—*

17 “(A) *is a dependent (as defined in section*
18 *152) of another taxpayer for the other taxpayer’s*
19 *taxable year including such month, such other*
20 *taxpayer shall be liable for such penalty, or*

21 “(B) *files a joint return for the taxable year*
22 *including such month, such individual and the*
23 *spouse of such individual shall be jointly liable*
24 *for such penalty.*

25 “(c) *AMOUNT OF PENALTY.*—

1 “(1) *IN GENERAL.*—*The penalty determined*
2 *under this subsection for any month with respect to*
3 *any individual is an amount equal to $\frac{1}{12}$ of the ap-*
4 *plicable dollar amount for the calendar year.*

5 “(2) *DOLLAR LIMITATION.*—*The amount of the*
6 *penalty imposed by this section on any taxpayer for*
7 *any taxable year with respect to all individuals for*
8 *whom the taxpayer is liable under subsection (b)(3)*
9 *shall not exceed an amount equal to 300 percent the*
10 *applicable dollar amount (determined without regard*
11 *to paragraph (3)(C)) for the calendar year with or*
12 *within which the taxable year ends.*

13 “(3) *APPLICABLE DOLLAR AMOUNT.*—*For pur-*
14 *poses of paragraph (1)—*

15 “(A) *IN GENERAL.*—*Except as provided in*
16 *subparagraphs (B) and (C), the applicable dollar*
17 *amount is \$750.*

18 “(B) *PHASE IN.*—*The applicable dollar*
19 *amount is \$95 for 2014 and \$350 for 2015.*

20 “(C) *SPECIAL RULE FOR INDIVIDUALS*
21 *UNDER AGE 18.*—*If an applicable individual has*
22 *not attained the age of 18 as of the beginning of*
23 *a month, the applicable dollar amount with re-*
24 *spect to such individual for the month shall be*

1 *equal to one-half of the applicable dollar amount*
2 *for the calendar year in which the month occurs.*

3 “(D) *INDEXING OF AMOUNT.*—*In the case of*
4 *any calendar year beginning after 2016, the ap-*
5 *licable dollar amount shall be equal to \$750, in-*
6 *creased by an amount equal to—*

7 “(i) *\$750, multiplied by*

8 “(ii) *the cost-of-living adjustment de-*
9 *termined under section 1(f)(3) for the cal-*
10 *endar year, determined by substituting ‘cal-*
11 *endar year 2015’ for ‘calendar year 1992’*
12 *in subparagraph (B) thereof.*

13 *If the amount of any increase under clause (i)*
14 *is not a multiple of \$50, such increase shall be*
15 *rounded to the next lowest multiple of \$50.*

16 “(4) *TERMS RELATING TO INCOME AND FAMI-*
17 *LIES.*—*For purposes of this section—*

18 “(A) *FAMILY SIZE.*—*The family size in-*
19 *volved with respect to any taxpayer shall be*
20 *equal to the number of individuals for whom the*
21 *taxpayer is allowed a deduction under section*
22 *151 (relating to allowance of deduction for per-*
23 *sonal exemptions) for the taxable year.*

24 “(B) *HOUSEHOLD INCOME.*—*The term*
25 *‘household income’ means, with respect to any*

1 taxpayer for any taxable year, an amount equal
2 to the sum of—

3 “(i) the modified gross income of the
4 taxpayer, plus

5 “(ii) the aggregate modified gross in-
6 comes of all other individuals who—

7 “(I) were taken into account in
8 determining the taxpayer’s family size
9 under paragraph (1), and

10 “(II) were required to file a re-
11 turn of tax imposed by section 1 for
12 the taxable year.

13 “(C) *MODIFIED GROSS INCOME.*—The term
14 ‘modified gross income’ means gross income—

15 “(i) decreased by the amount of any
16 deduction allowable under paragraph (1),
17 (3), (4), or (10) of section 62(a),

18 “(ii) increased by the amount of inter-
19 est received or accrued during the taxable
20 year which is exempt from tax imposed by
21 this chapter, and

22 “(iii) determined without regard to
23 sections 911, 931, and 933.

24 “(D) *POVERTY LINE.*—

1 “(i) *IN GENERAL.*—*The term ‘poverty*
2 *line’ has the meaning given that term in*
3 *section 2110(c)(5) of the Social Security Act*
4 *(42 U.S.C. 1397jj(c)(5)).*

5 “(ii) *POVERTY LINE USED.*—*In the*
6 *case of any taxable year ending with or*
7 *within a calendar year, the poverty line*
8 *used shall be the most recently published*
9 *poverty line as of the 1st day of such cal-*
10 *endar year.*

11 “(d) *APPLICABLE INDIVIDUAL.*—*For purposes of this*
12 *section—*

13 “(1) *IN GENERAL.*—*The term ‘applicable indi-*
14 *vidual’ means, with respect to any month, an indi-*
15 *vidual other than an individual described in para-*
16 *graph (2), (3), or (4).*

17 “(2) *RELIGIOUS EXEMPTIONS.*—

18 “(A) *RELIGIOUS CONSCIENCE EXEMP-*
19 *TION.*—*Such term shall not include any indi-*
20 *vidual for any month if such individual has in*
21 *effect an exemption under section 1311(d)(4)(H)*
22 *of the Patient Protection and Affordable Care*
23 *Act which certifies that such individual is a*
24 *member of a recognized religious sect or division*
25 *thereof described in section 1402(g)(1) and an*

1 *adherent of established tenets or teachings of such*
2 *sect or division as described in such section.*

3 “(B) *HEALTH CARE SHARING MINISTRY.*—

4 “(i) *IN GENERAL.*—*Such term shall*
5 *not include any individual for any month*
6 *if such individual is a member of a health*
7 *care sharing ministry for the month.*

8 “(ii) *HEALTH CARE SHARING MIN-*
9 *ISTRY.*—*The term ‘health care sharing min-*
10 *istry’ means an organization—*

11 “(I) *which is described in section*
12 *501(c)(3) and is exempt from taxation*
13 *under section 501(a),*

14 “(II) *members of which share a*
15 *common set of ethical or religious be-*
16 *liefs and share medical expenses among*
17 *members in accordance with those be-*
18 *liefs and without regard to the State in*
19 *which a member resides or is em-*
20 *ployed,*

21 “(III) *members of which retain*
22 *membership even after they develop a*
23 *medical condition,*

24 “(IV) *which (or a predecessor of*
25 *which) has been in existence at all*

1 *times since December 31, 1999, and*
2 *medical expenses of its members have*
3 *been shared continuously and without*
4 *interruption since at least December*
5 *31, 1999, and*

6 *“(V) which conducts an annual*
7 *audit which is performed by an inde-*
8 *pendent certified public accounting*
9 *firm in accordance with generally ac-*
10 *cepted accounting principles and*
11 *which is made available to the public*
12 *upon request.*

13 *“(3) INDIVIDUALS NOT LAWFULLY PRESENT.—*
14 *Such term shall not include an individual for any*
15 *month if for the month the individual is not a citizen*
16 *or national of the United States or an alien lawfully*
17 *present in the United States.*

18 *“(4) INCARCERATED INDIVIDUALS.—Such term*
19 *shall not include an individual for any month if for*
20 *the month the individual is incarcerated, other than*
21 *incarceration pending the disposition of charges.*

22 *“(e) EXEMPTIONS.—No penalty shall be imposed*
23 *under subsection (a) with respect to—*

24 *“(1) INDIVIDUALS WHO CANNOT AFFORD COV-*
25 *ERAGE.—*

1 “(A) *IN GENERAL.*—*Any applicable indi-*
2 *vidual for any month if the applicable individ-*
3 *ual’s required contribution (determined on an*
4 *annual basis) for coverage for the month exceeds*
5 *8 percent of such individual’s household income*
6 *for the taxable year described in section*
7 *1412(b)(1)(B) of the Patient Protection and Af-*
8 *fordable Care Act. For purposes of applying this*
9 *subparagraph, the taxpayer’s household income*
10 *shall be increased by any exclusion from gross*
11 *income for any portion of the required contribu-*
12 *tion made through a salary reduction arrange-*
13 *ment.*

14 “(B) *REQUIRED CONTRIBUTION.*—*For pur-*
15 *poses of this paragraph, the term ‘required con-*
16 *tribution’ means—*

17 “(i) *in the case of an individual eligi-*
18 *ble to purchase minimum essential coverage*
19 *consisting of coverage through an eligible-*
20 *employer-sponsored plan, the portion of the*
21 *annual premium which would be paid by*
22 *the individual (without regard to whether*
23 *paid through salary reduction or otherwise)*
24 *for self-only coverage, or*

1 “(ii) *in the case of an individual eligi-*
2 *ble only to purchase minimum essential*
3 *coverage described in subsection (f)(1)(C),*
4 *the annual premium for the lowest cost*
5 *bronze plan available in the individual*
6 *market through the Exchange in the State*
7 *in the rating area in which the individual*
8 *resides (without regard to whether the indi-*
9 *vidual purchased a qualified health plan*
10 *through the Exchange), reduced by the*
11 *amount of the credit allowable under section*
12 *36B for the taxable year (determined as if*
13 *the individual was covered by a qualified*
14 *health plan offered through the Exchange for*
15 *the entire taxable year).*

16 “(C) *SPECIAL RULES FOR INDIVIDUALS RE-*
17 *LATED TO EMPLOYEES.—For purposes of sub-*
18 *paragraph (B)(i), if an applicable individual is*
19 *eligible for minimum essential coverage through*
20 *an employer by reason of a relationship to an*
21 *employee, the determination shall be made by*
22 *reference to the affordability of the coverage to*
23 *the employee.*

24 “(D) *INDEXING.—In the case of plan years*
25 *beginning in any calendar year after 2014, sub-*

1 *paragraph (A) shall be applied by substituting*
2 *for ‘8 percent’ the percentage the Secretary of*
3 *Health and Human Services determines reflects*
4 *the excess of the rate of premium growth between*
5 *the preceding calendar year and 2013 over the*
6 *rate of income growth for such period.*

7 “(2) *TAXPAYERS WITH INCOME UNDER 100 PER-*
8 *CENT OF POVERTY LINE.—Any applicable individual*
9 *for any month during a calendar year if the individ-*
10 *ual’s household income for the taxable year described*
11 *in section 1412(b)(1)(B) of the Patient Protection and*
12 *Affordable Care Act is less than 100 percent of the*
13 *poverty line for the size of the family involved (deter-*
14 *mined in the same manner as under subsection*
15 *(b)(4)).*

16 “(3) *MEMBERS OF INDIAN TRIBES.—Any appli-*
17 *cable individual for any month during which the in-*
18 *dividual is a member of an Indian tribe (as defined*
19 *in section 45A(c)(6)).*

20 “(4) *MONTHS DURING SHORT COVERAGE GAPS.—*

21 “(A) *IN GENERAL.—Any month the last day*
22 *of which occurred during a period in which the*
23 *applicable individual was not covered by min-*
24 *imum essential coverage for a continuous period*
25 *of less than 3 months.*

1 “(B) *SPECIAL RULES.*—*For purposes of ap-*
2 *plying this paragraph—*

3 “(i) *the length of a continuous period*
4 *shall be determined without regard to the*
5 *calendar years in which months in such pe-*
6 *riod occur,*

7 “(ii) *if a continuous period is greater*
8 *than the period allowed under subpara-*
9 *graph (A), no exception shall be provided*
10 *under this paragraph for any month in the*
11 *period, and*

12 “(iii) *if there is more than 1 contin-*
13 *uous period described in subparagraph (A)*
14 *covering months in a calendar year, the ex-*
15 *ception provided by this paragraph shall*
16 *only apply to months in the first of such pe-*
17 *riods.*

18 *The Secretary shall prescribe rules for the collec-*
19 *tion of the penalty imposed by this section in*
20 *cases where continuous periods include months*
21 *in more than 1 taxable year.*

22 “(5) *HARDSHIPS.*—*Any applicable individual*
23 *who for any month is determined by the Secretary of*
24 *Health and Human Services under section*
25 *1311(d)(4)(H) to have suffered a hardship with re-*

1 *spect to the capability to obtain coverage under a*
2 *qualified health plan.*

3 “(f) *MINIMUM ESSENTIAL COVERAGE.*—*For purposes*
4 *of this section—*

5 “(1) *IN GENERAL.*—*The term ‘minimum essen-*
6 *tial coverage’ means any of the following:*

7 “(A) *GOVERNMENT SPONSORED PRO-*
8 *GRAMS.*—*Coverage under—*

9 “(i) *the Medicare program under part*
10 *A of title XVIII of the Social Security Act,*

11 “(ii) *the Medicaid program under title*
12 *XIX of the Social Security Act,*

13 “(iii) *the CHIP program under title*
14 *XXI of the Social Security Act,*

15 “(iv) *the TRICARE for Life program,*

16 “(v) *the veteran’s health care program*
17 *under chapter 17 of title 38, United States*
18 *Code, or*

19 “(vi) *a health plan under section*
20 *2504(e) of title 22, United States Code (re-*
21 *lating to Peace Corps volunteers).*

22 “(B) *EMPLOYER-SPONSORED PLAN.*—*Cov-*
23 *erage under an eligible employer-sponsored plan.*

1 “(C) *PLANS IN THE INDIVIDUAL MARKET.*—
2 *Coverage under a health plan offered in the indi-*
3 *vidual market within a State.*

4 “(D) *GRANDFATHERED HEALTH PLAN.*—
5 *Coverage under a grandfathered health plan.*

6 “(E) *OTHER COVERAGE.*—*Such other health*
7 *benefits coverage, such as a State health benefits*
8 *risk pool, as the Secretary of Health and Human*
9 *Services, in coordination with the Secretary, rec-*
10 *ognizes for purposes of this subsection.*

11 “(2) *ELIGIBLE EMPLOYER-SPONSORED PLAN.*—
12 *The term ‘eligible employer-sponsored plan’ means,*
13 *with respect to any employee, a group health plan or*
14 *group health insurance coverage offered by an em-*
15 *ployer to the employee which is—*

16 “(A) *a governmental plan (within the*
17 *meaning of section 2791(d)(8) of the Public*
18 *Health Service Act), or*

19 “(B) *any other plan or coverage offered in*
20 *the small or large group market within a State.*

21 *Such term shall include a grandfathered health plan*
22 *described in paragraph (1)(D) offered in a group*
23 *market.*

24 “(3) *EXCEPTED BENEFITS NOT TREATED AS MIN-*
25 *IMUM ESSENTIAL COVERAGE.*—*The term ‘minimum*

1 *essential coverage' shall not include health insurance*
2 *coverage which consists of coverage of excepted bene-*
3 *fits—*

4 *“(A) described in paragraph (1) of sub-*
5 *section (c) of section 2791 of the Public Health*
6 *Service Act; or*

7 *“(B) described in paragraph (2), (3), or (4)*
8 *of such subsection if the benefits are provided*
9 *under a separate policy, certificate, or contract*
10 *of insurance.*

11 *“(4) INDIVIDUALS RESIDING OUTSIDE UNITED*
12 *STATES OR RESIDENTS OF TERRITORIES.—Any appli-*
13 *cable individual shall be treated as having minimum*
14 *essential coverage for any month—*

15 *“(A) if such month occurs during any pe-*
16 *riod described in subparagraph (A) or (B) of sec-*
17 *tion 911(d)(1) which is applicable to the indi-*
18 *vidual, or*

19 *“(B) if such individual is a bona fide resi-*
20 *dent of any possession of the United States (as*
21 *determined under section 937(a)) for such*
22 *month.*

23 *“(5) INSURANCE-RELATED TERMS.—Any term*
24 *used in this section which is also used in title I of*

1 *the Patient Protection and Affordable Care Act shall*
2 *have the same meaning as when used in such title.*

3 “(g) *ADMINISTRATION AND PROCEDURE.*—

4 “(1) *IN GENERAL.*—*The penalty provided by this*
5 *section shall be paid upon notice and demand by the*
6 *Secretary, and except as provided in paragraph (2),*
7 *shall be assessed and collected in the same manner as*
8 *an assessable penalty under subchapter B of chapter*
9 *68.*

10 “(2) *SPECIAL RULES.*—*Notwithstanding any*
11 *other provision of law—*

12 “(A) *WAIVER OF CRIMINAL PENALTIES.*—*In*
13 *the case of any failure by a taxpayer to timely*
14 *pay any penalty imposed by this section, such*
15 *taxpayer shall not be subject to any criminal*
16 *prosecution or penalty with respect to such fail-*
17 *ure.*

18 “(B) *LIMITATIONS ON LIENS AND LEVIES.*—
19 *The Secretary shall not—*

20 “(i) *file notice of lien with respect to*
21 *any property of a taxpayer by reason of*
22 *any failure to pay the penalty imposed by*
23 *this section, or*

24 “(ii) *levy on any such property with*
25 *respect to such failure.”*

1 (c) *CLERICAL AMENDMENT.*—The table of chapters for
 2 subtitle D of the Internal Revenue Code of 1986 is amended
 3 by inserting after the item relating to chapter 47 the fol-
 4 lowing new item:

 “CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.”.

5 (d) *EFFECTIVE DATE.*—The amendments made by this
 6 section shall apply to taxable years ending after December
 7 31, 2013.

8 **SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.**

9 (a) *IN GENERAL.*—Part III of subchapter A of chapter
 10 61 of the Internal Revenue Code of 1986 is amended by
 11 inserting after subpart C the following new subpart:

12 **“Subpart D—Information Regarding Health**
 13 **Insurance Coverage**

 “Sec. 6055. Reporting of health insurance coverage.

14 **“SEC. 6055. REPORTING OF HEALTH INSURANCE COV-**
 15 **ERAGE.**

16 “(a) *IN GENERAL.*—Every person who provides min-
 17 imum essential coverage to an individual during a calendar
 18 year shall, at such time as the Secretary may prescribe,
 19 make a return described in subsection (b).

20 “(b) *FORM AND MANNER OF RETURN.*—

21 “(1) *IN GENERAL.*—A return is described in this
 22 subsection if such return—

23 “(A) is in such form as the Secretary may
 24 prescribe, and

1 “(B) contains—

2 “(i) the name, address and TIN of the
3 primary insured and the name and TIN of
4 each other individual obtaining coverage
5 under the policy,

6 “(ii) the dates during which such indi-
7 vidual was covered under minimum essen-
8 tial coverage during the calendar year,

9 “(iii) in the case of minimum essential
10 coverage which consists of health insurance
11 coverage, information concerning—

12 “(I) whether or not the coverage is
13 a qualified health plan offered through
14 an Exchange established under section
15 1311 of the Patient Protection and Af-
16 fordable Care Act, and

17 “(II) in the case of a qualified
18 health plan, the amount (if any) of
19 any advance payment under section
20 1412 of the Patient Protection and Af-
21 fordable Care Act of any cost-sharing
22 reduction under section 1402 of such
23 Act or of any premium tax credit
24 under section 36B with respect to such
25 coverage, and

1 “(iv) such other information as the
2 Secretary may require.

3 “(2) INFORMATION RELATING TO EMPLOYER-PRO-
4 VIDED COVERAGE.—If minimum essential coverage
5 provided to an individual under subsection (a) con-
6 sists of health insurance coverage of a health insur-
7 ance issuer provided through a group health plan of
8 an employer, a return described in this subsection
9 shall include—

10 “(A) the name, address, and employer iden-
11 tification number of the employer maintaining
12 the plan,

13 “(B) the portion of the premium (if any)
14 required to be paid by the employer, and

15 “(C) if the health insurance coverage is a
16 qualified health plan in the small group market
17 offered through an Exchange, such other infor-
18 mation as the Secretary may require for admin-
19 istration of the credit under section 45R (relat-
20 ing to credit for employee health insurance ex-
21 penses of small employers).

22 “(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS
23 WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

24 “(1) IN GENERAL.—Every person required to
25 make a return under subsection (a) shall furnish to

1 *each individual whose name is required to be set forth*
2 *in such return a written statement showing—*

3 “(A) *the name and address of the person re-*
4 *quired to make such return and the phone num-*
5 *ber of the information contact for such person,*
6 *and*

7 “(B) *the information required to be shown*
8 *on the return with respect to such individual.*

9 “(2) *TIME FOR FURNISHING STATEMENTS.—The*
10 *written statement required under paragraph (1) shall*
11 *be furnished on or before January 31 of the year fol-*
12 *lowing the calendar year for which the return under*
13 *subsection (a) was required to be made.*

14 “(d) *COVERAGE PROVIDED BY GOVERNMENTAL*
15 *UNITS.—In the case of coverage provided by any govern-*
16 *mental unit or any agency or instrumentality thereof, the*
17 *officer or employee who enters into the agreement to provide*
18 *such coverage (or the person appropriately designated for*
19 *purposes of this section) shall make the returns and state-*
20 *ments required by this section.*

21 “(e) *MINIMUM ESSENTIAL COVERAGE.—For purposes*
22 *of this section, the term ‘minimum essential coverage’ has*
23 *the meaning given such term by section 5000A(f).”.*

24 “(b) *ASSESSABLE PENALTIES.—*

1 (1) *Subparagraph (B) of section 6724(d)(1) of*
2 *the Internal Revenue Code of 1986 (relating to defini-*
3 *tions) is amended by striking “or” at the end of*
4 *clause (xxii), by striking “and” at the end of clause*
5 *(xxiii) and inserting “or”, and by inserting after*
6 *clause (xxiii) the following new clause:*

7 *“(xxiv) section 6055 (relating to re-*
8 *turns relating to information regarding*
9 *health insurance coverage), and”.*

10 (2) *Paragraph (2) of section 6724(d) of such*
11 *Code is amended by striking “or” at the end of sub-*
12 *paragraph (EE), by striking the period at the end of*
13 *subparagraph (FF) and inserting “, or” and by in-*
14 *serting after subparagraph (FF) the following new*
15 *subparagraph:*

16 *“(GG) section 6055(c) (relating to state-*
17 *ments relating to information regarding health*
18 *insurance coverage).”.*

19 (c) *NOTIFICATION OF NONENROLLMENT.*—*Not later*
20 *than June 30 of each year, the Secretary of the Treasury,*
21 *acting through the Internal Revenue Service and in con-*
22 *sultation with the Secretary of Health and Human Serv-*
23 *ices, shall send a notification to each individual who files*
24 *an individual income tax return and who is not enrolled*
25 *in minimum essential coverage (as defined in section 5000A*

1 *of the Internal Revenue Code of 1986). Such notification*
 2 *shall contain information on the services available through*
 3 *the Exchange operating in the State in which such indi-*
 4 *vidual resides.*

5 (d) *CONFORMING AMENDMENT.—The table of subparts*
 6 *for part III of subchapter A of chapter 61 of such Code*
 7 *is amended by inserting after the item relating to subpart*
 8 *C the following new item:*

“SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE”.

9 (e) *EFFECTIVE DATE.—The amendments made by this*
 10 *section shall apply to calendar years beginning after 2013.*

11 ***PART II—EMPLOYER RESPONSIBILITIES***

12 ***SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF***

13 ***LARGE EMPLOYERS.***

14 *The Fair Labor Standards Act of 1938 is amended by*
 15 *inserting after section 18 (29 U.S.C. 218) the following:*

16 ***“SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF***

17 ***LARGE EMPLOYERS.***

18 *“In accordance with regulations promulgated by the*
 19 *Secretary, an employer to which this Act applies that has*
 20 *more than 200 full-time employees and that offers employees*
 21 *enrollment in 1 or more health benefits plans shall auto-*
 22 *matically enroll new full-time employees in one of the plans*
 23 *offered (subject to any waiting period authorized by law)*
 24 *and to continue the enrollment of current employees in a*
 25 *health benefits plan offered through the employer. Any auto-*

1 *matic enrollment program shall include adequate notice*
2 *and the opportunity for an employee to opt out of any cov-*
3 *erage the individual or employee were automatically en-*
4 *rolled in. Nothing in this section shall be construed to super-*
5 *sede any State law which establishes, implements, or con-*
6 *tinues in effect any standard or requirement relating to em-*
7 *ployers in connection with payroll except to the extent that*
8 *such standard or requirement prevents an employer from*
9 *instituting the automatic enrollment program under this*
10 *section.”.*

11 **SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOY-**
12 **EES OF COVERAGE OPTIONS.**

13 *The Fair Labor Standards Act of 1938 is amended by*
14 *inserting after section 18A (as added by section 1513) the*
15 *following:*

16 **“SEC. 18B. NOTICE TO EMPLOYEES.**

17 *“(a) IN GENERAL.—In accordance with regulations*
18 *promulgated by the Secretary, an employer to which this*
19 *Act applies, shall provide to each employee at the time of*
20 *hiring (or with respect to current employees, not later than*
21 *March 1, 2013), written notice—*

22 *“(1) informing the employee of the existence of*
23 *an Exchange, including a description of the services*
24 *provided by such Exchange, and the manner in which*

1 *the employee may contact the Exchange to request as-*
2 *sistance;*

3 “(2) *if the employer plan’s share of the total al-*
4 *lowed costs of benefits provided under the plan is less*
5 *than 60 percent of such costs, that the employee may*
6 *be eligible for a premium tax credit under section*
7 *36B of the Internal Revenue Code of 1986 and a cost*
8 *sharing reduction under section 1402 of the Patient*
9 *Protection and Affordable Care Act if the employee*
10 *purchases a qualified health plan through the Ex-*
11 *change; and*

12 “(3) *if the employee purchases a qualified health*
13 *plan through the Exchange, the employee will lose the*
14 *employer contribution (if any) to any health benefits*
15 *plan offered by the employer and that all or a portion*
16 *of such contribution may be excludable from income*
17 *for Federal income tax purposes.*

18 “(b) *EFFECTIVE DATE.—Subsection (a) shall take ef-*
19 *fect with respect to employers in a State beginning on*
20 *March 1, 2013.”.*

21 **SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.**

22 “(a) *IN GENERAL.—Chapter 43 of the Internal Revenue*
23 *Code of 1986 is amended by adding at the end the following:*

1 **“SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS**
2 **REGARDING HEALTH COVERAGE.**

3 *“(a) LARGE EMPLOYERS NOT OFFERING HEALTH*
4 *COVERAGE.—If—*

5 *“(1) any applicable large employer fails to offer*
6 *to its full-time employees (and their dependents) the*
7 *opportunity to enroll in minimum essential coverage*
8 *under an eligible employer-sponsored plan (as defined*
9 *in section 5000A(f)(2)) for any month, and*

10 *“(2) at least one full-time employee of the appli-*
11 *cable large employer has been certified to the em-*
12 *ployer under section 1411 of the Patient Protection*
13 *and Affordable Care Act as having enrolled for such*
14 *month in a qualified health plan with respect to*
15 *which an applicable premium tax credit or cost-shar-*
16 *ing reduction is allowed or paid with respect to the*
17 *employee,*

18 *then there is hereby imposed on the employer an assessable*
19 *payment equal to the product of the applicable payment*
20 *amount and the number of individuals employed by the em-*
21 *ployer as full-time employees during such month.*

22 *“(b) LARGE EMPLOYERS WITH WAITING PERIODS EX-*
23 *CEEDING 30 DAYS.—*

24 *“(1) IN GENERAL.—In the case of any applicable*
25 *large employer which requires an extended waiting*
26 *period to enroll in any minimum essential coverage*

1 *under an employer-sponsored plan (as defined in sec-*
2 *tion 5000A(f)(2)), there is hereby imposed on the em-*
3 *ployer an assessable payment, in the amount specified*
4 *in paragraph (2), for each full-time employee of the*
5 *employer to whom the extended waiting period ap-*
6 *plies.*

7 “(2) *AMOUNT.*—*For purposes of paragraph (1),*
8 *the amount specified in this paragraph for a full-time*
9 *employee is—*

10 “(A) *in the case of an extended waiting pe-*
11 *riod which exceeds 30 days but does not exceed*
12 *60 days, \$400, and*

13 “(B) *in the case of an extended waiting pe-*
14 *riod which exceeds 60 days, \$600.*

15 “(3) *EXTENDED WAITING PERIOD.*—*The term*
16 *‘extended waiting period’ means any waiting period*
17 *(as defined in section 2701(b)(4) of the Public Health*
18 *Service Act) which exceeds 30 days.*

19 “(c) *LARGE EMPLOYERS OFFERING COVERAGE WITH*
20 *EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS*
21 *OR COST-SHARING REDUCTIONS.*—

22 “(1) *IN GENERAL.*—*If—*

23 “(A) *an applicable large employer offers to*
24 *its full-time employees (and their dependents) the*
25 *opportunity to enroll in minimum essential cov-*

1 *erage under an eligible employer-sponsored plan*
2 *(as defined in section 5000A(f)(2)) for any*
3 *month, and*

4 “(B) *1 or more full-time employees of the*
5 *applicable large employer has been certified to*
6 *the employer under section 1411 of the Patient*
7 *Protection and Affordable Care Act as having en-*
8 *rolled for such month in a qualified health plan*
9 *with respect to which an applicable premium tax*
10 *credit or cost-sharing reduction is allowed or*
11 *paid with respect to the employee,*
12 *then there is hereby imposed on the employer an as-*
13 *sessable payment equal to the product of the number*
14 *of full-time employees of the applicable large employer*
15 *described in subparagraph (B) for such month and*
16 *400 percent of the applicable payment amount.*

17 “(2) *OVERALL LIMITATION.—The aggregate*
18 *amount of tax determined under paragraph (1) with*
19 *respect to all employees of an applicable large em-*
20 *ployer for any month shall not exceed the product of*
21 *the applicable payment amount and the number of*
22 *individuals employed by the employer as full-time*
23 *employees during such month.*

24 “(d) *DEFINITIONS AND SPECIAL RULES.—For pur-*
25 *poses of this section—*

1 “(1) *APPLICABLE PAYMENT AMOUNT.*—*The term*
2 *‘applicable payment amount’ means, with respect to*
3 *any month, $\frac{1}{12}$ of \$750.*

4 “(2) *APPLICABLE LARGE EMPLOYER.*—

5 “(A) *IN GENERAL.*—*The term ‘applicable*
6 *large employer’ means, with respect to a cal-*
7 *endar year, an employer who employed an aver-*
8 *age of at least 50 full-time employees on business*
9 *days during the preceding calendar year.*

10 “(B) *EXEMPTION FOR CERTAIN EMPLOY-*
11 *ERS.*—

12 “(i) *IN GENERAL.*—*An employer shall*
13 *not be considered to employ more than 50*
14 *full-time employees if—*

15 “(I) *the employer’s workforce ex-*
16 *ceeds 50 full-time employees for 120*
17 *days or fewer during the calendar*
18 *year, and*

19 “(II) *the employees in excess of 50*
20 *employed during such 120-day period*
21 *were seasonal workers.*

22 “(ii) *DEFINITION OF SEASONAL WORK-*
23 *ERS.*—*The term ‘seasonal worker’ means a*
24 *worker who performs labor or services on a*
25 *seasonal basis as defined by the Secretary of*

1 *Labor, including workers covered by section*
2 *500.20(s)(1) of title 29, Code of Federal*
3 *Regulations and retail workers employed ex-*
4 *clusively during holiday seasons.*

5 “(C) *RULES FOR DETERMINING EMPLOYER*
6 *SIZE.—For purposes of this paragraph—*

7 “(i) *APPLICATION OF AGGREGATION*
8 *RULE FOR EMPLOYERS.—All persons treated*
9 *as a single employer under subsection (b),*
10 *(c), (m), or (o) of section 414 of the Internal*
11 *Revenue Code of 1986 shall be treated as 1*
12 *employer.*

13 “(ii) *EMPLOYERS NOT IN EXISTENCE*
14 *IN PRECEDING YEAR.—In the case of an em-*
15 *ployer which was not in existence through-*
16 *out the preceding calendar year, the deter-*
17 *mination of whether such employer is an*
18 *applicable large employer shall be based on*
19 *the average number of employees that it is*
20 *reasonably expected such employer will em-*
21 *ploy on business days in the current cal-*
22 *endar year.*

23 “(iii) *PREDECESSORS.—Any reference*
24 *in this subsection to an employer shall in-*

1 *clude a reference to any predecessor of such*
2 *employer.*

3 “(3) *APPLICABLE PREMIUM TAX CREDIT AND*
4 *COST-SHARING REDUCTION.—The term ‘applicable*
5 *premium tax credit and cost-sharing reduction’*
6 *means—*

7 “(A) *any premium tax credit allowed under*
8 *section 36B,*

9 “(B) *any cost-sharing reduction under sec-*
10 *tion 1402 of the Patient Protection and Afford-*
11 *able Care Act, and*

12 “(C) *any advance payment of such credit or*
13 *reduction under section 1412 of such Act.*

14 “(4) *FULL-TIME EMPLOYEE.—*

15 “(A) *IN GENERAL.—The term ‘full-time em-*
16 *ployee’ means an employee who is employed on*
17 *average at least 30 hours of service per week.*

18 “(B) *HOURS OF SERVICE.—The Secretary,*
19 *in consultation with the Secretary of Labor,*
20 *shall prescribe such regulations, rules, and guid-*
21 *ance as may be necessary to determine the hours*
22 *of service of an employee, including rules for the*
23 *application of this paragraph to employees who*
24 *are not compensated on an hourly basis.*

25 “(5) *INFLATION ADJUSTMENT.—*

1 “(A) *IN GENERAL.*—*In the case of any cal-*
2 *endar year after 2014, each of the dollar*
3 *amounts in subsection (b)(2) and (d)(1) shall be*
4 *increased by an amount equal to the product*
5 *of—*

6 “(i) *such dollar amount, and*

7 “(ii) *the premium adjustment percent-*
8 *age (as defined in section 1302(c)(4) of the*
9 *Patient Protection and Affordable Care Act)*
10 *for the calendar year.*

11 “(B) *ROUNDING.*—*If the amount of any in-*
12 *crease under subparagraph (A) is not a multiple*
13 *of \$10, such increase shall be rounded to the next*
14 *lowest multiple of \$10.*

15 “(6) *OTHER DEFINITIONS.*—*Any term used in*
16 *this section which is also used in the Patient Protec-*
17 *tion and Affordable Care Act shall have the same*
18 *meaning as when used in such Act.*

19 “(7) *TAX NONDEDUCTIBLE.*—*For denial of de-*
20 *duction for the tax imposed by this section, see section*
21 *275(a)(6).*

22 “(e) *ADMINISTRATION AND PROCEDURE.*—

23 “(1) *IN GENERAL.*—*Any assessable payment pro-*
24 *vided by this section shall be paid upon notice and*
25 *demand by the Secretary, and shall be assessed and*

1 *collected in the same manner as an assessable penalty*
2 *under subchapter B of chapter 68.*

3 “(2) *TIME FOR PAYMENT.*—*The Secretary may*
4 *provide for the payment of any assessable payment*
5 *provided by this section on an annual, monthly, or*
6 *other periodic basis as the Secretary may prescribe.*

7 “(3) *COORDINATION WITH CREDITS, ETC..*—*The*
8 *Secretary shall prescribe rules, regulations, or guid-*
9 *ance for the repayment of any assessable payment*
10 *(including interest) if such payment is based on the*
11 *allowance or payment of an applicable premium tax*
12 *credit or cost-sharing reduction with respect to an*
13 *employee, such allowance or payment is subsequently*
14 *disallowed, and the assessable payment would not*
15 *have been required to be made but for such allowance*
16 *or payment.”.*

17 “(b) *CLERICAL AMENDMENT.*—*The table of sections for*
18 *chapter 43 of such Code is amended by adding at the end*
19 *the following new item:*

 “*Sec. 4980H. Shared responsibility for employers regarding health coverage.*”.

20 “(c) *STUDY AND REPORT OF EFFECT OF TAX ON WORK-*
21 *ERS’ WAGES.*—

22 “(1) *IN GENERAL.*—*The Secretary of Labor shall*
23 *conduct a study to determine whether employees’*
24 *wages are reduced by reason of the application of the*
25 *assessable payments under section 4980H of the Inter-*

1 *nal Revenue Code of 1986 (as added by the amend-*
 2 *ments made by this section). The Secretary shall*
 3 *make such determination on the basis of the National*
 4 *Compensation Survey published by the Bureau of*
 5 *Labor Statistics.*

6 (2) *REPORT.*—*The Secretary shall report the re-*
 7 *sults of the study under paragraph (1) to the Com-*
 8 *mittee on Ways and Means of the House of Represent-*
 9 *atives and to the Committee on Finance of the Senate.*

10 (d) *EFFECTIVE DATE.*—*The amendments made by this*
 11 *section shall apply to months beginning after December 31,*
 12 *2013.*

13 **SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE**
 14 **COVERAGE.**

15 (a) *IN GENERAL.*—*Subpart D of part III of subchapter*
 16 *A of chapter 61 of the Internal Revenue Code of 1986, as*
 17 *added by section 1502, is amended by inserting after section*
 18 *6055 the following new section:*

19 **“SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON**
 20 **HEALTH INSURANCE COVERAGE.**

21 “(a) *IN GENERAL.*—*Every applicable large employer*
 22 *required to meet the requirements of section 4980H with*
 23 *respect to its full-time employees during a calendar year*
 24 *shall, at such time as the Secretary may prescribe, make*
 25 *a return described in subsection (b).*

1 “(b) *FORM AND MANNER OF RETURN.*—A return is de-
2 scribed in this subsection if such return—

3 “(1) is in such form as the Secretary may pre-
4 scribe, and

5 “(2) contains—

6 “(A) the name, date, and employer identi-
7 fication number of the employer,

8 “(B) a certification as to whether the em-
9 ployer offers to its full-time employees (and their
10 dependents) the opportunity to enroll in min-
11 imum essential coverage under an eligible em-
12 ployer-sponsored plan (as defined in section
13 5000A(f)(2)),

14 “(C) if the employer certifies that the em-
15 ployer did offer to its full-time employees (and
16 their dependents) the opportunity to so enroll—

17 “(i) the length of any waiting period
18 (as defined in section 2701(b)(4) of the Pub-
19 lic Health Service Act) with respect to such
20 coverage,

21 “(ii) the months during the calendar
22 year for which coverage under the plan was
23 available,

1 “(iii) the monthly premium for the
2 lowest cost option in each of the enrollment
3 categories under the plan, and

4 “(iv) the applicable large employer’s
5 share of the total allowed costs of benefits
6 provided under the plan,

7 “(D) the number of full-time employees for
8 each month during the calendar year,

9 “(E) the name, address, and TIN of each
10 full-time employee during the calendar year and
11 the months (if any) during which such employee
12 (and any dependents) were covered under any
13 such health benefits plans, and

14 “(F) such other information as the Sec-
15 retary may require.

16 “(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS
17 WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

18 “(1) IN GENERAL.—Every person required to
19 make a return under subsection (a) shall furnish to
20 each full-time employee whose name is required to be
21 set forth in such return under subsection (b)(2)(E) a
22 written statement showing—

23 “(A) the name and address of the person re-
24 quired to make such return and the phone num-

1 *ber of the information contact for such person,*
2 *and*

3 *“(B) the information required to be shown*
4 *on the return with respect to such individual.*

5 *“(2) TIME FOR FURNISHING STATEMENTS.—The*
6 *written statement required under paragraph (1) shall*
7 *be furnished on or before January 31 of the year fol-*
8 *lowing the calendar year for which the return under*
9 *subsection (a) was required to be made.*

10 *“(d) COORDINATION WITH OTHER REQUIREMENTS.—*
11 *To the maximum extent feasible, the Secretary may provide*
12 *that—*

13 *“(1) any return or statement required to be pro-*
14 *vided under this section may be provided as part of*
15 *any return or statement required under section 6051*
16 *or 6055, and*

17 *“(2) in the case of an applicable large employer*
18 *offering health insurance coverage of a health insur-*
19 *ance issuer, the employer may enter into an agree-*
20 *ment with the issuer to include information required*
21 *under this section with the return and statement re-*
22 *quired to be provided by the issuer under section*
23 *6055.*

24 *“(e) COVERAGE PROVIDED BY GOVERNMENTAL*
25 *UNITS.—In the case of any applicable large employer which*

1 *is a governmental unit or any agency or instrumentality*
2 *thereof, the person appropriately designated for purposes of*
3 *this section shall make the returns and statements required*
4 *by this section.*

5 “(f) *DEFINITIONS.—For purposes of this section, any*
6 *term used in this section which is also used in section*
7 *4980H shall have the meaning given such term by section*
8 *4980H.”.*

9 (b) *ASSESSABLE PENALTIES.—*

10 (1) *Subparagraph (B) of section 6724(d)(1) of*
11 *the Internal Revenue Code of 1986 (relating to defini-*
12 *tions), as amended by section 1502, is amended by*
13 *striking “or” at the end of clause (xxiii), by striking*
14 *“and” at the end of clause (xxiv) and inserting “or”,*
15 *and by inserting after clause (xxiv) the following new*
16 *clause:*

17 “(xxv) *section 6056 (relating to returns*
18 *relating to large employers required to re-*
19 *port on health insurance coverage), and”.*

20 (2) *Paragraph (2) of section 6724(d) of such*
21 *Code, as so amended, is amended by striking “or” at*
22 *the end of subparagraph (FF), by striking the period*
23 *at the end of subparagraph (GG) and inserting “, or”*
24 *and by inserting after subparagraph (GG) the fol-*
25 *lowing new subparagraph:*

1 “(HH) section 6056(c) (relating to state-
2 ments relating to large employers required to re-
3 port on health insurance coverage).”.

4 (c) *CONFORMING AMENDMENT.*—The table of sections
5 for subpart D of part III of subchapter A of chapter 61
6 of such Code, as added by section 1502, is amended by add-
7 ing at the end the following new item:

 “Sec. 6056. Large employers required to report on health insurance coverage.”.

8 (d) *EFFECTIVE DATE.*—The amendments made by this
9 section shall apply to periods beginning after December 31,
10 2013.

11 **SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALI-**
12 **FIED HEALTH PLANS THROUGH CAFETERIA**
13 **PLANS.**

14 (a) *IN GENERAL.*—Subsection (f) of section 125 of the
15 Internal Revenue Code of 1986 is amended by adding at
16 the end the following new paragraph:

17 “(3) *CERTAIN EXCHANGE-PARTICIPATING QUALI-*
18 *FIED HEALTH PLANS NOT QUALIFIED.*—

19 “(A) *IN GENERAL.*—The term ‘qualified
20 benefit’ shall not include any qualified health
21 plan (as defined in section 1301(a) of the Pa-
22 tient Protection and Affordable Care Act) offered
23 through an Exchange established under section
24 1311 of such Act.

1 “(B) *EXCEPTION FOR EXCHANGE-ELIGIBLE*
 2 *EMPLOYERS.*—Subparagraph (A) shall not apply
 3 with respect to any employee if such employee’s
 4 employer is a qualified employer (as defined in
 5 section 1312(f)(2) of the Patient Protection and
 6 Affordable Care Act) offering the employee the
 7 opportunity to enroll through such an Exchange
 8 in a qualified health plan in a group market.”.

9 (b) *CONFORMING AMENDMENTS.*—Subsection (f) of sec-
 10 tion 125 of such Code is amended—

11 (1) by striking “For purposes of this section, the
 12 term” and inserting “For purposes of this section—
 13 “(1) *IN GENERAL.*—The term”, and

14 (2) by striking “Such term shall not include”
 15 and inserting the following:

16 “(2) *LONG-TERM CARE INSURANCE NOT QUALI-*
 17 *FIED.*—The term ‘qualified benefit’ shall not include”.

18 (c) *EFFECTIVE DATE.*—The amendments made by this
 19 section shall apply to taxable years beginning after Decem-
 20 ber 31, 2013.

21 ***Subtitle G—Miscellaneous*** 22 ***Provisions***

23 ***SEC. 1551. DEFINITIONS.***

24 Unless specifically provided for otherwise, the defini-
 25 tions contained in section 2791 of the Public Health Service

1 *Act (42 U.S.C. 300gg–91) shall apply with respect to this*
2 *title.*

3 **SEC. 1552. TRANSPARENCY IN GOVERNMENT.**

4 *Not later than 30 days after the date of enactment of*
5 *this Act, the Secretary of Health and Human Services shall*
6 *publish on the Internet website of the Department of Health*
7 *and Human Services, a list of all of the authorities pro-*
8 *vided to the Secretary under this Act (and the amendments*
9 *made by this Act).*

10 **SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON AS-**
11 **SISTED SUICIDE.**

12 *(a) IN GENERAL.—The Federal Government, and any*
13 *State or local government or health care provider that re-*
14 *ceives Federal financial assistance under this Act (or under*
15 *an amendment made by this Act) or any health plan cre-*
16 *ated under this Act (or under an amendment made by this*
17 *Act), may not subject an individual or institutional health*
18 *care entity to discrimination on the basis that the entity*
19 *does not provide any health care item or service furnished*
20 *for the purpose of causing, or for the purpose of assisting*
21 *in causing, the death of any individual, such as by assisted*
22 *suicide, euthanasia, or mercy killing.*

23 *(b) DEFINITION.—In this section, the term “health care*
24 *entity” includes an individual physician or other health*
25 *care professional, a hospital, a provider-sponsored organi-*

1 zation, a health maintenance organization, a health insur-
2 ance plan, or any other kind of health care facility, organi-
3 zation, or plan.

4 (c) CONSTRUCTION AND TREATMENT OF CERTAIN
5 SERVICES.—Nothing in subsection (a) shall be construed to
6 apply to, or to affect, any limitation relating to—

7 (1) the withholding or withdrawing of medical
8 treatment or medical care;

9 (2) the withholding or withdrawing of nutrition
10 or hydration;

11 (3) abortion; or

12 (4) the use of an item, good, benefit, or service
13 furnished for the purpose of alleviating pain or dis-
14 comfort, even if such use may increase the risk of
15 death, so long as such item, good, benefit, or service
16 is not also furnished for the purpose of causing, or the
17 purpose of assisting in causing, death, for any reason.

18 (d) ADMINISTRATION.—The Office for Civil Rights of
19 the Department of Health and Human Services is des-
20 ignated to receive complaints of discrimination based on
21 this section.

22 **SEC. 1554. ACCESS TO THERAPIES.**

23 Notwithstanding any other provision of this Act, the
24 Secretary of Health and Human Services shall not promul-
25 gate any regulation that—

1 (1) *creates any unreasonable barriers to the abil-*
2 *ity of individuals to obtain appropriate medical care;*

3 (2) *impedes timely access to health care services;*

4 (3) *interferes with communications regarding a*
5 *full range of treatment options between the patient*
6 *and the provider;*

7 (4) *restricts the ability of health care providers*
8 *to provide full disclosure of all relevant information*
9 *to patients making health care decisions;*

10 (5) *violates the principles of informed consent*
11 *and the ethical standards of health care professionals;*
12 *or*

13 (6) *limits the availability of health care treat-*
14 *ment for the full duration of a patient's medical*
15 *needs.*

16 **SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL**
17 **HEALTH INSURANCE PROGRAMS.**

18 *No individual, company, business, nonprofit entity, or*
19 *health insurance issuer offering group or individual health*
20 *insurance coverage shall be required to participate in any*
21 *Federal health insurance program created under this Act*
22 *(or any amendments made by this Act), or in any Federal*
23 *health insurance program expanded by this Act (or any*
24 *such amendments), and there shall be no penalty or fine*

1 *imposed upon any such issuer for choosing not to partici-*
2 *pate in such programs.*

3 **SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.**

4 (a) *REBUTTABLE PRESUMPTION.*—Section 411(c)(4)
5 *of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is*
6 *amended by striking the last sentence.*

7 (b) *CONTINUATION OF BENEFITS.*—Section 422(l) of
8 *the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended*
9 *by striking “, except with respect to a claim filed under*
10 *this part on or after the effective date of the Black Lung*
11 *Benefits Amendments of 1981”.*

12 (c) *EFFECTIVE DATE.*—The amendments made by this
13 *section shall apply with respect to claims filed under part*
14 *B or part C of the Black Lung Benefits Act (30 U.S.C.*
15 *921 et seq., 931 et seq.) after January 1, 2005, that are*
16 *pending on or after the date of enactment of this Act.*

17 **SEC. 1557. NONDISCRIMINATION.**

18 (a) *IN GENERAL.*—Except as otherwise provided for
19 *in this title (or an amendment made by this title), an indi-*
20 *vidual shall not, on the ground prohibited under title VI*
21 *of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.),*
22 *title IX of the Education Amendments of 1972 (20 U.S.C.*
23 *1681 et seq.), the Age Discrimination Act of 1975 (42*
24 *U.S.C. 6101 et seq.), or section 504 of the Rehabilitation*
25 *Act of 1973 (29 U.S.C. 794), be excluded from participation*

1 *in, be denied the benefits of, or be subjected to discrimina-*
2 *tion under, any health program or activity, any part of*
3 *which is receiving Federal financial assistance, including*
4 *credits, subsidies, or contracts of insurance, or under any*
5 *program or activity that is administered by an Executive*
6 *Agency or any entity established under this title (or amend-*
7 *ments). The enforcement mechanisms provided for and*
8 *available under such title VI, title IX, section 504, or such*
9 *Age Discrimination Act shall apply for purposes of viola-*
10 *tions of this subsection.*

11 (b) *CONTINUED APPLICATION OF LAWS.—Nothing in*
12 *this title (or an amendment made by this title) shall be*
13 *construed to invalidate or limit the rights, remedies, proce-*
14 *dures, or legal standards available to individuals aggrieved*
15 *under title VI of the Civil Rights Act of 1964 (42 U.S.C.*
16 *2000d et seq.), title VII of the Civil Rights Act of 1964 (42*
17 *U.S.C. 2000e et seq.), title IX of the Education Amendments*
18 *of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabili-*
19 *tation Act of 1973 (29 U.S.C. 794), or the Age Discrimina-*
20 *tion Act of 1975 (42 U.S.C. 611 et seq.), or to supersede*
21 *State laws that provide additional protections against dis-*
22 *crimination on any basis described in subsection (a).*

23 (c) *REGULATIONS.—The Secretary may promulgate*
24 *regulations to implement this section.*

1 **SEC. 1558. PROTECTIONS FOR EMPLOYEES.**

2 *The Fair Labor Standards Act of 1938 is amended by*
3 *inserting after section 18B (as added by section 1512) the*
4 *following:*

5 **“SEC. 18C. PROTECTIONS FOR EMPLOYEES.**

6 *“(a) PROHIBITION.—No employer shall discharge or in*
7 *any manner discriminate against any employee with re-*
8 *spect to his or her compensation, terms, conditions, or other*
9 *privileges of employment because the employee (or an indi-*
10 *vidual acting at the request of the employee) has—*

11 *“(1) received a credit under section 36B of the*
12 *Internal Revenue Code of 1986 or a subsidy under*
13 *section 1402 of this Act;*

14 *“(2) provided, caused to be provided, or is about*
15 *to provide or cause to be provided to the employer, the*
16 *Federal Government, or the attorney general of a*
17 *State information relating to any violation of, or any*
18 *act or omission the employee reasonably believes to be*
19 *a violation of, any provision of this title (or an*
20 *amendment made by this title);*

21 *“(3) testified or is about to testify in a pro-*
22 *ceeding concerning such violation;*

23 *“(4) assisted or participated, or is about to assist*
24 *or participate, in such a proceeding; or*

25 *“(5) objected to, or refused to participate in, any*
26 *activity, policy, practice, or assigned task that the*

1 *employee (or other such person) reasonably believed to*
2 *be in violation of any provision of this title (or*
3 *amendment), or any order, rule, regulation, standard,*
4 *or ban under this title (or amendment).*

5 “(b) *COMPLAINT PROCEDURE.—*

6 “(1) *IN GENERAL.—An employee who believes*
7 *that he or she has been discharged or otherwise dis-*
8 *criminated against by any employer in violation of*
9 *this section may seek relief in accordance with the*
10 *procedures, notifications, burdens of proof, remedies,*
11 *and statutes of limitation set forth in section 2087(b)*
12 *of title 15, United States Code.*

13 “(2) *NO LIMITATION ON RIGHTS.—Nothing in*
14 *this section shall be deemed to diminish the rights,*
15 *privileges, or remedies of any employee under any*
16 *Federal or State law or under any collective bar-*
17 *gaining agreement. The rights and remedies in this*
18 *section may not be waived by any agreement, policy,*
19 *form, or condition of employment.”.*

20 **SEC. 1559. OVERSIGHT.**

21 *The Inspector General of the Department of Health*
22 *and Human Services shall have oversight authority with*
23 *respect to the administration and implementation of this*
24 *title as it relates to such Department.*

1 **SEC. 1560. RULES OF CONSTRUCTION.**

2 (a) *NO EFFECT ON ANTITRUST LAWS.*—Nothing in
3 this title (or an amendment made by this title) shall be
4 construed to modify, impair, or supersede the operation of
5 any of the antitrust laws. For the purposes of this section,
6 the term “antitrust laws” has the meaning given such term
7 in subsection (a) of the first section of the Clayton Act, ex-
8 cept that such term includes section 5 of the Federal Trade
9 Commission Act to the extent that such section 5 applies
10 to unfair methods of competition.

11 (b) *RULE OF CONSTRUCTION REGARDING HAWAII’S*
12 *PREPAID HEALTH CARE ACT.*—Nothing in this title (or an
13 amendment made by this title) shall be construed to modify
14 or limit the application of the exemption for Hawaii’s Pre-
15 paid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.)
16 as provided for under section 514(b)(5) of the Employee Re-
17 tirement Income Security Act of 1974 (29 U.S.C.
18 1144(b)(5)).

19 (c) *STUDENT HEALTH INSURANCE PLANS.*—Nothing
20 in this title (or an amendment made by this title) shall
21 be construed to prohibit an institution of higher education
22 (as such term is defined for purposes of the Higher Edu-
23 cation Act of 1965) from offering a student health insurance
24 plan, to the extent that such requirement is otherwise per-
25 mitted under applicable Federal, State or local law.

1 (d) *NO EFFECT ON EXISTING REQUIREMENTS.*—*Noth-*
 2 *ing in this title (or an amendment made by this title, unless*
 3 *specified by direct statutory reference) shall be construed*
 4 *to modify any existing Federal requirement concerning the*
 5 *State agency responsible for determining eligibility for pro-*
 6 *grams identified in section 1413.*

7 **SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLL-**
 8 **MENT STANDARDS AND PROTOCOLS.**

9 *Title XXX of the Public Health Service Act (42 U.S.C.*
 10 *300jj et seq.) is amended by adding at the end the following:*

11 **“Subtitle C—Other Provisions**

12 **“SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLL-**
 13 **MENT STANDARDS AND PROTOCOLS.**

14 “(a) *IN GENERAL.*—

15 “(1) *STANDARDS AND PROTOCOLS.*—*Not later*
 16 *than 180 days after the date of enactment of this title,*
 17 *the Secretary, in consultation with the HIT Policy*
 18 *Committee and the HIT Standards Committee, shall*
 19 *develop interoperable and secure standards and proto-*
 20 *cols that facilitate enrollment of individuals in Fed-*
 21 *eral and State health and human services programs,*
 22 *as determined by the Secretary.*

23 “(2) *METHODS.*—*The Secretary shall facilitate*
 24 *enrollment in such programs through methods deter-*
 25 *mined appropriate by the Secretary, which shall in-*

1 *clude providing individuals and third parties author-*
2 *ized by such individuals and their designees notifica-*
3 *tion of eligibility and verification of eligibility re-*
4 *quired under such programs.*

5 “(b) *CONTENT.—The standards and protocols for elec-*
6 *tronic enrollment in the Federal and State programs de-*
7 *scribed in subsection (a) shall allow for the following:*

8 “(1) *Electronic matching against existing Fed-*
9 *eral and State data, including vital records, employ-*
10 *ment history, enrollment systems, tax records, and*
11 *other data determined appropriate by the Secretary to*
12 *serve as evidence of eligibility and in lieu of paper-*
13 *based documentation.*

14 “(2) *Simplification and submission of electronic*
15 *documentation, digitization of documents, and sys-*
16 *tems verification of eligibility.*

17 “(3) *Reuse of stored eligibility information (in-*
18 *cluding documentation) to assist with retention of eli-*
19 *gible individuals.*

20 “(4) *Capability for individuals to apply, recer-*
21 *tify and manage their eligibility information online,*
22 *including at home, at points of service, and other*
23 *community-based locations.*

24 “(5) *Ability to expand the enrollment system to*
25 *integrate new programs, rules, and functionalities, to*

1 *operate at increased volume, and to apply stream-*
2 *lined verification and eligibility processes to other*
3 *Federal and State programs, as appropriate.*

4 “(6) *Notification of eligibility, recertification,*
5 *and other needed communication regarding eligi-*
6 *bility, which may include communication via email*
7 *and cellular phones.*

8 “(7) *Other functionalities necessary to provide*
9 *eligibles with streamlined enrollment process.*

10 “(c) *APPROVAL AND NOTIFICATION.—With respect to*
11 *any standard or protocol developed under subsection (a)*
12 *that has been approved by the HIT Policy Committee and*
13 *the HIT Standards Committee, the Secretary—*

14 “(1) *shall notify States of such standards or pro-*
15 *ocols; and*

16 “(2) *may require, as a condition of receiving*
17 *Federal funds for the health information technology*
18 *investments, that States or other entities incorporate*
19 *such standards and protocols into such investments.*

20 “(d) *GRANTS FOR IMPLEMENTATION OF APPROPRIATE*
21 *ENROLLMENT HIT.—*

22 “(1) *IN GENERAL.—The Secretary shall award*
23 *grant to eligible entities to develop new, and adapt*
24 *existing, technology systems to implement the HIT en-*
25 *rollment standards and protocols developed under*

1 *subsection (a) (referred to in this subsection as ‘ap-*
2 *propriate HIT technology’).*

3 *“(2) ELIGIBLE ENTITIES.—To be eligible for a*
4 *grant under this subsection, an entity shall—*

5 *“(A) be a State, political subdivision of a*
6 *State, or a local governmental entity; and*

7 *“(B) submit to the Secretary an application*
8 *at such time, in such manner, and containing—*

9 *“(i) a plan to adopt and implement*
10 *appropriate enrollment technology that in-*
11 *cludes—*

12 *“(I) proposed reduction in main-*
13 *tenance costs of technology systems;*

14 *“(II) elimination or updating of*
15 *legacy systems; and*

16 *“(III) demonstrated collaboration*
17 *with other entities that may receive a*
18 *grant under this section that are lo-*
19 *cated in the same State, political sub-*
20 *division, or locality;*

21 *“(ii) an assurance that the entity will*
22 *share such appropriate enrollment tech-*
23 *nology in accordance with paragraph (4);*
24 *and*

1 “(iii) such other information as the
2 Secretary may require.

3 “(3) SHARING.—

4 “(A) IN GENERAL.—The Secretary shall en-
5 sure that appropriate enrollment HIT adopted
6 under grants under this subsection is made
7 available to other qualified State, qualified polit-
8 ical subdivisions of a State, or other appropriate
9 qualified entities (as described in subparagraph
10 (B)) at no cost.

11 “(B) QUALIFIED ENTITIES.—The Secretary
12 shall determine what entities are qualified to re-
13 ceive enrollment HIT under subparagraph (A),
14 taking into consideration the recommendations
15 of the HIT Policy Committee and the HIT
16 Standards Committee.”.

17 **SEC. 1562. CONFORMING AMENDMENTS.**

18 (a) APPLICABILITY.—Section 2735 of the Public
19 Health Service Act (42 U.S.C. 300gg-21), as so redesi-
20 gnated by section 1001(4), is amended—

21 (1) by striking subsection (a);

22 (2) in subsection (b)—

23 (A) in paragraph (1), by striking “1
24 through 3” and inserting “1 and 2”; and

25 (B) in paragraph (2)—

1 (i) in subparagraph (A), by striking
2 “subparagraph (D)” and inserting “sub-
3 paragraph (D) or (E)”;

4 (ii) by striking “1 through 3” and in-
5 serting “1 and 2”; and

6 (iii) by adding at the end the fol-
7 lowing:

8 “(E) *ELECTION NOT APPLICABLE.*—The
9 election described in subparagraph (A) shall not
10 be available with respect to the provisions of sub-
11 part 1.”;

12 (3) in subsection (c), by striking “1 through 3
13 shall not apply to any group” and inserting “1 and
14 2 shall not apply to any individual coverage or any
15 group”; and

16 (4) in subsection (d)—

17 (A) in paragraph (1), by striking “1
18 through 3 shall not apply to any group” and in-
19 serting “1 and 2 shall not apply to any indi-
20 vidual coverage or any group”;

21 (B) in paragraph (2)—

22 (i) in the matter preceding subpara-
23 graph (A), by striking “1 through 3 shall
24 not apply to any group” and inserting “1

1 *and 2 shall not apply to any individual*
2 *coverage or any group”*; and

3 *(ii) in subparagraph (C), by inserting*
4 *“or, with respect to individual coverage,*
5 *under any health insurance coverage main-*
6 *tained by the same health insurance issuer”*;
7 *and*

8 *(C) in paragraph (3), by striking “any*
9 *group” and inserting “any individual coverage*
10 *or any group”*.

11 **(b) DEFINITIONS.**—*Section 2791(d) of the Public*
12 *Health Service Act (42 U.S.C. 300gg–91(d)) is amended by*
13 *adding at the end the following:*

14 **“(20) QUALIFIED HEALTH PLAN.**—*The term*
15 *‘qualified health plan’ has the meaning given such*
16 *term in section 1301(a) of the Patient Protection and*
17 *Affordable Care Act.*

18 **“(21) EXCHANGE.**—*The term ‘Exchange’ means*
19 *an American Health Benefit Exchange established*
20 *under section 1311 of the Patient Protection and Af-*
21 *fordable Care Act.”*.

22 **(c) TECHNICAL AND CONFORMING AMENDMENTS.**—
23 *Title XXVII of the Public Health Service Act (42 U.S.C.*
24 *300gg et seq.) is amended—*

1 (1) *in section 2704 (42 U.S.C. 300gg), as so re-*
2 *designated by section 1201(2)—*

3 (A) *in subsection (c)—*

4 (i) *in paragraph (2), by striking*
5 *“group health plan” each place that such*
6 *term appears and inserting “group or indi-*
7 *vidual health plan”; and*

8 (ii) *in paragraph (3)—*

9 (I) *by striking “group health in-*
10 *surance” each place that such term ap-*
11 *pears and inserting “group or indi-*
12 *vidual health insurance”; and*

13 (II) *in subparagraph (D), by*
14 *striking “small or large” and inserting*
15 *“individual or group”;*

16 (B) *in subsection (d), by striking “group*
17 *health insurance” each place that such term ap-*
18 *pears and inserting “group or individual health*
19 *insurance”; and*

20 (C) *in subsection (e)(1)(A), by striking*
21 *“group health insurance” and inserting “group*
22 *or individual health insurance”;*

23 (2) *by striking the second heading for subpart 2*
24 *of part A (relating to other requirements);*

1 (3) in section 2725 (42 U.S.C. 300gg-4), as so
2 redesignated by section 1001(2)—

3 (A) in subsection (a), by striking “health
4 insurance issuer offering group health insurance
5 coverage” and inserting “health insurance issuer
6 offering group or individual health insurance
7 coverage”;

8 (B) in subsection (b)—

9 (i) by striking “health insurance issuer
10 offering group health insurance coverage in
11 connection with a group health plan” in the
12 matter preceding paragraph (1) and insert-
13 ing “health insurance issuer offering group
14 or individual health insurance coverage”;
15 and

16 (ii) in paragraph (1), by striking
17 “plan” and inserting “plan or coverage”;

18 (C) in subsection (c)—

19 (i) in paragraph (2), by striking
20 “group health insurance coverage offered by
21 a health insurance issuer” and inserting
22 “health insurance issuer offering group or
23 individual health insurance coverage”; and

1 (ii) in paragraph (3), by striking
2 “issuer” and inserting “health insurance
3 issuer”; and

4 (D) in subsection (e), by striking “health
5 insurance issuer offering group health insurance
6 coverage” and inserting “health insurance issuer
7 offering group or individual health insurance
8 coverage”;

9 (4) in section 2726 (42 U.S.C. 300gg-5), as so
10 redesignated by section 1001(2)—

11 (A) in subsection (a), by striking “(or
12 health insurance coverage offered in connection
13 with such a plan)” each place that such term ap-
14 pears and inserting “or a health insurance
15 issuer offering group or individual health insur-
16 ance coverage”;

17 (B) in subsection (b), by striking “(or
18 health insurance coverage offered in connection
19 with such a plan)” each place that such term ap-
20 pears and inserting “or a health insurance
21 issuer offering group or individual health insur-
22 ance coverage”; and

23 (C) in subsection (c)—

24 (i) in paragraph (1), by striking “(and
25 group health insurance coverage offered in

1 *connection with a group health plan)” and*
2 *inserting “and a health insurance issuer of-*
3 *fering group or individual health insurance*
4 *coverage”;*

5 *(ii) in paragraph (2), by striking “(or*
6 *health insurance coverage offered in connec-*
7 *tion with such a plan)” each place that*
8 *such term appears and inserting “or a*
9 *health insurance issuer offering group or in-*
10 *dividual health insurance coverage”;*

11 *(5) in section 2727 (42 U.S.C. 300gg–6), as so*
12 *redesignated by section 1001(2), by striking “health*
13 *insurance issuers providing health insurance coverage*
14 *in connection with group health plans” and inserting*
15 *“and health insurance issuers offering group or indi-*
16 *vidual health insurance coverage”;*

17 *(6) in section 2728 (42 U.S.C. 300gg–7), as so*
18 *redesignated by section 1001(2)—*

19 *(A) in subsection (a), by striking “health*
20 *insurance coverage offered in connection with*
21 *such plan” and inserting “individual health in-*
22 *surance coverage”;*

23 *(B) in subsection (b)—*

24 *(i) in paragraph (1), by striking “or a*
25 *health insurance issuer that provides health*

1 *insurance coverage in connection with a*
2 *group health plan” and inserting “or a*
3 *health insurance issuer that offers group or*
4 *individual health insurance coverage”;*

5 *(ii) in paragraph (2), by striking*
6 *“health insurance coverage offered in con-*
7 *nection with the plan” and inserting “indi-*
8 *vidual health insurance coverage”;* and

9 *(iii) in paragraph (3), by striking*
10 *“health insurance coverage offered by an*
11 *issuer in connection with such plan” and*
12 *inserting “individual health insurance cov-*
13 *erage”;*

14 *(C) in subsection (c), by striking “health in-*
15 *surance issuer providing health insurance cov-*
16 *erage in connection with a group health plan”*
17 *and inserting “health insurance issuer that offers*
18 *group or individual health insurance coverage”;*
19 *and*

20 *(D) in subsection (e)(1), by striking “health*
21 *insurance coverage offered in connection with*
22 *such a plan” and inserting “individual health*
23 *insurance coverage”;*

24 *(7) by striking the heading for subpart 3;*

1 (8) in section 2731 (42 U.S.C. 300gg–11), as so
2 redesignated by section 1001(3)—

3 (A) by striking the section heading and all
4 that follows through subsection (b);

5 (B) in subsection (c)—

6 (i) in paragraph (1)—

7 (I) in the matter preceding sub-
8 paragraph (A), by striking “small
9 group” and inserting “group and indi-
10 vidual”; and

11 (II) in subparagraph (B)—

12 (aa) in the matter preceding
13 clause (i), by inserting “and indi-
14 viduals” after “employers”;

15 (bb) in clause (i), by insert-
16 ing “or any additional individ-
17 uals” after “additional groups”;
18 and

19 (cc) in clause (ii), by strik-
20 ing “without regard to the claims
21 experience of those employers and
22 their employees (and their de-
23 pendents) or any health status-re-
24 lated factor relating to such” and
25 inserting “and individuals with-

1 out regard to the claims experi-
2 ence of those individuals, employ-
3 ers and their employees (and their
4 dependents) or any health status-
5 related factor relating to such in-
6 dividuals”; and

7 (ii) in paragraph (2), by striking
8 “small group” and inserting “group or in-
9 dividual”;

10 (C) in subsection (d)—

11 (i) by striking “small group” each
12 place that such appears and inserting
13 “group or individual”; and

14 (ii) in paragraph (1)(B)—

15 (I) by striking “all employers”
16 and inserting “all employers and indi-
17 viduals”;

18 (II) by striking “those employers”
19 and inserting “those individuals, em-
20 ployers”; and

21 (III) by striking “such employees”
22 and inserting “such individuals, em-
23 ployees”;

24 (D) by striking subsection (e);

25 (E) by striking subsection (f); and

1 (F) by transferring such section (as amend-
2 ed by this paragraph) to appear at the end of
3 section 2702 (as added by section 1001(4));

4 (9) in section 2732 (42 U.S.C. 300gg-12), as so
5 redesignated by section 1001(3)—

6 (A) by striking the section heading and all
7 that follows through subsection (a);

8 (B) in subsection (b)—

9 (i) in the matter preceding paragraph
10 (1), by striking “group health plan in the
11 small or large group market” and inserting
12 “health insurance coverage offered in the
13 group or individual market”;

14 (ii) in paragraph (1), by inserting “,
15 or individual, as applicable,” after “plan
16 sponsor”;

17 (iii) in paragraph (2), by inserting “,
18 or individual, as applicable,” after “plan
19 sponsor”; and

20 (iv) by striking paragraph (3) and in-
21 serting the following:

22 “(3) VIOLATION OF PARTICIPATION OR CON-
23 TRIBUTION RATES.—In the case of a group health
24 plan, the plan sponsor has failed to comply with a
25 material plan provision relating to employer con-

1 *tribution or group participation rules, pursuant to*
2 *applicable State law.”;*

3 *(C) in subsection (c)—*

4 *(i) in paragraph (1)—*

5 *(I) in the matter preceding sub-*
6 *paragraph (A), by striking “group*
7 *health insurance coverage offered in the*
8 *small or large group market” and in-*
9 *serting “group or individual health in-*
10 *surance coverage”;*

11 *(II) in subparagraph (A), by in-*
12 *serting “or individual, as applicable,”*
13 *after “plan sponsor”;*

14 *(III) in subparagraph (B)—*

15 *(aa) by inserting “or indi-*
16 *vidual, as applicable,” after “plan*
17 *sponsor”;* and

18 *(bb) by inserting “or indi-*
19 *vidual health insurance coverage”;*

20 *and*

21 *(IV) in subparagraph (C), by in-*
22 *serting “or individuals, as applicable,”*
23 *after “those sponsors”;* and

24 *(ii) in paragraph (2)(A)—*

1 (I) in the matter preceding clause
2 (i), by striking “small group market or
3 the large group market, or both mar-
4 kets,” and inserting “individual or
5 group market, or all markets,”; and

6 (II) in clause (i), by inserting “or
7 individual, as applicable,” after “plan
8 sponsor”; and

9 (D) by transferring such section (as amend-
10 ed by this paragraph) to appear at the end of
11 section 2703 (as added by section 1001(4));

12 (10) in section 2733 (42 U.S.C. 300gg-13), as so
13 redesignated by section 1001(4)—

14 (A) in subsection (a)—

15 (i) in the matter preceding paragraph
16 (1), by striking “small employer” and in-
17 serting “small employer or an individual”;

18 (ii) in paragraph (1), by inserting “,
19 or individual, as applicable,” after “em-
20 ployer” each place that such appears; and

21 (iii) in paragraph (2), by striking
22 “small employer” and inserting “employer,
23 or individual, as applicable,”;

24 (B) in subsection (b)—

25 (i) in paragraph (1)—

1 (I) in the matter preceding sub-
2 paragraph (A), by striking “small em-
3 ployer” and inserting “employer, or
4 individual, as applicable,”;

5 (II) in subparagraph (A), by add-
6 ing “and” at the end;

7 (III) by striking subparagraphs
8 (B) and (C); and

9 (IV) in subparagraph (D)—

10 (aa) by inserting “, or indi-
11 vidual, as applicable,” after “em-
12 ployer”; and

13 (bb) by redesignating such
14 subparagraph as subparagraph
15 (B);

16 (ii) in paragraph (2)—

17 (I) by striking “small employers”
18 each place that such term appears and
19 inserting “employers, or individuals,
20 as applicable,”; and

21 (II) by striking “small employer”
22 and inserting “employer, or indi-
23 vidual, as applicable,”; and

24 (C) by redesignating such section (as
25 amended by this paragraph) as section 2709 and

1 *transferring such section to appear after section*
2 *2708 (as added by section 1001(5));*

3 *(11) by redesignating subpart 4 as subpart 2;*

4 *(12) in section 2735 (42 U.S.C. 300gg–21), as so*
5 *redesignated by section 1001(4)—*

6 *(A) by striking subsection (a);*

7 *(B) by striking “subparts 1 through 3” each*
8 *place that such appears and inserting “subpart*
9 *1”;*

10 *(C) by redesignating subsections (b) through*
11 *(e) as subsections (a) through (d), respectively;*
12 *and*

13 *(D) by redesignating such section (as*
14 *amended by this paragraph) as section 2722;*

15 *(13) in section 2736 (42 U.S.C. 300gg–22), as so*
16 *redesignated by section 1001(4)—*

17 *(A) in subsection (a)—*

18 *(i) in paragraph (1), by striking*
19 *“small or large group markets” and insert-*
20 *ing “individual or group market”; and*

21 *(ii) in paragraph (2), by inserting “or*
22 *individual health insurance coverage” after*
23 *“group health plans”;*

1 (B) in subsection (b)(1)(B), by inserting
2 “individual health insurance coverage or” after
3 “respect to”; and

4 (C) by redesignating such section (as
5 amended by this paragraph) as section 2723;

6 (14) in section 2737(a)(1) (42 U.S.C. 300gg–23),
7 as so redesignated by section 1001(4)—

8 (A) by inserting “individual or” before
9 “group health insurance”; and

10 (B) by redesignating such section (as amend-
11 ed by this paragraph) as section 2724;

12 (15) in section 2762 (42 U.S.C. 300gg–62)—

13 (A) in the section heading by inserting
14 “**AND APPLICATION**” before the period; and

15 (B) by adding at the end the following:

16 “(c) *APPLICATION OF PART A PROVISIONS.*—

17 “(1) *IN GENERAL.*—The provisions of part A
18 shall apply to health insurance issuers providing
19 health insurance coverage in the individual market in
20 a State as provided for in such part.

21 “(2) *CLARIFICATION.*—To the extent that any
22 provision of this part conflicts with a provision of
23 part A with respect to health insurance issuers pro-
24 viding health insurance coverage in the individual

1 *market in a State, the provisions of such part A shall*
2 *apply.”; and*

3 *(16) in section 2791(e) (42 U.S.C. 300gg–*
4 *91(e))—*

5 *(A) in paragraph (2), by striking “51” and*
6 *inserting “101”; and*

7 *(B) in paragraph (4)—*

8 *(i) by striking “at least 2” each place*
9 *that such appears and inserting “at least*
10 *1”; and*

11 *(ii) by striking “50” and inserting*
12 *“100”.*

13 *(d) APPLICATION.—Notwithstanding any other provi-*
14 *sion of the Patient Protection and Affordable Care Act,*
15 *nothing in such Act (or an amendment made by such Act)*
16 *shall be construed to—*

17 *(1) prohibit (or authorize the Secretary of*
18 *Health and Human Services to promulgate regula-*
19 *tions that prohibit) a group health plan or health in-*
20 *surance issuer from carrying out utilization manage-*
21 *ment techniques that are commonly used as of the*
22 *date of enactment of this Act; or*

23 *(2) restrict the application of the amendments*
24 *made by this subtitle.*

1 (e) *TECHNICAL AMENDMENT TO THE EMPLOYEE RE-*
2 *TIREMENT INCOME SECURITY ACT OF 1974.*—Subpart B of
3 *part 7 of subtitle A of title I of the Employee Retirement*
4 *Income Security Act of 1974 (29 U.S.C. 1181 et. seq.) is*
5 *amended, by adding at the end the following:*

6 **“SEC. 715. ADDITIONAL MARKET REFORMS.**

7 “(a) *GENERAL RULE.*—*Except as provided in sub-*
8 *section (b)—*

9 “(1) *the provisions of part A of title XXVII of*
10 *the Public Health Service Act (as amended by the Pa-*
11 *tient Protection and Affordable Care Act) shall apply*
12 *to group health plans, and health insurance issuers*
13 *providing health insurance coverage in connection*
14 *with group health plans, as if included in this sub-*
15 *part; and*

16 “(2) *to the extent that any provision of this part*
17 *conflicts with a provision of such part A with respect*
18 *to group health plans, or health insurance issuers pro-*
19 *viding health insurance coverage in connection with*
20 *group health plans, the provisions of such part A*
21 *shall apply.*

22 “(b) *EXCEPTION.*—*Notwithstanding subsection (a), the*
23 *provisions of sections 2716 and 2718 of title XXVII of the*
24 *Public Health Service Act (as amended by the Patient Pro-*
25 *tection and Affordable Care Act) shall not apply with re-*

1 *spect to self-insured group health plans, and the provisions*
2 *of this part shall continue to apply to such plans as if such*
3 *sections of the Public Health Service Act (as so amended)*
4 *had not been enacted.”.*

5 (f) *TECHNICAL AMENDMENT TO THE INTERNAL REV-*
6 *ENUE CODE OF 1986.—Subchapter B of chapter 100 of the*
7 *Internal Revenue Code of 1986 is amended by adding at*
8 *the end the following:*

9 **“SEC. 9815. ADDITIONAL MARKET REFORMS.**

10 “(a) *GENERAL RULE.—Except as provided in sub-*
11 *section (b)—*

12 “(1) *the provisions of part A of title XXVII of*
13 *the Public Health Service Act (as amended by the Pa-*
14 *tient Protection and Affordable Care Act) shall apply*
15 *to group health plans, and health insurance issuers*
16 *providing health insurance coverage in connection*
17 *with group health plans, as if included in this sub-*
18 *chapter; and*

19 “(2) *to the extent that any provision of this sub-*
20 *chapter conflicts with a provision of such part A with*
21 *respect to group health plans, or health insurance*
22 *issuers providing health insurance coverage in connec-*
23 *tion with group health plans, the provisions of such*
24 *part A shall apply.*

1 “(b) *EXCEPTION.*—Notwithstanding subsection (a), the
 2 *provisions of sections 2716 and 2718 of title XXVII of the*
 3 *Public Health Service Act (as amended by the Patient Pro-*
 4 *tection and Affordable Care Act) shall not apply with re-*
 5 *spect to self-insured group health plans, and the provisions*
 6 *of this subchapter shall continue to apply to such plans as*
 7 *if such sections of the Public Health Service Act (as so*
 8 *amended) had not been enacted.”.*

9 **SEC. 1563. SENSE OF THE SENATE PROMOTING FISCAL RE-**
 10 **SPONSIBILITY.**

11 (a) *FINDINGS.*—The Senate makes the following find-
 12 *ings:*

13 (1) *Based on Congressional Budget Office (CBO)*
 14 *estimates, this Act will reduce the Federal deficit be-*
 15 *tween 2010 and 2019.*

16 (2) *CBO projects this Act will continue to reduce*
 17 *budget deficits after 2019.*

18 (3) *Based on CBO estimates, this Act will extend*
 19 *the solvency of the Medicare HI Trust Fund.*

20 (4) *This Act will increase the surplus in the So-*
 21 *cial Security Trust Fund, which should be reserved to*
 22 *strengthen the finances of Social Security.*

23 (5) *The initial net savings generated by the*
 24 *Community Living Assistance Services and Supports*