# *TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS*

## *Subtitle A—Immediate Improvements in Health Care Coverage for All Americans*

### *SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.*

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

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

***"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";***

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

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

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

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

***"Subpart II—Improving Coverage***

***"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.***

*"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—*

*"(1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or*

*"(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.*

*"(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.*

***"SEC. 2712. PROHIBITION ON RESCISSIONS.***

*"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that con-*

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

***"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.***

*"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—*

*"(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;*

*"(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and*

*"(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.*

*"(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.*

*"(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.*

*Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.*

*"(b) INTERVAL.—*

*"(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to*

*the service described in such recommendation or guideline.*

*"(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.*

*"(c) VALUE-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.*

***"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.***

*"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.*

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

*"(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of 'depend-*

*ent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.*

***"SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.***

*"(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the 'NAIC'), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.*

*"(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:*

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

*"(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.*

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

*"(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);*

*"(B) a description of the coverage, including cost sharing for—*

*"(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and*

*"(ii) other benefits, as identified by the Secretary;*

*"(C) the exceptions, reductions, and limitations on coverage;*

*"(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;*

*"(E) the renewability and continuation of coverage provisions;*

*"(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;*

*"(G) a statement of whether the plan or coverage—*

*"(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and*

*"(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;*

*"(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to*

*determine the governing contractual provisions; and*

*"(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.*

*"(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.*

*"(d) REQUIREMENT TO PROVIDE.—*

*"(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—*

*"(A) an applicant at the time of application;*

*"(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and*

*"(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.*

*"(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.*

*"(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—*

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

*"(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).*

*"(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to en-*

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

*"(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.*

*"(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.*

*"(g) DEVELOPMENT OF STANDARD DEFINITIONS.—*

*"(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).*

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

*vider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.*

*"(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).*

***"SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.***

*"(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise*

*establish eligibility rules that have the effect of discriminating in favor of higher wage employees.*

*"(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.*

***"SEC. 2717. ENSURING THE QUALITY OF CARE.***

*"(a) QUALITY REPORTING.—*

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

*"(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medi-*

*cation and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;*

*"(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;*

*"(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and*

*"(D) implement wellness and health promotion activities.*

*"(2) REPORTING REQUIREMENTS.—*

*"(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether*

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

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

*"(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.*

*"(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.*

*"(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.*

*"(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and*

*prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:*

*"(1) Smoking cessation.*

*"(2) Weight management.*

*"(3) Stress management.*

*"(4) Physical fitness.*

*"(5) Nutrition.*

*"(6) Heart disease prevention.*

*"(7) Healthy lifestyle support.*

*"(8) Diabetes prevention.*

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

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

*to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.*

***"SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.***

*"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—*

*"(1) on reimbursement for clinical services provided to enrollees under such coverage;*

*"(2) for activities that improve health care quality; and*

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

*The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.*

*"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—*

*"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—*

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

*"(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.*

*"(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in*

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

*"(3) TERMINATION.—The provisions of this subsection shall have no force or effect after December 31, 2013.*

*"(c) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.*

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

***"SEC. 2719. APPEALS PROCESS.***

*"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—*

*"(1) have in effect an internal claims appeal process;*

*"(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes;*

*"(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and*

*"(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.".*

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

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

***"SEC. 2793. HEALTH INSURANCE CONSUMER INFORMATION.***

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

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

*"(1) offices of health insurance consumer assistance; or*

*"(2) health insurance ombudsman programs.*

*"(b) ELIGIBILITY.—*

*"(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.*

*"(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.*

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

*"(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or*

*health insurance issuer involved and providing information about the external appeal process;*

*"(2) collect, track, and quantify problems and inquiries encountered by consumers;*

*"(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;*

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

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

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

*"(e) FUNDING.—*

*"(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.*

*"(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.".*

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

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

***"SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.***

*"(a) INITIAL PREMIUM REVIEW PROCESS.—*

*"(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.*

*"(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.*

*"(b) CONTINUING PREMIUM REVIEW PROCESS.—*

*"(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—*

*"(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and*

*"(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.*

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

*"(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.*

*"(B) CONSIDERATION IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.*

*"(c) GRANTS IN SUPPORT OF PROCESS.—*

*"(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—*

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

*"(B) in providing information and recommendations to the Secretary under subsection (b)(1).*

*"(2) FUNDING.—*

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

*"(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.*

*"(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—*

*"(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and*

*"(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.".*

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

*(a) IN GENERAL.—Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.*

*(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.*

# *Subtitle B—Immediate Actions to Preserve and Expand Coverage*

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

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

*(b) ADMINISTRATION.—*

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

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

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

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

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

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

*(c) QUALIFIED HIGH RISK POOL.—*

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

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

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

*(B) provides health insurance coverage—*

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

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

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

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

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

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

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

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

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

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

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

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

*(e) PROTECTION AGAINST DUMPING RISK BY INSURERS.—*

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

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

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

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

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

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

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

*(I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or*

*(II) the prior coverage is a policy for which duration of coverage form issue or health status are factors that can be considered in determining premiums at renewal.*

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

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

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

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

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

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

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

*(3) TERMINATION OF AUTHORITY.—*

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

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

*(4) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation*

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

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

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

*(a) ADMINISTRATION.—*

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

*(2) REFERENCE.—In this section:*

*(A) HEALTH BENEFITS.—The term "health benefits" means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-*

*funded, or delivered through the purchase of insurance or otherwise.*

*(B) EMPLOYMENT-BASED PLAN.—The term "employment-based plan" means a group health benefits plan that—*

*(i) is—*

*(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or*

*(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and*

*(ii) provides health benefits to early retirees.*

*(C) EARLY RETIREES.—The term "early retirees" means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are*

*not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.*

*(b) PARTICIPATION.—*

*(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—A participating employment-based plan is an employment-based plan that—*

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

*(B) submits to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.*

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

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

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

*(C) is certified by the Secretary.*

*(c) PAYMENTS.—*

*(1) SUBMISSION OF CLAIMS.—*

*(A) IN GENERAL.—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.*

*(B) BASIS FOR CLAIMS.—Claims submitted under subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles,*

*co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.*

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

*(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.*

*(4) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments,*

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

*(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.*

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

*(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and*

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

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

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

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

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

***SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.***

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

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

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

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

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

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

*(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);*

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

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

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

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

*(b) ENHANCING COMPARATIVE PURCHASING OPTIONS.—*

*(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under sec-*

*tion 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.*

*(2) USE OF FORMAT.—The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).*

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

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

*(a) PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—*

*(1) by inserting "uniform" before "standards"; and*

*(2) by inserting "and to reduce the clerical burden on patients, health care providers, and health plans" before the period at the end.*

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

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

*"(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.".*

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

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

*"(J) Electronic funds transfers.";*

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

*"(4) REQUIREMENTS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—*

*"(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—*

*"(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility*

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

*"(ii) be comprehensive, requiring minimal augmentation by paper or other communications;*

*"(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and*

*"(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).*

*"(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers."; and*

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

*"(g) OPERATING RULES.—*

*"(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.*

*"(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:*

*"(A) The entity focuses its mission on administrative simplification.*

*"(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agen-*

*cies, and other standard development organizations.*

*"(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.*

*"(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.*

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

*"(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—*

*"(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);*

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

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

*"(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and*

*"(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.*

*"(4) IMPLEMENTATION.—*

*"(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.*

*"(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—*

*"(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than Jan-*

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

*"(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall—*

*"(I) allow for automated reconciliation of the electronic payment with the remittance advice; and*

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

*"(iii) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization trans-*

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

*"(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.*

*"(h) COMPLIANCE.—*

*"(1) HEALTH PLAN CERTIFICATION.—*

*"(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and associated*

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

*"(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIMS ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance*

*with the transactions specified in subparagraph (A).*

*"(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—*

*"(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and*

*"(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.*

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

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

*"(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.*

*"(5) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—*

*"(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that—*

*"(i) amends any standard or operating rule described under paragraph (1) of this subsection; or*

*"(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.*

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

*"(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).*

*"(i) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—*

*"(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).*

*"(2) EVALUATIONS AND REPORTS.—*

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

*adopted standards and operating rules established under this section.*

*"(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.*

*"(3) INTERIM FINAL RULEMAKING.—*

*"(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.*

*"(B) PUBLIC COMMENT.—*

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

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

*"(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.*

*"(4) REVIEW COMMITTEE.—*

*"(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—*

*"(i) the National Committee on Vital and Health Statistics; or*

*"(ii) any appropriate committee as determined by the Secretary.*

*"(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record tech-*

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

*"(5) OPERATING RULES FOR OTHER STANDARDS ADOPTED BY THE SECRETARY.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).*

*"(j) PENALTIES.—*

*"(1) PENALTY FEE.—*

*"(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—*

*"(i) the standards and associated operating rules described under paragraph (1) of such subsection; and*

*"(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.*

*"(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).*

*"(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.*

*"(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.*

*"(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—*

*"(i) an amount equal to $20 per covered life under such plan; or*

*"(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).*

*"(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.*

*"(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).*

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

*shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.*

*"(4) COLLECTION OF PENALTY FEE.—*

*"(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).*

*"(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).*

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

*"(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—*

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

*"(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.*

*"(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.".*

*(c) PROMULGATION OF RULES.—*

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

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

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

*(3) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act (42 U.S.C. 1320d–2(a)(2)(B))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.*

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

*(1) in paragraph (23), by striking the "or" at the end;*

*(2) in paragraph (24), by striking the period and inserting "; or"; and*

*(3) by inserting after paragraph (24) the following new paragraph:*

*"(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.".*

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

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

# *Subtitle C—Quality Health Insurance Coverage for All Americans*

## *PART I—HEALTH INSURANCE MARKET REFORMS*

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

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

*(1) by striking the heading for subpart 1 and inserting the following:*

***"Subpart I—General Reform";***

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

***"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.***

*"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."; and*

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

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

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

*(ii) in subsection (b)—*

*(I) by striking "health insurance issuer offering health insurance coverage in connection with a group health plan" each place that such appears and inserting*

*"health insurance issuer offering group or individual health insurance coverage"; and*

*(II) in paragraph (2)(A)—*

*(aa) by inserting "or individual" after "employer"; and*

*(bb) by inserting "or individual health coverage, as the case may be" before the semicolon; and*

*(iii) in subsection (e)—*

*(I) by striking "(a)(1)(F)" and inserting "(a)(6)";*

*(II) by striking "2701" and inserting "2704"; and*

*(III) by striking "2721(a)" and inserting "2735(a)"; and*

*(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and*

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

***"SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.***

*"(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—*

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

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

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

*"(i) whether such plan or coverage covers an individual or family;*

*"(ii) rating area, as established in accordance with paragraph (2);*

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

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

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

*"(2) RATING AREA.—*

*"(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.*

*"(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure*

*the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.*

*"(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).*

*"(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.*

*"(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the*

*provisions of this subsection shall apply to all coverage offered in such market in the State.*

***"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.***

*"(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.*

*"(b) ENROLLMENT.—*

*"(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.*

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

*"(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).*

***"SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.***

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

***"SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.***

*"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:*

*"(1) Health status.*

*"(2) Medical condition (including both physical and mental illnesses).*

*"(3) Claims experience.*

*"(4) Receipt of health care.*

*"(5) Medical history.*

*"(6) Genetic information.*

*"(7) Evidence of insurability (including conditions arising out of acts of domestic violence).*

*"(8) Disability.*

*"(9) Any other health status-related factor determined appropriate by the Secretary.*

*"(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—*

*"(1) GENERAL PROVISIONS.—*

*"(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.*

*"(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.*

*"(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other*

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

*"(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:*

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

*"(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.*

*"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).*

*"(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.*

*"(E) A program that provides a reward to individuals for attending a periodic health education seminar.*

*"(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:*

*"(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status*

*factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.*

*"(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.*

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

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

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

*"(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom,*

*for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and*

*"(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.*

*"(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.*

*"(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan mate-*

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

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

*"(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—*

*"(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.*

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

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

*"(3) REQUIREMENTS.—*

*"(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—*

*"(i) will not result in any decrease in coverage; and*

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

*"(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—*

*"(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably*

*designed program of health promotion and disease prevention;*

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

*"(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—*

*"(I) do not create undue burdens for individuals insured in the individual market;*

*"(II) do not lead to cost shifting; and*

*"(III) are not a subterfuge for discrimination;*

*"(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and*

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

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

*"(m) REPORT.—*

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

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

*"(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;*

*"(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and*

*"(D) the effectiveness of different types of rewards.*

*"(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall*

*gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.*

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

***"SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.***

*"(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.*

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

*health plan or health insurance issuer offering group or individual health insurance coverage.*

***"SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.***

*"(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.*

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

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

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

***"SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.***

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

## *PART II—OTHER PROVISIONS*

### *SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.*

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

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

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

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

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

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

*(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this*

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

*(e) DEFINITION.—In this title, the term "grandfathered health plan" means any group health plan or health insurance coverage to which this section applies.*

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

*Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).*

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

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

# *Subtitle D—Available Coverage Choices for All Americans*

## *PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS*

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

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

*(1) IN GENERAL.—The term "qualified health plan" means a health plan that—*

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

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

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

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

*(ii) agrees to offer at least one qualified health plan in the silver level and at*

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

*(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and*

*(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.*

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

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

*(1) HEALTH PLAN.—*

*(A) IN GENERAL.—The term "health plan" means health insurance coverage and a group health plan.*

*(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term "health plan" shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.*

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

*(3) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term by section 2791(a) of the Public Health Service Act.*

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

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

*(1) provides for the essential health benefits defined by the Secretary under subsection (b);*

*(2) limits cost-sharing for such coverage in accordance with subsection (c); and*

*(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).*

*(b) ESSENTIAL HEALTH BENEFITS.—*

*(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:*

*(A) Ambulatory patient services.*

*(B) Emergency services.*

*(C) Hospitalization.*

*(D) Maternity and newborn care.*

*(E) Mental health and substance use disorder services, including behavioral health treatment.*

*(F) Prescription drugs.*

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

*(H) Laboratory services.*

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

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

*(2) LIMITATION.—*

*(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.*

*(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).*

*(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.*

*(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—*

*(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;*

*(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;*

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

*(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;*

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

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

*(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and*

*(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;*

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

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

*(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—*

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

*(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;*

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

*(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and*

*(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).*

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

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

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

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

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

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

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

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

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

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

*(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—*

*(i) $2,000 in the case of a plan covering a single individual; and*

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

*The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Rev-*

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

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

*(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and*

*(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).*

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

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

*(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.*

*(3) COST-SHARING.—In this title—*

*(A) IN GENERAL.—The term "cost-sharing" includes—*

*(i) deductibles, coinsurance, copayments, or similar charges; and*

*(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.*

*(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.*

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

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

*(d) LEVELS OF COVERAGE.—*

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

*(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.*

*(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.*

*(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.*

*(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that*

*is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.*

*(2) ACTUARIAL VALUE.—*

*(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).*

*(B) EMPLOYER CONTRIBUTIONS.—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.*

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

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

*(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.*

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

*(e) CATASTROPHIC PLAN.—*

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

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

*(B) the plan provides—*

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

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

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

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

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

*(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—*

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

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

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

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

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

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

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

*(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—*

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

*(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and*

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

*(B) ABORTION SERVICES.—*

*(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.*

*(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.*

*(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—*

*(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—*

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

*(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and*

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

*bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).*

*(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3)(A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).*

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

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

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

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

*(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and*

*(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).*

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

*(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and*

*(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the re-*

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

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

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

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

*(ii) Any cost-sharing reduction under section 1402 of thePatient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).*

*(B) SEGREGATION OF FUNDS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an*

*amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).*

*(C) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—*

*(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).*

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

*(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;*

*(II) shall estimate such costs as if such coverage were included for the entire population covered; and*

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

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

*(b) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—*

*(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.*

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

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

*(i) conscience protection;*

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

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

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

*(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as "EMTALA").*

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

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

*(1) GROUP MARKET.—The term "group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.*

*(2) INDIVIDUAL MARKET.—The term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.*

*(3) LARGE AND SMALL GROUP MARKETS.—The terms ''large group market'' and ''small group market'' mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.*

*(b) EMPLOYERS.—In this title:*

*(1) LARGE EMPLOYER.—The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.*

*(2) SMALL EMPLOYER.—The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1*

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

*(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting "51 employees" for "101 employees" in paragraph (1) and by substituting "50 employees" for "100 employees" in paragraph (2).*

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

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

*(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.*

*(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.*

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

*(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and*

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

*the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.*

*(c) SECRETARY.—In this title, the term "Secretary" means the Secretary of Health and Human Services.*

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

## *PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES*

### *SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.*

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

*(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).*

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

*(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).*

*(4) RENEWABILITY OF GRANT.—*

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

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

*(I) establishing an Exchange; and*

*(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and*

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

*(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.*

*(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.*

*(b) AMERICAN HEALTH BENEFIT EXCHANGES.—*

*(1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an "Exchange") for the State that—*

*(A) facilitates the purchase of qualified health plans;*

*(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and*

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

*(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.*

*(c) RESPONSIBILITIES OF THE SECRETARY.—*

*(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—*

*(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;*

*(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;*

*(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;*

*(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or*

*(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;*

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

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

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

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

*(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.*

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

*(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).*

*(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.*

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

*(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and*

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

*ized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.*

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

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

*(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);*

*(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;*

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

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

*(d) REQUIREMENTS.—*

*(1) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.*

*(2) OFFERING OF COVERAGE.—*

*(A) IN GENERAL.—An Exchange shall make available qualified health plans to qualified individuals and qualified employers.*

*(B) LIMITATION.—*

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

*(ii) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan*

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

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

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

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

*(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).*

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

*efits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).*

*(4) FUNCTIONS.—An Exchange shall, at a minimum—*

*(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;*

*(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;*

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

*(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);*

*(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline*

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

*(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;*

*(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;*

*(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because—*

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

*(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;*

*(I) transfer to the Secretary of the Treasury—*

*(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;*

*(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—*

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

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

*of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and*

*(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);*

*(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and*

*(K) establish the Navigator program described in subsection (i).*

*(5) FUNDING LIMITATIONS.—*

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

*ticipating health insurance issuers, or to otherwise generate funding, to support its operations.*

*(B) PROHIBITING WASTEFUL USE OF FUNDS.—In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.*

*(6) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—*

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

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

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

*(D) State Medicaid offices; and*

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

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

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

*(e) CERTIFICATION.—*

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

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

*(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—*

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

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

*(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.*

*(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.*

*(f) FLEXIBILITY.—*

*(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—*

*(A) each State in which such Exchange operates permits such operation; and*

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

*(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—*

*(A) each such Exchange serves a geographically distinct area; and*

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

*(3) AUTHORITY TO CONTRACT.—*

*(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.*

*(B) ELIGIBLE ENTITY.—In this paragraph, the term "eligible entity" means—*

*(i) a person—*

*(I) incorporated under, and subject to the laws of, 1 or more States;*

*(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and*

*(III) that is not a health insurance issuer or that is treated under*

*subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or*

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

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

*(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—*

*(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;*

*(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes*

*patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;*

*(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and*

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

*(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).*

*(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).*

*(h) QUALITY IMPROVEMENT.—*

*(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—*

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

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

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

*(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.*

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

*(3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).*

*(i) NAVIGATORS.—*

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

*scribed in paragraph (2) to carry out the duties described in paragraph (3).*

*(2) ELIGIBILITY.—*

*(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.*

*(B) TYPES.—Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—*

*(i) are capable of carrying out the duties described in paragraph (3);*

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

*(iii) provide information consistent with the standards developed under paragraph (5).*

*(3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—*

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

*(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;*

*(C) facilitate enrollment in qualified health plans;*

*(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and*

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

*(4) STANDARDS.—*

*(A) IN GENERAL.—The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—*

*(i) be a health insurance issuer; or*

*(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.*

*(5) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.*

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

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

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

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

*(a) CHOICE.—*

*(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.*

*(2) QUALIFIED EMPLOYERS.—*

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

*(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.*

*(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.*

*(c) SINGLE RISK POOL.—*

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

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

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

*kets within a State to be merged if the State determines appropriate.*

*(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.*

*(d) EMPOWERING CONSUMER CHOICE.—*

*(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this title shall be construed to prohibit—*

*(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and*

*(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.*

*(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.*

*(3) VOLUNTARY NATURE OF AN EXCHANGE.—*

*(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to*

*restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.*

*(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.*

*(C) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).*

*(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—*

*(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—*

*(I) created under this Act (or an amendment made by this Act); or*

*(II) offered through an Exchange established under this Act (or an amendment made by this Act).*

*(ii) DEFINITIONS.—In this section:*

*(I) MEMBER OF CONGRESS.—The term "Member of Congress" means any member of the House of Representatives or the Senate.*

*(II) CONGRESSIONAL STAFF.—The term "congressional staff" means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.*

*(4) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 with-*

*out regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).*

*(e) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers—*

*(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and*

*(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.*

*Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.*

*(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—*

*(1) QUALIFIED INDIVIDUALS.—In this title:*

*(A) IN GENERAL.—The term "qualified individual" means, with respect to an Exchange, an individual who—*

*(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and*

*(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).*

*(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.*

*(2) QUALIFIED EMPLOYER.—In this title:*

*(A) IN GENERAL.—The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.*

*(B) EXTENSION TO LARGE GROUPS.—*

*(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.*

*(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.*

*(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.*

***SEC. 1313. FINANCIAL INTEGRITY.***

*(a) ACCOUNTING FOR EXPENDITURES.—*

*(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.*

*(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.*

*(3) AUDITS.—An Exchange shall be subject to annual audits by the Secretary.*

*(4) PATTERN OF ABUSE.—If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.*

*(5) PROTECTIONS AGAINST FRAUD AND ABUSE.—With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-*

*discriminatory administration of Exchange activities and implement any measure or procedure that—*

*(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and*

*(B) the Secretary has authority to implement under this title or any other Act.*

*(6) APPLICATION OF THE FALSE CLAIMS ACT.—*

*(A) IN GENERAL.—Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.*

*(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall*

*be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.*

*(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—*

*(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;*

*(2) any significant observations regarding the utilization and adoption of Exchanges;*

*(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; and*

*(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.*

## *PART III—STATE FLEXIBILITY RELATING TO EXCHANGES*

### *SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.*

*(a) ESTABLISHMENT OF STANDARDS.—*

*(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—*

*(A) the establishment and operation of Exchanges (including SHOP Exchanges);*

*(B) the offering of qualified health plans through such Exchanges;*

*(C) the establishment of the reinsurance and risk adjustment programs under part V; and*

*(D) such other requirements as the Secretary determines appropriate.*

*The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.*

*(2) CONSULTATION.—In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.*

*(b) STATE ACTION.—Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—*

*(1) the Federal standards established under subsection (a); or*

*(2) a State law or regulation that the Secretary determines implements the standards within the State.*

*(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—*

*(1) IN GENERAL.—If—*

*(A) a State is not an electing State under subsection (b); or*

*(B) the Secretary determines, on or before January 1, 2013, that an electing State—*

*(i) will not have any required Exchange operational by January 1, 2014; or*

*(ii) has not taken the actions the Secretary determines necessary to implement—*

*(I) the other requirements set forth in the standards under subsection (a); or*

*(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;*

*the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.*

*(2) ENFORCEMENT AUTHORITY.—The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).*

*(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.*

*(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES.—*

*(1) IN GENERAL.—In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.*

*(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.*

***SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.***

*(a) ESTABLISHMENT OF PROGRAM.—*

*(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO–OP) program.*

*(2) PURPOSE.—It is the purpose of the CO–OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.*

*(b) LOANS AND GRANTS UNDER THE CO–OP PROGRAM.—*

*(1) IN GENERAL.—The Secretary shall provide through the CO–OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—*

*(A) loans to provide assistance to such person in meeting its start-up costs; and*

*(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.*

*(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—*

*(A) IN GENERAL.—In awarding loans and grants under the CO–OP program, the Secretary shall—*

*(i) take into account the recommendations of the advisory board established under paragraph (3);*

*(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and*

*(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.*

*(B) STATES WITHOUT ISSUERS IN PROGRAM.—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts*

*appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.*

*(C) AGREEMENT.—*

*(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO–OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—*

*(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and*

*(II) any requirements contained in the agreement for such person to receive such loan or grant.*

*(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—*

*(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or*

*(II) for marketing.*

*Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.*

*(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—*

*(I) 110 percent of the aggregate amount of loans and grants received under this section; plus*

*(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.*

*The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.*

*(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO–OP program and begin the distribution of amounts awarded under such loans and grants.*

*(3) ADVISORY BOARD.—*

*(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.*

*(B) RULES RELATING TO APPOINTMENTS.—*

*(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.*

*(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.*

*(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.*

*(D) PAY AND REIMBURSEMENT.—*

*(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.*

*(ii) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.*

*(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.*

*(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.*

*(c) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—*

*(1) IN GENERAL.—The term "qualified nonprofit health insurance issuer" means a health insurance issuer that is an organization—*

*(A) that is organized under State law as a nonprofit, member corporation;*

*(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and*

*(C) that meets the other requirements of this subsection.*

*(2) CERTAIN ORGANIZATIONS PROHIBITED.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—*

*(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or*

*(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.*

*(3) GOVERNANCE REQUIREMENTS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—*

*(A) the governance of the organization is subject to a majority vote of its members;*

*(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and*

*(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.*

*(4) PROFITS INURE TO BENEFIT OF MEMBERS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.*

*(5) COMPLIANCE WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).*

*(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).*

*(d) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—*

*(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO–OP program under this section may establish a private purchasing*

*council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.*

*(2) COUNCIL MAY NOT SET PAYMENT RATES.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.*

*(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—*

*(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.*

*(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term "antitrust laws" has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to*

*the extent that such section 5 applies to unfair methods of competition.*

*(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).*

*(f) LIMITATIONS ON SECRETARY.—*

*(1) IN GENERAL.—The Secretary shall not—*

*(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and*

*(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.*

*(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.*

*(g) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.*

*(h) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—*

*(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:*

*"(29) CO–OP HEALTH INSURANCE ISSUERS.—*

*"(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO–OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.*

*"(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—*

*"(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it*

*is applying for recognition of its status under this paragraph,*

*"(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,*

*"(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and*

*"(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.".*

*(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:*

*"(m) ADDITIONAL INFORMATION REQUIRED FROM CO–OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:*

*"(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.*

*"(2) The amount of reserves on hand.".*

*(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking "paragraph (3) or (4)" and inserting "paragraph (3), (4), or (29)".*

*(i) GAO STUDY AND REPORT.—*

*(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.*

*(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative*

*changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.*

***SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.***

*(a) VOLUNTARY NATURE.—*

*(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.*

*(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.*

*(3) STATE OPT OUT.—*

*(A) IN GENERAL.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.*

*(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.*

*(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—*

*(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.*

*(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term "community health insurance option" means health insurance coverage that—*

*(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;*

*(B) provides high value for the premium charged;*

*(C) reduces administrative costs and promotes administrative simplification for beneficiaries;*

*(D) promotes high quality clinical care;*

*(E) provides high quality customer service to beneficiaries;*

*(F) offers a sufficient choice of providers; and*

*(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).*

*(3) ESSENTIAL HEALTH BENEFITS.—*

*(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).*

*(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.*

*(C) CREDITS.—*

*(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner*

*as an individual who is enrolled in a qualified health plan.*

*(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.*

*(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).*

*(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an in-*

*dividual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.*

*(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.*

*(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).*

*(5) PREMIUMS.—*

*(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.*

*(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.*

*(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).*

*(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.*

*(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.*

*(6) REIMBURSEMENT RATES.—*

*(A) NEGOTIATED RATES.—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.*

*(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.*

*(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of*

*innovative payment policies that promote quality, efficiency and savings to consumers.*

*(7) SOLVENCY AND CONSUMER PROTECTION.—*

*(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.*

*(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.*

*(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option.*

*(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—*

*(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the "NAIC"), may promulgate regu-*

*lations to establish additional requirements for a community health insurance option.*

*(B) APPLICABILITY.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.*

*(c) START-UP FUND.—*

*(1) ESTABLISHMENT OF FUND.—*

*(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the "Health Benefit Plan Start-Up Fund" (referred to in this section as the "Start-Up Fund"), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.*

*(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—*

*(i) pay the start-up costs associated with the initial operations of a community health insurance option; and*

*(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.*

*(2) USE OF START-UP FUND.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).*

*(3) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.*

*(4) REPAYMENT.—*

*(A) IN GENERAL.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repay-*

*ments at rates that do not exceed the market interest rate (as determined by the Secretary).*

*(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—*

*(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and*

*(ii) permanently ineligible to offer a qualified health plan.*

*(d) STATE ADVISORY COUNCIL.—*

*(1) ESTABLISHMENT.—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:*

*(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;*

*(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and*

*(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.*

*(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.*

*(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.*

*(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—*

*(1) AUTHORITY.—*

*(A) IN GENERAL.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions de-*

*scribed in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.*

*(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—*

*(i) shall meet the criteria established under paragraph (2); and*

*(ii) shall receive an administrative fee under paragraph (7).*

*(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.*

*(D) REFERENCE.—An entity with which the Secretary has entered into a contract under*

*this paragraph shall be referred to as a "contracting administrator".*

*(2) QUALIFIED ENTITY.—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—*

*(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;*

*(B) be a nonprofit entity for purposes of offering such option;*

*(C) meet the solvency standards applicable under subsection (b)(7);*

*(D) be eligible to offer health insurance or health benefits coverage;*

*(E) meet quality standards specified by the Secretary;*

*(F) have in place effective procedures to control fraud, abuse, and waste; and*

*(G) meet such other requirements as the Secretary may impose.*

*Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-*

*end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.*

*(3) TERM.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.*

*(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).*

*(5) AUDITS.—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.*

*(6) REVOCATION.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.*

*(7) FEE FOR ADMINISTRATION.—*

*(A) IN GENERAL.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.*

*(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements estab-*

*lished by the Secretary, in at least the following areas:*

*(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.*

*(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.*

*(iii) Promoting high quality clinical care.*

*(iv) Providing high quality customer service to beneficiaries.*

*(C) NON-RENEWAL.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.*

*(8) LIMITATION.—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).*

*(f) REPORT BY HHS AND INSOLVENCY WARNINGS.—*

*(1) IN GENERAL.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.*

*(2) RESULT.—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.*

*(3) SUBMISSION OF PLAN AND PROCEDURE.—*

*(A) IN GENERAL.—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.*

*(B) PROCEDURE.—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement,*

*and Modernization Act of 2003 that shall be used for a medicare funding warning.*

*(g) MARKETING PARITY.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.*

*(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.*

***SEC. 1324. LEVEL PLAYING FIELD.***

*(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.*

*(b) LAWS DESCRIBED.—The Federal and State laws described in this subsection are those Federal and State laws relating to—*

*(1) guaranteed renewal;*

*(2) rating;*

*(3) preexisting conditions;*

*(4) non-discrimination;*

*(5) quality improvement and reporting;*

*(6) fraud and abuse;*

*(7) solvency and financial requirements;*

*(8) market conduct;*

*(9) prompt payment;*

*(10) appeals and grievances;*

*(11) privacy and confidentiality;*

*(12) licensure; and*

*(13) benefit plan material or information.*

## ***PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS***

### ***SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.***

*(a) ESTABLISHMENT OF PROGRAM.—*

*(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into con-*

*tracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.*

*(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—*

*(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—*

*(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Inter-*

*nal Revenue Code of 1986) offered to the individual through an Exchange; and*

*(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—*

*(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and*

*(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and*

*(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).*

*For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits*

*and cost-sharing reductions allowable with respect to either plan.*

*(b) STANDARD HEALTH PLAN.—In this section, the term "standard heath plan" means a health benefits plan that the State contracts with under this section—*

*(1) under which the only individuals eligible to enroll are eligible individuals;*

*(2) that provides at least the essential health benefits described in section 1302(b); and*

*(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.*

*(c) CONTRACTING PROCESS.—*

*(1) IN GENERAL.—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).*

*(2) SPECIFIC ITEMS TO BE CONSIDERED.—A State shall, as part of its competitive process under paragraph (1), include at least the following:*

*(A) INNOVATION.—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—*

*(i) care coordination and care management for enrollees, especially for those with chronic health conditions;*

*(ii) incentives for use of preventive services; and*

*(iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.*

*(B) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.*

*(C) MANAGED CARE.—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.*

*(D) PERFORMANCE MEASURES.—Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.*

*(3) ENHANCED AVAILABILITY.—*

*(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.*

*(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.*

*(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the*

*State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.*

*(d) TRANSFER OF FUNDS TO STATES.—*

*(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).*

*(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.*

*(3) AMOUNT OF PAYMENT.—*

*(A) SECRETARIAL DETERMINATION.—*

*(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.*

*(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rat-*

*ing areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.*

*(iii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from com-*

*parable States about their experience with programs created by this Act.*

*(B) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.*

*(4) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.*

*(e) ELIGIBLE INDIVIDUAL.—*

*(1) IN GENERAL.—In this section, the term "eligible individual" means, with respect to any State, an individual—*

*(A) who a resident of the State who is not eligible to enroll in the State's medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);*

*(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;*

*(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of*

*the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and*

*(D) who has not attained age 65 as of the beginning of the plan year.*

*Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.*

*(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.*

*(f) SECRETARIAL OVERSIGHT.—The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—*

*(1) eligibility verification requirements for participation in the program;*

*(2) the requirements for use of Federal funds received by the program; and*

*(3) the quality and performance standards under this section.*

*(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.*

*(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.*

***SEC. 1332. WAIVER FOR STATE INNOVATION.***

*(a) APPLICATION.—*

*(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall—*

*(A) be filed at such time and in such manner as the Secretary may require;*

*(B) contain such information as the Secretary may require, including—*

*(i) a comprehensive description of the State legislation and program to implement*

*a plan meeting the requirements for a waiver under this section; and*

*(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and*

*(C) provide an assurance that the State has enacted the law described in subsection (b)(2).*

*(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:*

*(A) Part I of subtitle D.*

*(B) Part II of subtitle D.*

*(C) Section 1402.*

*(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.*

*(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by*

*which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.*

*(4) WAIVER CONSIDERATION AND TRANSPARENCY.—*

*(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).*

*(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—*

*(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;*

*(ii) a process for the submission of an application that ensures the disclosure of—*

*(I) the provisions of law that the State involved seeks to waive; and*

*(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);*

*(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;*

*(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and*

*(v) a process for the periodic evaluation by the Secretary of the program under the waiver.*

*(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.*

*(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.*

*(6) DEFINITION.—In this section, the term "Secretary" means—*

*(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and*

*(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).*

*(b) GRANTING OF WAIVERS.—*

*(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—*

*(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;*

*(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;*

*(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and*

*(D) will not increase the Federal deficit.*

*(2) REQUIREMENT TO ENACT A LAW.—*

*(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, in-*

*cluding the implementation of the State plan under subsection (a)(1)(B).*

*(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.*

*(c) SCOPE OF WAIVER.—*

*(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).*

*(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.*

*(d) DETERMINATIONS BY SECRETARY.—*

*(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.*

*(2) EFFECT OF DETERMINATION.—*

*(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.*

*(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.*

*(e) TERM OF WAIVER.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.*

***SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.***

*(a) HEALTH CARE CHOICE COMPACTS.—*

*(1) IN GENERAL.—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—*

*(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;*

*(B) the issuer of any qualified health plan to which the compact applies—*

*(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;*

*(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and*

*(iii) must clearly notify consumers that the policy may not be subject to all the*

*laws and regulations of the State in which the purchaser resides.*

*(2) STATE AUTHORITY.—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.*

*(3) APPROVAL OF COMPACTS.—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—*

*(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;*

*(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;*

*(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;*

*(D) will not increase the Federal deficit; and*

*(E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.*

*(4) EFFECTIVE DATE.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.*

*(b) AUTHORITY FOR NATIONWIDE PLANS.—*

*(1) IN GENERAL.—Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a "nationwide qualified health plan")—*

*(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and*

*(B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.*

*(2) STATE OPT-OUT.—A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.*

*(3) PLAN REQUIREMENTS.—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—*

*(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);*

*(B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;*

*(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver and*

*gold levels of the plan in each Exchange in the State for the market in which the plan is offered;*

*(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;*

*(E) the issuer offers the nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such States in the second year, 70 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;*

*(F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act; and*

*(G) the issuer clearly notifies consumers that the policy may not contain some benefits otherwise mandated for plans in the State in which the purchaser resides and provides a detailed statement of the benefits offered and the*

*benefit differences in that State, in accordance with rules promulgated by the Secretary.*

*(4) FORM REVIEW FOR NATIONWIDE PLANS.—Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.*

*(5) APPLICABLE RULES.—The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.*

*(6) COVERAGE.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.*

*(7) STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.—For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health*

*insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A law that mandates health insurance coverage or reimbursement for services provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.*

***PART V—REINSURANCE AND RISK ADJUSTMENT***

***SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.***

*(a) IN GENERAL.—Each State shall, not later than January 1, 2014—*

*(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and*

*(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.*

*(b) MODEL REGULATION.—*

*(1) IN GENERAL.—In establishing the Federal standards under section 1321(a), the Secretary, in*

*consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that enable States to establish and maintain a program under which—*

*(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and*

*(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.*

*(2) HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS.—The Secretary shall include the following in the provisions under paragraph (1):*

*(A) DETERMINATION OF HIGH-RISK INDIVIDUALS.—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established*

*under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—*

*(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or*

*(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.*

*(B) PAYMENT AMOUNT.—The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—*

*(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or*

*(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.*

*(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—*

*(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.*

*(B) SPECIFIC REQUIREMENTS.—The method under this paragraph shall be designed so that—*

*(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;*

*(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;*

*(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning 2015, and $4,000,000,000 for plan years beginning in 2016; and*

*(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional $2,000,000,000 for 2014, an additional*

*$2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.*

*Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.*

*(4) EXPENDITURE OF FUNDS.—The provisions under paragraph (1) shall provide that—*

*(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and*

*(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.*

*Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.*

*(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—*

*(1) IN GENERAL.—The term "applicable reinsurance entity" means a not-for-profit organization—*

*(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and*

*(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.*

*(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.*

*(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511*

*such Code (relating to tax on unrelated business taxable income of an exempt organization).*

*(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.*

***SEC. 1342. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.***

*(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.*

*(b) PAYMENT METHODOLOGY.—*

*(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—*

*(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and*

*(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.*

*(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—*

*(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and*

*(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Sec-*

*retary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.*

*(c) DEFINITIONS.—In this section:*

*(1) ALLOWABLE COSTS.—*

*(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.*

*(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.*

*(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.*

***SEC. 1343. RISK ADJUSTMENT.***

*(a) IN GENERAL.—*

*(1) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b),*

*each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).*

*(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).*

*(b) CRITERIA AND METHODS.—The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and*

*methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.*

*(c) SCOPE.—A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.*

# *Subtitle E—Affordable Coverage Choices for All Americans*

## *PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS*

### *Subpart A—Premium Tax Credits and Cost-sharing Reductions*

#### *SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.*

*(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:*

***"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.***

*"(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.*

*"(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—*

*"(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.*

*"(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—*

*"(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of*

*the Patient Protection and Affordable Care Act, or*

*"(B) the excess (if any) of—*

*"(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over*

*"(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.*

*"(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—*

*"(A) APPLICABLE PERCENTAGE.—*

*"(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—*

*"(I) the taxpayer's household income for the taxable year in excess of*

*100 percent of the poverty line for a family of the size involved, bears to*

*"(II) an amount equal to 200 percent of the poverty line for a family of the size involved.*

*"(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer's household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer's applicable percentage shall be 2 percent.*

*"(iii) INDEXING.—In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.*

*"(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost*

*silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—*

*"(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and*

*"(ii) provides—*

*"(I) self-only coverage in the case of an applicable taxpayer—*

*"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or*

*"(bb) who is not described in item (aa) but who purchases only self-only coverage, and*

*"(II) family coverage in the case of any other applicable taxpayer.*

*If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.*

*"(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined*

*without regard to any premium discount or rebate under such project.*

*"(D) ADDITIONAL BENEFITS.—If—*

*"(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or*

*"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,*

*the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).*

*"(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection*

*and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.*

*"(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—*

*"(1) APPLICABLE TAXPAYER.—*

*"(A) IN GENERAL.—The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.*

*"(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—*

*"(i) a taxpayer has a household income which is not greater than 100 percent of an*

*amount equal to the poverty line for a family of the size involved, and*

*"(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,*

*the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.*

*"(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.*

*"(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in*

*the calendar year in which such individual's taxable year begins.*

*"(2) COVERAGE MONTH.—For purposes of this subsection—*

*"(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—*

*"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and*

*"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).*

*"(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—*

*"(i) IN GENERAL.—The term 'coverage month' shall not include any month with*

*respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).*

*"(ii) MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).*

*"(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—*

*"(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—*

*"(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and*

*"(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to*

*the plan exceeds 9.8 percent of the applicable taxpayer's household income.*

*This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.*

*"(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.*

*"(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.*

*"(iv) INDEXING.—In the case of plan years beginning in any calendar year after*

*2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).*

*"(3) DEFINITIONS AND OTHER RULES.—*

*"(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.*

*"(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.*

*"(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—*

*"(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.*

*"(2) HOUSEHOLD INCOME.—*

*"(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—*

*"(i) the modified gross income of the taxpayer, plus*

*"(ii) the aggregate modified gross incomes of all other individuals who—*

*"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and*

*"(II) were required to file a return of tax imposed by section 1 for the taxable year.*

*"(B) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—*

*"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),*

*"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and*

*"(iii) determined without regard to sections 911, 931, and 933.*

*"(3) POVERTY LINE.—*

*"(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).*

*"(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.*

*"(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—*

*"(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—*

*"(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and*

*"(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:*

*"(i) A method under which—*

*"(I) the taxpayer's family size is determined by not taking such individuals into account, and*

*"(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—*

*"(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and*

*"(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).*

*"(ii) A comparable method reaching the same result as the method under clause (i).*

*"(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.*

*"(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.*

*"(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—*

*"(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any*

*advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.*

*"(2) EXCESS ADVANCE PAYMENTS.—*

*"(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.*

*"(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—*

*"(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).*

*"(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after*

*2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—*

*"(I) such dollar amount, multiplied by*

*"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.*

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

*"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—*

*"(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and*

*"(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is dif-*

*ferent from such status used for determining the advance payment of the credit.".*

*(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:*

*"(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.".*

*(c) STUDY ON AFFORDABLE COVERAGE.—*

*(1) STUDY AND REPORT.—*

*(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—*

*(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code*

*on maintaining and expanding the health insurance coverage of individuals;*

*(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and*

*(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).*

*(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.*

*(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term "appropriate committees of Congress" means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.*

*(d) CONFORMING AMENDMENTS.—*

*(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "36A,".*

*(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:*

*"Sec. 36B. Refundable credit for coverage under a qualified health plan.".*

*(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.*

***SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.***

*(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—*

*(1) the Secretary shall notify the issuer of the plan of such eligibility; and*

*(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).*

*(b) ELIGIBLE INSURED.—In this section, the term "eligible insured" means an individual—*

*(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and*

*(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.*

*In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.*

*(c) DETERMINATION OF REDUCTION IN COST-SHARING.—*

*(1) REDUCTION IN OUT-OF-POCKET LIMIT.—*

*(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of—*

*(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line*

*for a family of the size involved, by two-thirds;*

*(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and*

*(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.*

*(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—*

*(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—*

*(I) 90 percent in the case of an eligible insured described in paragraph (2)(A);*

*(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and*

*(III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).*

*(ii) ADJUSTMENT.—The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).*

*(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—*

*(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and*

*(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's*

*share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.*

*(3) METHODS FOR REDUCING COST-SHARING.—*

*(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.*

*(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.*

*(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.*

*(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).*

*(d) SPECIAL RULES FOR INDIANS.—*

*(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—*

*(A) such individual shall be treated as an eligible insured; and*

*(B) the issuer of the plan shall eliminate any cost-sharing under the plan.*

*(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—*

*(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and*

*(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).*

*(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.*

*(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—*

*(1) IN GENERAL.—If an individual who is an eligible insured is not lawfully present—*

*(A) no cost-sharing reduction under this section shall apply with respect to the individual; and*

*(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:*

*(i) A method under which—*

*(I) the taxpayer's family size is determined by not taking such individuals into account, and*

*(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—*

*(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and*

*(bb) the denominator of which is the poverty line for the*

*taxpayer's family size determined without regard to subclause (I).*

*(ii) A comparable method reaching the same result as the method under clause (i).*

*(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.*

*(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.*

*(f) DEFINITIONS AND SPECIAL RULES.—In this section:*

*(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Rev-*

*enue Code of 1986 shall have the meaning given such term by such section.*

*(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.*

*(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.*

***Subpart B—Eligibility Determinations***

***SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.***

*(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—*

*(1) whether an individual who is to be covered in the individual market by a qualified health plan*

*offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;*

*(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—*

*(A) whether the individual meets the income and coverage requirements of such sections; and*

*(B) the amount of the tax credit or reduced cost-sharing;*

*(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and*

*(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.*

*(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—*

*(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—*

*(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an "enrollee"); and*

*(B) the information required by any of the following paragraphs that is applicable to an enrollee.*

*(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:*

*(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.*

*(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation*

*with the Secretary of Homeland Security, determines appropriate.*

*(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:*

*(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.*

*(B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.*

*(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being*

*established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:*

*(A) The name, address, and employer identification number (if available) of the employer.*

*(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.*

*(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.*

*(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).*

*If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the in-*

*formation described in this paragraph with respect to the new employer.*

*(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:*

*(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.*

*(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.*

*(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—*

*(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the*

*Secretary for verification in accordance with the requirements of this subsection and subsection (d).*

*(2) CITIZENSHIP OR IMMIGRATION STATUS.—*

*(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:*

*(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).*

*(ii) The attestation of an individual that the individual is a citizen.*

*(B) SECRETARY OF HOMELAND SECURITY.—*

*(i) IN GENERAL.—In the case of an individual—*

*(I) who attests that the individual is an alien lawfully present in the United States; or*

*(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Se-*

*curity has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;*

*the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.*

*(ii) INFORMATION.—The information described in clause (ii) is the following:*

*(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).*

*(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.*

*(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.*

*(4) METHODS.—*

*(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—*

*(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or*

*(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of*

*Social Security through such other method as is approved by the Secretary.*

*(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.*

*(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.*

*(e) ACTIONS RELATING TO VERIFICATION.—*

*(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.*

*(2) VERIFICATION.—*

*(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—*

*(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and*

*(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.*

*(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).*

*(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).*

*(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—*

*(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify*

*the Exchange and the Exchange shall take the following actions:*

*(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.*

*(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—*

*(I) notify the applicant of such fact;*

*(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required*

*under subclause (I) is sent to the applicant.*

*The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.*

*(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—*

*(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.*

*(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).*

*(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.*

*(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.*

*(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice*

*under this paragraph of the appeals processes established under subsection (f).*

*(f) APPEALS AND REDETERMINATIONS.—*

*(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—*

*(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and*

*(B) redetermines eligibility on a periodic basis in appropriate circumstances.*

*(2) EMPLOYER LIABILITY.—*

*(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable cov-*

*erage with respect to an employee. Such process shall provide an employer the opportunity to—*

*(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and*

*(ii) have access to the data used to make the determination to the extent allowable by law.*

*Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.*

*(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—*

*(i) the employer may be notified as to the name of an employee and whether or*

*not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and*

*(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.*

*(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—*

*(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.*

*(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—*

*(A) use the information only for the purposes of, and to the extent necessary in, ensuring*

*the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and*

*(B) not disclose the information to any other person except as provided in this section.*

*(h) PENALTIES.—*

*(1) FALSE OR FRAUDULENT INFORMATION.—*

*(A) CIVIL PENALTY.—*

*(i) IN GENERAL.—If—*

*(I) any person fails to provides correct information under subsection (b); and*

*(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,*

*such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the*

*same meanings as when used in section 6662 of the Internal Revenue Code of 1986.*

*(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.*

*(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $250,000.*

*(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.*

*(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—*

*(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or*

*(B) levy on any such property with respect to such failure.*

*(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—*

*(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:*

*(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.*

*(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.*

*(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and*

*Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.*

***SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.***

*(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—*

*(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;*

*(2) the Secretary notifies—*

*(A) the Exchange and the Secretary of the Treasury of the advance determinations; and*

*(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section*

*36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—*

*(i) the employer did not provide minimum essential coverage; or*

*(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and*

*(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.*

*(b) ADVANCE DETERMINATIONS.—*

*(1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—*

*(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and*

*(B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.*

*(2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—*

*(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and*

*(B) the determination of household income in cases where the taxpayer was not required to*

*file a return of tax imposed by this chapter for the second preceding taxable year.*

*(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—*

*(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.*

*(2) PREMIUM TAX CREDIT.—*

*(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).*

*(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—*

*(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;*

*(ii) notify the Exchange and the Secretary of such reduction;*

*(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and*

*(iv) in the case of any nonpayment of premiums by the insured—*

*(I) notify the Secretary of such nonpayment; and*

*(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.*

*(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.*

*(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.*

*(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.*

***SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.***

*(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.*

*(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—*

*(1) REQUIREMENTS RELATING TO FORMS.—*

*(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—*

*(i) may be used to apply for all applicable State health subsidy programs within the State;*

*(ii) may be filed online, in person, by mail, or by telephone;*

*(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and*

*(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.*

*(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.*

*(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).*

*(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.*

*(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—*

*(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility*

*for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).*

*(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—*

*(A) provides access to data described in paragraph (3);*

*(B) applies only to individuals who—*

*(i) receive assistance from an applicable State health subsidy program; or*

*(ii) apply for such assistance—*

*(I) by filing a form described in subsection (b); or*

*(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and*

*(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.*

*(3) DETERMINATION OF ELIGIBILITY.—*

*(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—*

*(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and*

*(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.*

*(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.*

*(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.*

*(d) ADMINISTRATIVE AUTHORITY.—*

*(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.*

*(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—*

*(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring*

*reduced administrative costs, eligibility errors, and disruptions in coverage; or*

*(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.*

*(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term "applicable State health subsidy program" means—*

*(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;*

*(2) a State medicaid program under title XIX of the Social Security Act;*

*(3) a State children's health insurance program (CHIP) under title XXI of such Act; and*

*(4) a State program under section 1331 establishing qualified basic health plans.*

***SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.***

*(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—*

*(1) TAXPAYER RETURN INFORMATION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:*

*"(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—*

*"(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to—*

*"(i) taxpayer identity information with respect to such taxpayer,*

*"(ii) the filing status of such taxpayer,*

*"(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),*

*"(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,*

*"(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and*

*"(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.*

*"(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an Exchange*

*established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).*

*"(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in—*

*"(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),*

*"(ii) determining eligibility for participation in the State programs described in subparagraph (A).".*

*(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:*

*"(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act.".*

*(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".*

*(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—*

*(1) by inserting ", or any entity described in subsection (l)(21)," after "or (20)" in the matter preceding subparagraph (A),*

*(2) by inserting "or any entity described in subsection (l)(21)," after "or (o)(1)(A)" in subparagraph (F)(ii), and*

*(3) by inserting "or any entity described in subsection (l)(21)," after "or (20)" both places it appears in the matter after subparagraph (F).*

*(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".*

***SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.***

*For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—*

*(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and*

*(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.*

***PART II—SMALL BUSINESS TAX CREDIT***

***SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.***

*(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:*

***"SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.***

*"(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).*

*"(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—*

*"(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or*

*"(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.*

*"(c) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:*

*"(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.*

*"(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.*

*"(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—*

*"(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—*

*"(A) which has no more than 25 full-time equivalent employees for the taxable year,*

*"(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and*

*"(C) which has in effect an arrangement described in paragraph (4).*

*"(2) FULL-TIME EQUIVALENT EMPLOYEES.—*

*"(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—*

*"(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by*

*"(ii) 2,080.*

*Such number shall be rounded to the next lowest whole number if not otherwise a whole number.*

*"(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours of serv-*

*ice during any taxable year, such excess shall not be taken into account under subparagraph (A).*

*"(C) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.*

*"(3) AVERAGE ANNUAL WAGES.—*

*"(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—*

*"(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by*

*"(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.*

*Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.*

*"(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—*

*"(i) 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.*

*"(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.*

*"(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.*

*"(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—*

*"(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal*

*worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.*

*"(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.*

*"(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—*

*"(1) EMPLOYEE.—*

*"(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—*

*"(i) an employee within the meaning of section 401(c)(1),*

*"(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,*

*"(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or*

*"(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).*

*"(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).*

*"(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.*

*"(3) NONELECTIVE CONTRIBUTION.—The term 'nonelective contribution' means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.*

*"(4) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).*

*"(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—*

*"(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.*

*"(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.*

*"(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—*

*"(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of—*

*"(A) the amount of the credit determined under this section with respect to such employer, or*

*"(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.*

*"(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term 'tax-exempt eligible small employer' means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).*

*"(3) PAYROLL TAXES.—For purposes of this subsection—*

*"(A) IN GENERAL.—The term 'payroll taxes' means—*

*"(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),*

*"(ii) amounts required to be withheld from such employees under section 3101(b), and*

*"(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).*

*"(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).*

*"(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):*

*"(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after*

*2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.*

*"(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—*

*"(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '50 percent (35 percent in the case of a tax-exempt eligible small employer)',*

*"(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and*

*"(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).*

*"(3) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of*

*subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.*

*"(h) INSURANCE DEFINITIONS.—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.*

*"(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities.".*

*(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking "plus" at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting ", plus", and by inserting after paragraph (35) the following:*

*"(36) the small employer health insurance credit determined under section 45R.".*

*(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by re-*

*designating clauses (vi), (vii), and (viii) as clauses (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:*

*"(vi) the credit determined under section 45R,".*

*(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—*

*(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:*

*"(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums.".*

*(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ",*

*and", and by adding at the end the following new paragraph:*

*"(14) the small employer health insurance credit determined under section 45R(a).".*

*(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:*

*"Sec. 45R. Employee health insurance expenses of small employers.".*

*(f) EFFECTIVE DATES.—*

*(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.*

*(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.*

# *Subtitle F—Shared Responsibility for Health Care*

## *PART I—INDIVIDUAL RESPONSIBILITY*

### *SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.*

*(a) FINDINGS.—Congress makes the following findings:*

*(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this sub-*

*section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).*

*(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:*

*(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.*

*(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.*

*(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.*

*(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.*

*(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.*

*(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et*

*seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.*

*(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.*

*(H) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with*

*the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.*

*(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.*

*(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:*

## *"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE*

*"Sec. 5000A. Requirement to maintain minimum essential coverage.*

### *"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.*

*"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.*

*"(b) SHARED RESPONSIBILITY PAYMENT.—*

*"(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).*

*"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.*

*"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—*

*"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or*

*"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.*

*"(c) AMOUNT OF PENALTY.—*

*"(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.*

*"(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.*

*"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—*

*"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.*

*"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.*

*"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be*

*equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.*

*"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—*

*"(i) $750, multiplied by*

*"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.*

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

*"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—*

*"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.*

*"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any*

*taxpayer for any taxable year, an amount equal to the sum of—*

*"(i) the modified gross income of the taxpayer, plus*

*"(ii) the aggregate modified gross incomes of all other individuals who—*

*"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and*

*"(II) were required to file a return of tax imposed by section 1 for the taxable year.*

*"(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—*

*"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),*

*"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and*

*"(iii) determined without regard to sections 911, 931, and 933.*

*"(D) POVERTY LINE.—*

*"(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).*

*"(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.*

*"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—*

*"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).*

*"(2) RELIGIOUS EXEMPTIONS.—*

*"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an*

*adherent of established tenets or teachings of such sect or division as described in such section.*

*"(B) HEALTH CARE SHARING MINISTRY.—*

*"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.*

*"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—*

*"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),*

*"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,*

*"(III) members of which retain membership even after they develop a medical condition,*

*"(IV) which (or a predecessor of which) has been in existence at all*

*times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and*

*"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.*

*"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.*

*"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.*

*"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—*

*"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—*

*"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.*

*"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—*

*"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or*

*"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).*

*"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.*

*"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, sub-*

*paragraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.*

*"(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).*

*"(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).*

*"(4) MONTHS DURING SHORT COVERAGE GAPS.—*

*"(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.*

*"(B) SPECIAL RULES.—For purposes of applying this paragraph—*

*"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,*

*"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and*

*"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.*

*The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.*

*"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with re-*

*spect to the capability to obtain coverage under a qualified health plan.*

*"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—*

*"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:*

*"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—*

*"(i) the Medicare program under part A of title XVIII of the Social Security Act,*

*"(ii) the Medicaid program under title XIX of the Social Security Act,*

*"(iii) the CHIP program under title XXI of the Social Security Act,*

*"(iv) the TRICARE for Life program,*

*"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or*

*"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).*

*"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.*

*"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.*

*"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.*

*"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.*

*"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—*

*"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or*

*"(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.*

*"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum*

*essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—*

*"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or*

*"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.*

*"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—*

*"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or*

*"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.*

*"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of*

*the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.*

*"(g) ADMINISTRATION AND PROCEDURE.—*

*"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.*

*"(2) SPECIAL RULES.—Notwithstanding any other provision of law—*

*"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.*

*"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—*

*"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or*

*"(ii) levy on any such property with respect to such failure.".*

*(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:*

*"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".*

*(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.*

***SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.***

*(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:*

***"Subpart D—Information Regarding Health Insurance Coverage***

*"Sec. 6055. Reporting of health insurance coverage.*

***"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.***

*"(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).*

*"(b) FORM AND MANNER OF RETURN.—*

*"(1) IN GENERAL.—A return is described in this subsection if such return—*

*"(A) is in such form as the Secretary may prescribe, and*

*"(B) contains—*

*"(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,*

*"(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,*

*"(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—*

*"(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and*

*"(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and*

*"(iv) such other information as the Secretary may require.*

*"(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—*

*"(A) the name, address, and employer identification number of the employer maintaining the plan,*

*"(B) the portion of the premium (if any) required to be paid by the employer, and*

*"(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).*

*"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—*

*"(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to*

*each individual whose name is required to be set forth in such return a written statement showing—*

*"(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and*

*"(B) the information required to be shown on the return with respect to such individual.*

*"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.*

*"(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.*

*"(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).".*

*(b) ASSESSABLE PENALTIES.—*

*(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or", and by inserting after clause (xxiii) the following new clause:*

*"(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and".*

*(2) Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or" and by inserting after subparagraph (FF) the following new subparagraph:*

*"(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).".*

*(c) NOTIFICATION OF NONENROLLMENT.—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A*

*of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.*

*(d) CONFORMING AMENDMENT.—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:*

*"SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE".*

*(e) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after 2013.*

## *PART II—EMPLOYER RESPONSIBILITIES*

### *SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.*

*The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:*

### *"SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.*

*"In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any auto-*

*matic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.".*

***SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.***

*The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:*

***"SEC. 18B. NOTICE TO EMPLOYEES.***

*"(a) IN GENERAL.—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—*

*"(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which*

*the employee may contact the Exchange to request assistance;*

*"(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and*

*"(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.*

*"(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.".*

***SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.***

*(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:*

***"SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.***

*"(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—*

*"(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and*

*"(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,*

*then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.*

*"(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.—*

*"(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage*

*under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.*

*"(2) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—*

*"(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, $400, and*

*"(B) in the case of an extended waiting period which exceeds 60 days, $600.*

*"(3) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.*

*"(c) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—*

*"(1) IN GENERAL.—If—*

*"(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential cov-*

*erage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and*

*"(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,*

*then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.*

*"(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.*

*"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—*

*"(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1/12 of $750.*

*"(2) APPLICABLE LARGE EMPLOYER.—*

*"(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.*

*"(B) EXEMPTION FOR CERTAIN EMPLOYERS.—*

*"(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—*

*"(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and*

*"(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.*

*"(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of*

*Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.*

*"(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—*

*"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.*

*"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.*

*"(iii) PREDECESSORS.—Any reference in this subsection to an employer shall in-*

*clude a reference to any predecessor of such employer.*

*"(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term 'applicable premium tax credit and cost-sharing reduction' means—*

*"(A) any premium tax credit allowed under section 36B,*

*"(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and*

*"(C) any advance payment of such credit or reduction under section 1412 of such Act.*

*"(4) FULL-TIME EMPLOYEE.—*

*"(A) IN GENERAL.—The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.*

*"(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.*

*"(5) INFLATION ADJUSTMENT.—*

*"(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—*

*"(i) such dollar amount, and*

*"(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.*

*"(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.*

*"(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.*

*"(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).*

*"(e) ADMINISTRATION AND PROCEDURE.—*

*"(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and*

*collected in the same manner as an assessable penalty under subchapter B of chapter 68.*

*"(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.*

*"(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.".*

*(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:*

*"Sec. 4980H. Shared responsibility for employers regarding health coverage.".*

*(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—*

*(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Inter-*

*nal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.*

*(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.*

*(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.*

***SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.***

*(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:*

***"SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.***

*"(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).*

*"(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—*

*"(1) is in such form as the Secretary may prescribe, and*

*"(2) contains—*

*"(A) the name, date, and employer identification number of the employer,*

*"(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),*

*"(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—*

*"(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,*

*"(ii) the months during the calendar year for which coverage under the plan was available,*

*"(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and*

*"(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,*

*"(D) the number of full-time employees for each month during the calendar year,*

*"(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and*

*"(F) such other information as the Secretary may require.*

*"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—*

*"(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—*

*"(A) the name and address of the person required to make such return and the phone num-*

*ber of the information contact for such person, and*

*"(B) the information required to be shown on the return with respect to such individual.*

*"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.*

*"(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—*

*"(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and*

*"(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.*

*"(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which*

*is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.*

*"(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.".*

*(b) ASSESSABLE PENALTIES.—*

*(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking "or" at the end of clause (xxiii), by striking "and" at the end of clause (xxiv) and inserting "or", and by inserting after clause (xxiv) the following new clause:*

*"(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and".*

*(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking "or" at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting ", or" and by inserting after subparagraph (GG) the following new subparagraph:*

*"(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).".*

*(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:*

*"Sec. 6056. Large employers required to report on health insurance coverage.".*

*(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.*

***SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.***

*(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:*

*"(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—*

*"(A) IN GENERAL.—The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.*

*"(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.".*

*(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—*

*(1) by striking "For purposes of this section, the term" and inserting "For purposes of this section—*

*"(1) IN GENERAL.—The term", and*

*(2) by striking "Such term shall not include" and inserting the following:*

*"(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include".*

*(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.*

# *Subtitle G—Miscellaneous Provisions*

***SEC. 1551. DEFINITIONS.***

*Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service*

*Act (42 U.S.C. 300gg–91) shall apply with respect to this title.*

***SEC. 1552. TRANSPARENCY IN GOVERNMENT.***

*Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).*

***SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.***

*(a) IN GENERAL.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.*

*(b) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organi-*

*zation, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.*

*(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—*

*(1) the withholding or withdrawing of medical treatment or medical care;*

*(2) the withholding or withdrawing of nutrition or hydration;*

*(3) abortion; or*

*(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.*

*(d) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.*

***SEC. 1554. ACCESS TO THERAPIES.***

*Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—*

*(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;*

*(2) impedes timely access to health care services;*

*(3) interferes with communications regarding a full range of treatment options between the patient and the provider;*

*(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;*

*(5) violates the principles of informed consent and the ethical standards of health care professionals; or*

*(6) limits the availability of health care treatment for the full duration of a patient's medical needs.*

***SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.***

*No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine*

*imposed upon any such issuer for choosing not to participate in such programs.*

***SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.***

*(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.*

*(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking ", except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981".*

*(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.*

***SEC. 1557. NONDISCRIMINATION.***

*(a) IN GENERAL.—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation*

*in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.*

*(b) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).*

*(c) REGULATIONS.—The Secretary may promulgate regulations to implement this section.*

***SEC. 1558. PROTECTIONS FOR EMPLOYEES.***

*The Fair Labor Standards Act of 1938 is amended by inserting after section 18B (as added by section 1512) the following:*

***"SEC. 18C. PROTECTIONS FOR EMPLOYEES.***

*"(a) PROHIBITION.—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—*

*"(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;*

*"(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);*

*"(3) testified or is about to testify in a proceeding concerning such violation;*

*"(4) assisted or participated, or is about to assist or participate, in such a proceeding; or*

*"(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the*

*employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).*

*"(b) COMPLAINT PROCEDURE.—*

*"(1) IN GENERAL.—An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.*

*"(2) NO LIMITATION ON RIGHTS.—Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.".*

***SEC. 1559. OVERSIGHT.***

*The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.*

***SEC. 1560. RULES OF CONSTRUCTION.***

*(a) NO EFFECT ON ANTITRUST LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term "antitrust laws" has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.*

*(b) RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.—Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393–1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).*

*(c) STUDENT HEALTH INSURANCE PLANS.—Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.*

*(d) NO EFFECT ON EXISTING REQUIREMENTS.—Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.*

***SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.***

*Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:*

## *"Subtitle C—Other Provisions*

***"SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.***

*"(a) IN GENERAL.—*

*"(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.*

*"(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall in-*

*clude providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.*

*"(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:*

*"(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.*

*"(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.*

*"(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.*

*"(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.*

*"(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to*

*operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.*

*"(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.*

*"(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.*

*"(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—*

*"(1) shall notify States of such standards or protocols; and*

*"(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.*

*"(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—*

*"(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under*

*subsection (a) (referred to in this subsection as 'appropriate HIT technology').*

*"(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—*

*"(A) be a State, political subdivision of a State, or a local governmental entity; and*

*"(B) submit to the Secretary an application at such time, in such manner, and containing—*

*"(i) a plan to adopt and implement appropriate enrollment technology that includes—*

*"(I) proposed reduction in maintenance costs of technology systems;*

*"(II) elimination or updating of legacy systems; and*

*"(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;*

*"(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and*

*"(iii) such other information as the Secretary may require.*

*"(3) SHARING.—*

*"(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.*

*"(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.".*

***SEC. 1562. CONFORMING AMENDMENTS.***

*(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg–21), as so redesignated by section 1001(4), is amended—*

*(1) by striking subsection (a);*

*(2) in subsection (b)—*

*(A) in paragraph (1), by striking "1 through 3" and inserting "1 and 2"; and*

*(B) in paragraph (2)—*

*(i) in subparagraph (A), by striking "subparagraph (D)" and inserting "subparagraph (D) or (E)";*

*(ii) by striking "1 through 3" and inserting "1 and 2"; and*

*(iii) by adding at the end the following:*

*"(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.";*

*(3) in subsection (c), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group"; and*

*(4) in subsection (d)—*

*(A) in paragraph (1), by striking "1 through 3 shall not apply to any group" and inserting "1 and 2 shall not apply to any individual coverage or any group";*

*(B) in paragraph (2)—*

*(i) in the matter preceding subparagraph (A), by striking "1 through 3 shall not apply to any group" and inserting "1*

*and 2 shall not apply to any individual coverage or any group''; and*

*(ii) in subparagraph (C), by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer''; and*

*(C) in paragraph (3), by striking ''any group'' and inserting ''any individual coverage or any group''.*

*(b) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:*

*''(20) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.*

*''(21) EXCHANGE.—The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.''.*

*(c) TECHNICAL AND CONFORMING AMENDMENTS.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—*

*(1) in section 2704 (42 U.S.C. 300gg), as so redesignated by section 1201(2)—*

*(A) in subsection (c)—*

*(i) in paragraph (2), by striking "group health plan" each place that such term appears and inserting "group or individual health plan"; and*

*(ii) in paragraph (3)—*

*(I) by striking "group health insurance" each place that such term appears and inserting "group or individual health insurance"; and*

*(II) in subparagraph (D), by striking "small or large" and inserting "individual or group";*

*(B) in subsection (d), by striking "group health insurance" each place that such term appears and inserting "group or individual health insurance"; and*

*(C) in subsection (e)(1)(A), by striking "group health insurance" and inserting "group or individual health insurance";*

*(2) by striking the second heading for subpart 2 of part A (relating to other requirements);*

*(3) in section 2725 (42 U.S.C. 300gg–4), as so redesignated by section 1001(2)—*

*(A) in subsection (a), by striking "health insurance issuer offering group health insurance coverage" and inserting "health insurance issuer offering group or individual health insurance coverage";*

*(B) in subsection (b)—*

*(i) by striking "health insurance issuer offering group health insurance coverage in connection with a group health plan" in the matter preceding paragraph (1) and inserting "health insurance issuer offering group or individual health insurance coverage"; and*

*(ii) in paragraph (1), by striking "plan" and inserting "plan or coverage";*

*(C) in subsection (c)—*

*(i) in paragraph (2), by striking "group health insurance coverage offered by a health insurance issuer" and inserting "health insurance issuer offering group or individual health insurance coverage"; and*

*(ii) in paragraph (3), by striking "issuer" and inserting "health insurance issuer"; and*

*(D) in subsection (e), by striking "health insurance issuer offering group health insurance coverage" and inserting "health insurance issuer offering group or individual health insurance coverage";*

*(4) in section 2726 (42 U.S.C. 300gg–5), as so redesignated by section 1001(2)—*

*(A) in subsection (a), by striking "(or health insurance coverage offered in connection with such a plan)" each place that such term appears and inserting "or a health insurance issuer offering group or individual health insurance coverage";*

*(B) in subsection (b), by striking "(or health insurance coverage offered in connection with such a plan)" each place that such term appears and inserting "or a health insurance issuer offering group or individual health insurance coverage"; and*

*(C) in subsection (c)—*

*(i) in paragraph (1), by striking "(and group health insurance coverage offered in*

*connection with a group health plan)" and inserting "and a health insurance issuer offering group or individual health insurance coverage";*

*(ii) in paragraph (2), by striking "(or health insurance coverage offered in connection with such a plan)" each place that such term appears and inserting "or a health insurance issuer offering group or individual health insurance coverage";*

*(5) in section 2727 (42 U.S.C. 300gg–6), as so redesignated by section 1001(2), by striking "health insurance issuers providing health insurance coverage in connection with group health plans" and inserting "and health insurance issuers offering group or individual health insurance coverage";*

*(6) in section 2728 (42 U.S.C. 300gg–7), as so redesignated by section 1001(2)—*

*(A) in subsection (a), by striking "health insurance coverage offered in connection with such plan" and inserting "individual health insurance coverage";*

*(B) in subsection (b)—*

*(i) in paragraph (1), by striking "or a health insurance issuer that provides health*

*insurance coverage in connection with a group health plan'' and inserting ''or a health insurance issuer that offers group or individual health insurance coverage'';*

*(ii) in paragraph (2), by striking ''health insurance coverage offered in connection with the plan'' and inserting ''individual health insurance coverage''; and*

*(iii) in paragraph (3), by striking ''health insurance coverage offered by an issuer in connection with such plan'' and inserting ''individual health insurance coverage'';*

*(C) in subsection (c), by striking ''health insurance issuer providing health insurance coverage in connection with a group health plan'' and inserting ''health insurance issuer that offers group or individual health insurance coverage''; and*

*(D) in subsection (e)(1), by striking ''health insurance coverage offered in connection with such a plan'' and inserting ''individual health insurance coverage'';*

*(7) by striking the heading for subpart 3;*

*(8) in section 2731 (42 U.S.C. 300gg–11), as so redesignated by section 1001(3)—*

*(A) by striking the section heading and all that follows through subsection (b);*

*(B) in subsection (c)—*

*(i) in paragraph (1)—*

*(I) in the matter preceding subparagraph (A), by striking "small group" and inserting "group and individual"; and*

*(II) in subparagraph (B)—*

*(aa) in the matter preceding clause (i), by inserting "and individuals" after "employers";*

*(bb) in clause (i), by inserting "or any additional individuals" after "additional groups"; and*

*(cc) in clause (ii), by striking "without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such" and inserting "and individuals with-*

*out regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals"; and*

*(ii) in paragraph (2), by striking "small group" and inserting "group or individual";*

*(C) in subsection (d)—*

*(i) by striking "small group" each place that such appears and inserting "group or individual"; and*

*(ii) in paragraph (1)(B)—*

*(I) by striking "all employers" and inserting "all employers and individuals";*

*(II) by striking "those employers" and inserting "those individuals, employers"; and*

*(III) by striking "such employees" and inserting "such individuals, employees";*

*(D) by striking subsection (e);*

*(E) by striking subsection (f); and*

*(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));*

*(9) in section 2732 (42 U.S.C. 300gg–12), as so redesignated by section 1001(3)—*

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

*(B) in subsection (b)—*

*(i) in the matter preceding paragraph (1), by striking "group health plan in the small or large group market" and inserting "health insurance coverage offered in the group or individual market";*

*(ii) in paragraph (1), by inserting ", or individual, as applicable," after "plan sponsor";*

*(iii) in paragraph (2), by inserting ", or individual, as applicable," after "plan sponsor"; and*

*(iv) by striking paragraph (3) and inserting the following:*

*"(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer con-*

*tribution or group participation rules, pursuant to applicable State law.";*

*(C) in subsection (c)—*

*(i) in paragraph (1)—*

*(I) in the matter preceding subparagraph (A), by striking "group health insurance coverage offered in the small or large group market" and inserting "group or individual health insurance coverage";*

*(II) in subparagraph (A), by inserting "or individual, as applicable," after "plan sponsor";*

*(III) in subparagraph (B)—*

*(aa) by inserting "or individual, as applicable," after "plan sponsor"; and*

*(bb) by inserting "or individual health insurance coverage"; and*

*(IV) in subparagraph (C), by inserting "or individuals, as applicable," after "those sponsors"; and*

*(ii) in paragraph (2)(A)—*

*(I) in the matter preceding clause (i), by striking "small group market or the large group market, or both markets," and inserting "individual or group market, or all markets,"; and*

*(II) in clause (i), by inserting "or individual, as applicable," after "plan sponsor"; and*

*(D) by transferring such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));*

*(10) in section 2733 (42 U.S.C. 300gg–13), as so redesignated by section 1001(4)—*

*(A) in subsection (a)—*

*(i) in the matter preceding paragraph (1), by striking "small employer" and inserting "small employer or an individual";*

*(ii) in paragraph (1), by inserting ", or individual, as applicable," after "employer" each place that such appears; and*

*(iii) in paragraph (2), by striking "small employer" and inserting "employer, or individual, as applicable,";*

*(B) in subsection (b)—*

*(i) in paragraph (1)—*

*(I) in the matter preceding subparagraph (A), by striking "small employer" and inserting "employer, or individual, as applicable,";*

*(II) in subparagraph (A), by adding "and" at the end;*

*(III) by striking subparagraphs (B) and (C); and*

*(IV) in subparagraph (D)—*

*(aa) by inserting ", or individual, as applicable," after "employer"; and*

*(bb) by redesignating such subparagraph as subparagraph (B);*

*(ii) in paragraph (2)—*

*(I) by striking "small employers" each place that such term appears and inserting "employers, or individuals, as applicable,"; and*

*(II) by striking "small employer" and inserting "employer, or individual, as applicable,"; and*

*(C) by redesignating such section (as amended by this paragraph) as section 2709 and*

*transferring such section to appear after section 2708 (as added by section 1001(5));*

*(11) by redesignating subpart 4 as subpart 2;*

*(12) in section 2735 (42 U.S.C. 300gg–21), as so redesignated by section 1001(4)—*

*(A) by striking subsection (a);*

*(B) by striking "subparts 1 through 3" each place that such appears and inserting "subpart 1";*

*(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and*

*(D) by redesignating such section (as amended by this paragraph) as section 2722;*

*(13) in section 2736 (42 U.S.C. 300gg–22), as so redesignated by section 1001(4)—*

*(A) in subsection (a)—*

*(i) in paragraph (1), by striking "small or large group markets" and inserting "individual or group market"; and*

*(ii) in paragraph (2), by inserting "or individual health insurance coverage" after "group health plans";*

*(B) in subsection (b)(1)(B), by inserting "individual health insurance coverage or" after "respect to"; and*

*(C) by redesignating such section (as amended by this paragraph) as section 2723;*

*(14) in section 2737(a)(1) (42 U.S.C. 300gg–23), as so redesignated by section 1001(4)—*

*(A) by inserting "individual or" before "group health insurance"; and*

*(B) by redesignating such section(as amended by this paragraph) as section 2724;*

*(15) in section 2762 (42 U.S.C. 300gg–62)—*

*(A) in the section heading by inserting "**AND APPLICATION**" before the period; and*

*(B) by adding at the end the following:*

*"(c) APPLICATION OF PART A PROVISIONS.—*

*"(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.*

*"(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual*

*market in a State, the provisions of such part A shall apply."; and*

*(16) in section 2791(e) (42 U.S.C. 300gg–91(e))—*

*(A) in paragraph (2), by striking "51" and inserting "101"; and*

*(B) in paragraph (4)—*

*(i) by striking "at least 2" each place that such appears and inserting "at least 1"; and*

*(ii) by striking "50" and inserting "100".*

*(d) APPLICATION.—Notwithstanding any other provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to—*

*(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or*

*(2) restrict the application of the amendments made by this subtitle.*

*(e) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle A of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et. seq.) is amended, by adding at the end the following:*

***"SEC. 715. ADDITIONAL MARKET REFORMS.***

*"(a) GENERAL RULE.—Except as provided in subsection (b)—*

*"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and*

*"(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.*

*"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with re-*

*spect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.".*

*(f) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:*

***"SEC. 9815. ADDITIONAL MARKET REFORMS.***

*"(a) GENERAL RULE.—Except as provided in subsection (b)—*

*"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and*

*"(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.*

*"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.".*

***SEC. 1563. SENSE OF THE SENATE PROMOTING FISCAL RESPONSIBILITY.***

*(a) FINDINGS.—The Senate makes the following findings:*

*(1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019.*

*(2) CBO projects this Act will continue to reduce budget deficits after 2019.*

*(3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.*

*(4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.*

*(5) The initial net savings generated by the Community Living Assistance Services and Supports*