111TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 111–

AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

JULY , 2009.—Ordered to be printed

Mr. GEORGE MILLER of California, from the Committee on Education and Labor, submitted the following

R E P O R T

together with

_____ VIEWS

[To accompany H.R. 3200]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 3200) to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause (other than sections 161 through 163, 322, and 323 and title IV of division A, division B, section 2002 and titles I through IV of division C, and subtitles A, B, C, and E of title V of division C) and insert the following:

SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES, AND SUBTITLES.

(a) TABLE OF DIVISIONS, TITLES, AND SUBTITLES.—This Act is divided into divisions, titles, and subtitles as follows:

(b) SHORT TITLE.—This Act may be cited as the "America's Affordable Health Choices Act of 2009".

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.

(a) PURPOSE.—

(1) IN GENERAL.—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today's health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;

(C) includes sliding scale affordability credits; and

(D) initiates shared responsibility among workers, employers, and the government;

so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and government.

(b) TABLE OF CONTENTS OF DIVISION.—The table of contents of this division is as follows:

[FOR TITLE IV, SEE TEXT OF INTRODUCED BILL.]

(c) GENERAL DEFINITIONS.—Except as otherwise provided, in this division:

(1) ACCEPTABLE COVERAGE.—The term "acceptable coverage" has the meaning given such term in section 202(d)(2).

(2) BASIC PLAN.—The term "basic plan" has the meaning given such term in section 203(c).

(3) COMMISSIONER.—The term "Commissioner" means the Health Choices Commissioner established under section 141.

(4) COST-SHARING.—The term "cost-sharing" includes deductibles, coinsurance, copayments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.

(5) DEPENDENT.—The term "dependent" has the meaning given such term by the Commissioner and includes a spouse.

(6) EMPLOYMENT-BASED HEALTH PLAN.—The term "employment-based health plan"—

(A) means a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974);

(B) includes such a plan that is the following:

(i) FEDERAL, STATE, AND TRIBAL GOVERNMENTAL PLANS.—A governmental plan (as defined in section 3(32) of the Employee Retirement Income Security Act of 1974), including a health benefits plan offered under chapter 89 of title 5, United States Code; or

(ii) CHURCH PLANS.—A church plan (as defined in section 3(33) of the Employee Retirement Income Security Act of 1974); and

(C) excludes coverage described in section 202(d)(2)(E) (relating to TRICARE).

(7) ENHANCED PLAN.—The term "enhanced plan" has the meaning given such term in section 203(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term "essential benefits package" is defined in section 122(a).

(9) FAMILY.—The term "family" means an individual and includes the individual's dependents.

(10) FEDERAL POVERTY LEVEL; FPL.—The terms "Federal poverty level" and "FPL" have the meaning given the term "poverty line" in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(11) HEALTH BENEFITS PLAN.—The terms "health benefits plan" means health insurance coverage and an employment-based health plan and includes the public health insurance option.

(12) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms in section 2791 of the Public Health Service Act.

(13) HEALTH INSURANCE EXCHANGE.—The term "Health Insurance Exchange" means the Health Insurance Exchange established under section 201.

(14) MEDICAID.—The term "Medicaid" means a State plan under title XIX of the Social Security Act (whether or not the plan is operating under a waiver under section 1115 of such Act).

(15) MEDICARE.—The term "Medicare" means the health insurance programs under title XVIII of the Social Security Act.

(16) PLAN SPONSOR.—The term "plan sponsor" has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(17) PLAN YEAR.—The term "plan year" means—

(A) with respect to an employment-based health plan, a plan year as specified under such plan; or

(B) with respect to a health benefits plan other than an employment-based health plan, a 12-month period as specified by the Commissioner.

(18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms "premium plan" and "premium-plus plan" have the meanings given such terms in section 203(c).

(19) QHBP OFFERING ENTITY.—The terms "QHBP offering entity" means, with respect to a health benefits plan that is—

(A) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, except that, in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such term means such employer;

(B) health insurance coverage, the health insurance issuer offering the coverage;

(C) the public health insurance option, the Secretary of Health and Human Services;

(D) a non-Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the State or political subdivision of a State (or agency or instrumentality of such State or subdivision) which establishes or maintains such plan; or

(E) a Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the appropriate Federal official.

(20) QUALIFIED HEALTH BENEFITS PLAN.—The term "qualified health benefits plan" means a health benefits plan that meets the requirements for such a plan under title I and includes the public health insurance option.

(21) PUBLIC HEALTH INSURANCE OPTION.—The term "public health insurance option" means the public health insurance option as provided under subtitle B of title II.

(22) SERVICE AREA; PREMIUM RATING AREA.—The terms "service area" and "premium rating area" mean with respect to health insurance coverage—

(A) offered other than through the Health Insurance Exchange, such an area as established by the QHBP offering entity of such coverage in accordance with applicable State law; and

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

(23) STATE.—The term "State" means the 50 States and the District of Columbia.

(24) STATE MEDICAID AGENCY.—The term "State Medicaid agency" means, with respect to a Medicaid plan, the single State agency responsible for administering such plan under title XIX of the Social Security Act.

(25) Y1, Y2, ETC..—The terms "Y1" , "Y2", "Y3", "Y4", "Y5", and similar subsequently numbered terms, mean 2013 and subsequent years, respectively.

(26) EMPLOYEE PREMIUM.—The term "employee premium" does not include a collectively bargained premium in the case of a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974) that is a multiemployer plan (as defined in section 3(37) of such Act).

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle A—General Standards

SEC. 101. REQUIREMENTS REFORMING HEALTH INSURANCE MARKETPLACE.

(a) PURPOSE.—The purpose of this title is to establish standards to ensure that new health insurance coverage and employment-based health plans that are offered meet standards guaranteeing access to affordable coverage, essential benefits, and other consumer protections.

(b) REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS.—On or after the first day of Y1, a health benefits plan shall not be a qualified health benefits plan under this division unless the plan meets the applicable requirements of the following subtitles for the type of plan and plan year involved:

(1) Subtitle B (relating to affordable coverage).

(2) Subtitle C (relating to essential benefits).

(3) Subtitle D (relating to consumer protection).

(c) TERMINOLOGY.—In this division:

(1) ENROLLMENT IN EMPLOYMENT-BASED HEALTH PLANS.—An individual shall be treated as being "enrolled" in an employment-based health plan if the individual is a participant or beneficiary (as such terms are defined in section 3(7) and 3(8), respectively, of the Employee Retirement Income Security Act of 1974) in such plan.

(2) INDIVIDUAL AND GROUP HEALTH INSURANCE COVERAGE.—The terms "individual health insurance coverage" and "group health insurance coverage" mean health insurance coverage offered in the individual market or large or small group market, respectively, as defined in section 2791 of the Public Health Service Act.

(d) SENSE OF CONGRESS ON HEALTH CARE NEEDS OF UNITED STATES TERRITORIES.—It is the sense of the Congress that the reforms made by H.R. 3200, as introduced, must be strengthened to meaningfully address the health care needs of residents of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands and Congress is committed to working with the representatives of these territories to ensure that residents of these territories have access to high-quality and affordable health care in such a way that best serves their unique needs.

SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) GRANDFATHERED HEALTH INSURANCE COVERAGE DEFINED.—Subject to the succeeding provisions of this section, for purposes of establishing acceptable coverage under this division, the term "grandfathered health insurance coverage" means individual health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT.—

(A) IN GENERAL.—Except as provided in this paragraph, the individual health insurance issuer offering such coverage does not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y1.

(B) DEPENDENT COVERAGE PERMITTED.—Subparagraph (A) shall not affect the subsequent enrollment of a dependent of an individual who is covered as of such first day.

(2) LIMITATION ON CHANGES IN TERMS OR CONDITIONS.—Subject to paragraph (3) and except as required by law, the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1.

(3) RESTRICTIONS ON PREMIUM INCREASES.—The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

(b) GRACE PERIOD FOR CURRENT EMPLOYMENT-BASED HEALTH PLANS.—

(1) GRACE PERIOD.—

(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in operation as of the day before the first day of Y1 must meet the same requirements as apply to a qualified health benefits plan under section 101, including the essential benefit package requirement under section 121.

(B) EXCEPTION FOR LIMITED BENEFITS PLANS.—Subparagraph (A) shall not apply to an employment-based health plan in which the coverage consists only of one or more of the following:

(i) Any coverage described in section 3001(a)(1)(B)(ii)(IV) of division B of the American Recovery and Reinvestment Act of 2009 (PL 111–5).

(ii) Excepted benefits (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974), including coverage under a specified disease or illness policy described in paragraph (3)(A) of such section.

(iii) Such other limited benefits as the Commissioner may specify.

In no case shall an employment-based health plan in which the coverage consists only of one or more of the coverage or benefits described in clauses (i) through (iii) be treated as acceptable coverage under this division

(2) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE.—During the grace period specified in paragraph (1)(A), an employment-based health plan that is described in such paragraph shall be treated as acceptable coverage under this division.

(3) EXCEPTION FOR CONSUMER-DIRECTED HEALTH PLANS AND ARRANGEMENTS.—In the case of a group health plan which consists of a consumer-directed health plan or arrangement (including a high deductible health plan, within the meaning of section 223(c)(2) of the Internal Revenue Code of 1986), such group health plan shall be treated as acceptable coverage under a current group health plan for purposes of this division.

(c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may only be offered on or after the first day of Y1 as an Exchange-participating health benefits plan.

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Excepted benefits (as defined in section 2791(c) of the Public Health Service Act) are not included within the definition of health insurance coverage. Nothing in paragraph (1) shall prevent the offering, other than through the Health Insurance Exchange, of excepted benefits so long as it is offered and priced separately from health insurance coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.

A qualified health benefits plan may not impose any pre-existing condition exclusion (as defined in section 2701(b)(1)(A) of the Public Health Service Act) or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any health status-related factors (as defined in section 2791(d)(9) of the Public Health Service Act) in relation to the individual or dependent.

SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS.

The requirements of sections 2711 (other than subsections (c) and (e)) and 2712 (other than paragraphs (3), and (6) of subsection (b) and subsection (e)) of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such section 2712(b)(1) shall apply only if, before nonrenewal or discontinuation of coverage, the issuer has provided the enrollee with notice of non-payment of premiums and there is a grace period during which the enrollees has an opportunity to correct such nonpayment. Rescissions of such coverage shall be prohibited except in cases of fraud as defined in sections 2712(b)(2) of such Act.

SEC. 113. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for an insured qualified health benefits plan may not vary except as follows:

(1) LIMITED AGE VARIATION PERMITTED.—By age (within such age categories as the Commissioner shall specify) so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1.

(2) BY AREA.—By premium rating area (as permitted by State insurance regulators or, in the case of Exchange-participating health benefits plans, as specified by the Commissioner in consultation with such regulators).

(3) BY FAMILY ENROLLMENT.—By family enrollment (such as variations within categories and compositions of families) so long as the ratio of the premium for family enrollment (or enrollments) to the premium for individual enrollment is uniform, as specified under State law and consistent with rules of the Commissioner.

(b) STUDY AND REPORTS.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large group insured and self-insured employer health care markets. Such study shall examine the following:

(A) The types of employers by key characteristics, including size, that purchase insured products versus those that self-insure.

(B) The similarities and differences between typical insured and self-insured health plans.

(C) The financial solvency and capital reserve levels of employers that self-insure by employer size.

(D) The risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent.

(E) The extent to which rating rules are likely to cause adverse selection in the large group market or to encourage small and mid size employers to self-insure

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations the Commissioner deems appropriate to ensure that

the law does not provide incentives for small and mid-size employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. Not later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations.

SEC. 114. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

(a) NONDISCRIMINATION IN BENEFITS.—A qualified health benefits plan shall comply with standards established by the Commissioner to prohibit discrimination in health benefits or benefit structures for qualified health benefits plans, building from sections 702 of Employee Retirement Income Security Act of 1974, 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.

(b) PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.—To the extent such provisions are not superceded by or inconsistent with subtitle C, the provisions of section 2705 (other than subsections (a)(1), (a)(2), and (c)) of section 2705 of the Public Health Service Act shall apply to a qualified health benefits plan, regardless of whether it is offered in the individual or group market, in the same manner as such provisions apply to health insurance coverage offered in the large group market.

SEC. 115. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) IN GENERAL.—A qualified health benefits plan that uses a provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such networks in ensuring enrollee access to such items and services and transparency in the cost-sharing differentials between in-network coverage and out-of-network coverage.

(b) INTERNET ACCESS TO INFORMATION.—A qualified health benefits plan that uses a provider network shall provide a current listing of all providers in its network on its website and such data shall be available on the Health Insurance Exchange website as a 'click through' from the basic information on that plan. The Commissioner shall also establish an on-line system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) PROVIDER NETWORK DEFINED.—In this division, the term "provider network" means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 116. ENSURING VALUE AND LOWER PREMIUMS.

The QHBP offering entity shall provide that for any plan year in which a qualified health benefits plan that the entity offers has a medical loss ratio (expressed as a percentage) that is less than a percentage (not less than 85 percent) specified by the Commissioner, the QHBP offering entity offering such plan shall provide for rebates to enrollees of payment sufficient to meet such loss ratio. The Commissioner shall establish a uniform definition of medical loss ratio and methodology for determining how to calculate the medical loss ratio. Such methodology shall be designed to take into account the special circumstances of smaller and newer plans.

SEC. 117. CONSISTENCY OF COSTS AND COVERAGE UNDER QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

In the case of health insurance coverage offered under a qualified health benefits plan, the coverage and cost of coverage may not be changed during the course of a plan year except to increase coverage to the enrollee or to lower costs to the enrollee.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

(a) IN GENERAL.—A qualified health benefits plan shall provide coverage that at least meets the benefit standards adopted under section 124 for the essential benefits package described in section 122 for the plan year involved.

(b) CHOICE OF COVERAGE.—

(1) NON-EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of a qualified health benefits plan that is not an Exchange-participating health benefits plan, such plan may offer such coverage in addition to the essential benefits package as the QHBP offering entity may specify.

(2) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of an Exchange-participating health benefits plan, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium-plus level of benefits, provide additional benefits.

(3) CONTINUATION OF OFFERING OF SEPARATE EXCEPTED BENEFITS COVERAGE.—Nothing in this division shall be construed as affecting the offering of health benefits in the form of excepted benefits (described in section 102(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

(c) NO RESTRICTIONS ON COVERAGE UNRELATED TO CLINICAL APPROPRIATENESS.—A qualified health benefits plan may not impose any restriction (other than cost-sharing) unrelated to clinical appropriateness on the coverage of the health care items and services.

SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term "essential benefits package" means health benefits coverage, consistent with standards adopted under section 124 to ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;

(4) complies with section 115(a) (relating to network adequacy); and

(5) is equivalent, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage.

(b) MINIMUM SERVICES TO BE COVERED.—The items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and including mental health and substance abuse services recommended by the Task Force on Clinical Preventive Services and those mental health and substance abuse services with compelling research or evidence, including Screening, Brief Intervention and Referral to Treatment (SBIRT), and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well baby and well child care and early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act) at least for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for preventive items and services (as specified under the benefit standards), including well baby and well child care.

(2) ANNUAL LIMITATION.—

(A) ANNUAL LIMITATION.—The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).

(B) APPLICABLE LEVEL.—The applicable level specified in this subparagraph for Y1 is $5,000 for an individual and $10,000 for a family. Such levels shall be increased (rounded to the nearest $100) for each subsequent

year by the annual percentage increase in the Consumer Price Index (United States city average) applicable to such year.

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

(2) CHAIR.—The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee.

(3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) 9 members who are not Federal employees or officers and who are appointed by the President.

(B) 9 members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint.

The membership of the Committee shall include one or more experts in scientific evidence and clinical practice of integrative health care services. Such initial appointments shall be made not later than 60 days after the date of the enactment of this Act.

(4) TERMS.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term on the Committee, except that the terms of the initial members shall be adjusted in order to provide for a staggered term of appointment for all such members.

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, employers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in care for those with disabilities, representatives of relevant governmental agencies. and at least one practicing physician or other health professional and an expert on children's health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee. The membership of the Committee shall also include educated patients, consumer advocates, or both, who shall include persons who represent individuals affected by a specific disease or medical condition, are knowledgeable about the health care system, and have received training regarding health, medical, and scientific matters.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") benefit standards (as defined in paragraph (4)), and periodic updates to such standards. In developing such recommendations, the Committee shall—

(A) take into account innovation in health care,

(B) consider how such standards could reduce health disparities,

(C) take into account integrative health care services, and

(D) take into account typical multiemployer plan benefit structures and the impact of the essential benefit package on such plans.

(2) DEADLINE.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(3) STATE INPUT.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act. The Health Benefits Advisory Committee shall also seek input from the States and consider recommendations on how to ensure that the quality of health coverage does not decline in any State.

(4) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this subsection.

(5) BENEFIT STANDARDS DEFINED.—In this subtitle, the term "benefit standards" means standards respecting—

(A) the essential benefits package described in section 122, including categories of covered treatments, items and services within benefit classes, and cost-sharing; and

(B) the cost-sharing levels for enhanced plans and premium plans (as provided under section 203(c)) consistent with paragraph (5).

(6) LEVELS OF COST-SHARING FOR ENHANCED AND PREMIUM PLANS.—

(A) ENHANCED PLAN.—The level of cost-sharing for enhanced plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 85 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(B) PREMIUM PLAN.—The level of cost-sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 122(c)(3)(B).

(7) RECOMMENDATIONS OF INTEGRATIVE HEALTH CARE SERVICES TASK FORCE.—

(A) INCLUSION IN COMMITTEE'S RECOMMENDATIONS.—The Health Benefits Advisory Committee shall include in its recommendations under paragraph (1) the recommendations made by the Integrative Health Care Services Task Force established under subparagraph (B).

(B) ESTABLISHMENT OF TASK FORCE.—The Health Benefits Advisory Committee shall establish an Integrative Health Care Services Task Force. Such Task Force shall consist of 5 experts with expertise in research in, and practice of, integrative health care. Such experts shall be appointed by the Committee from among experts nominated by the Secretary, in consultation with the National Center for Complementary and Alternative Medicine at the National Institutes of Health. The duty of the Task Force shall be to make recommendations to the Committee on evidence-based, clinically effective, and safe integrative care services.

(c) OPERATIONS.—

(1) PER DIEM PAY.—Each member of the Health Benefits Advisory Committee shall receive travel expenses, including per diem in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code, and shall otherwise serve without additional pay.

(2) MEMBERS NOT TREATED AS FEDERAL EMPLOYEES.—Members of the Health Benefits Advisory Committee shall not be considered employees of the Federal government solely by reason of any service on the Committee.

(3) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the Health Benefits Advisory Committee.

(d) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDATIONS; ADOPTION OF BENEFIT STANDARDS.

(a) PROCESS FOR ADOPTION OF RECOMMENDATIONS.—

(1) REVIEW OF RECOMMENDED STANDARDS.—Not later than 45 days after the date of receipt of benefit standards recommended under section 123 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

(2) DETERMINATION TO ADOPT STANDARDS.—If the Secretary determines—

(A) to propose adoption of benefit standards so recommended as a package, the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption such standards; or

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) CONTINGENCY.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of initial benefit standards by such deadline.

(4) PUBLICATION.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under this subsection.

(b) ADOPTION OF STANDARDS.—

(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall, through the rulemaking process consistent with subsection (a), adopt an initial set of benefit standards.

(2) PERIODIC UPDATING STANDARDS.—Under subsection (a), the Secretary shall provide for the periodic updating of the benefit standards previously adopted under this section.

(3) REQUIREMENT.—The Secretary may not adopt any benefit standards for an essential benefits package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 122 and 123(b)(5).

SEC. 125 PROHIBITION OF DISCRIMINATION IN HEALTH CARE SERVICES BASED ON RELIGIOUS OR SPIRITUAL CONTENT.

Neither the Commissioner nor any health insurance issuer offering health insurance coverage through the Exchange shall discriminate in approving or covering a health care service on the basis of its religious or spiritual content if expenditures for such a health care service are allowable as a deduction under 213(d) of the Internal Revenue Code of 1986, as in effect on January 1, 2009.

Subtitle D—Additional Consumer Protections

SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY HEALTH INSURERS.

The Commissioner shall establish uniform marketing standards that all insured QHBP offering entities shall meet.

SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.

(a) IN GENERAL.—A QHBP offering entity shall provide for timely grievance and appeals mechanisms that the Commissioner shall establish.

(b) INTERNAL CLAIMS AND APPEALS PROCESS.—Under a qualified health benefits plan the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update such process in accordance with any standards that the Commissioner may establish.

(c) EXTERNAL REVIEW PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent, and de novo review of denied claims under this division.

(2) REQUIRING FAIR GRIEVANCE AND APPEALS MECHANISMS.—A determination made, with respect to a qualified health benefits plan offered by a QHBP offering entity, under the external review process established under this subsection shall be binding on the plan and the entity.

(d) CONSTRUCTION.—Nothing in this section shall be construed as affecting the availability of judicial review under State law for adverse decisions under subsection (b) or (c), subject to section 151.

SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND PLAN DISCLOSURE.

(a) ACCURATE AND TIMELY DISCLOSURE.—

(1) IN GENERAL.—A qualified health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure of

plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner. The Commissioner shall require that such disclosure be provided in plain language.

(2) PLAIN LANGUAGE.—In this subsection, the term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clean, concise, well-organized, and follows other best practices of plain language writing.

(3) GUIDANCE.—The Commissioner shall develop and issue guidance on best practices of plain language writing.

(b) CONTRACTING REIMBURSEMENT.—A qualified health benefits plan shall comply with standards established by the Commissioner to ensure transparency to each health care provider relating to reimbursement arrangements between such plan and such provider.

(c) ADVANCE NOTICE OF PLAN CHANGES.—A change in a qualified health benefits plan shall not be made without such reasonable and timely advance notice to enrollees of such change.

(d) IDENTIFICATION OF PROVIDERS TRAINED AND ACCREDITED IN INTEGRATIVE MEDICINE.—A qualified health benefit plan shall include in the disclosure required under subsection (a) identification to enrollees of any providers of services under the plan that are trained and accredited in integrative health medicine.

SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS PLANS NOT OFFERED THROUGH THE HEALTH INSURANCE EXCHANGE.

The requirements of the previous provisions of this subtitle shall apply to qualified health benefits plans that are not being offered through the Health Insurance Exchange only to the extent specified by the Commissioner.

SEC. 135. TIMELY PAYMENT OF CLAIMS.

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to a qualified health benefits plan it offers in the same manner an Medicare Advantage organization is required to comply with such requirements with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 136. STANDARDIZED RULES FOR COORDINATION AND SUBROGATION OF BENEFITS.

The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.

SEC. 137. APPLICATION OF ADMINISTRATIVE SIMPLIFICATION.

A QHBP offering entity is required to comply with standards for electronic financial and administrative transactions under section 1173A of the Social Security Act, added by section 163(a).

SEC. 138. RECORDS RELATIVE TO PRESCRIPTION INFORMATION.

(a) IN GENERAL.—A qualified health benefits plan shall ensure that its records relative to prescription information containing patient identifiable and prescriber-identifiable data are maintained in accordance with this section."

(b) REQUIREMENTS.—

(1) IN GENERAL.—Records described in subsection (a) may not be licensed, transferred, used, or sold by any pharmacy benefits manager, insurance company, electronic transmission intermediary, retail, mail order, or Internet pharmacy or other similar entity, for any commercial purpose, except for the limited purposes of—

(A) pharmacy reimbursement;

(B) formulary compliance;

(C) care management;

(D) utilization review by a health care provider, the patient's insurance provider or the agent of either;

(E) health care research; or

(F) as otherwise provided by law.

(2) COMMERCIAL PURPOSE.—For purposes of paragraph (1), the term "commercial purpose" includes, but is not limited to, advertising, marketing, promotion, or any activity that could be used to influence sales or market share of a pharmaceutical product, influence or evaluate the prescribing behavior of an individual health care professional, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(c) CONSTRUCTION.—

(1) PERMITTED PRACTICES.—Nothing in this section shall prohibit—

(A) the dispensing of prescription medications to a patient or to the patient's authorized representative;

(B) the transmission of prescription information between an authorized prescriber and a licensed pharmacy;

(C) the transfer of prescription information between licensed pharmacies;

(D) the transfer of prescription records that may occur in the event a pharmacy ownership is changed or transferred;

(E) care management educational communications provided to a patient about the patient's health condition, adherence to a prescribed course of therapy, or other information about the drug being dispensed, treatment options, or clinical trials.

(2) DE-IDENTIFIED DATA.—Nothing in this section shall prohibit the collection, use, transfer, or sale of patient and prescriber de-identified data by zip code, geographic region, or medical specialty for commercial purposes.

Subtitle E—Governance

SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH CHOICES COMMISSIONER.

(a) IN GENERAL.—There is hereby established, as an independent agency in the executive branch of the Government, a Health Choices Administration (in this division referred to as the "Administration").

(b) COMMISSIONER.—

(1) IN GENERAL.—The Administration shall be headed by a Health Choices Commissioner (in this division referred to as the "Commissioner") who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) COMPENSATION; ETC.—The provisions of paragraphs (2), (5) and (7) of subsection (a) (relating to compensation, terms, general powers, rulemaking, and delegation) of section 702 of the Social Security Act (42 U.S.C. 902) shall apply to the Commissioner and the Administration in the same manner as such provisions apply to the Commissioner of Social Security and the Social Security Administration.

SEC. 142. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) DUTIES.—The Commissioner is responsible for carrying out the following functions under this division:

(1) QUALIFIED PLAN STANDARDS.—The establishment of qualified health benefits plan standards under this title, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH INSURANCE EXCHANGE.—The establishment and operation of a Health Insurance Exchange under subtitle A of title II.

(3) INDIVIDUAL AFFORDABILITY CREDITS.—The administration of individual affordability credits under subtitle C of title II, including determination of eligibility for such credits.

(4) ADDITIONAL FUNCTIONS.—Such additional functions as may be specified in this division.

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(A) IN GENERAL.—The commissioner shall, in coordination with States, conduct audits of qualified health benefits plan compliance with Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected non-compliance.

(B) RECOUPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner is authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities.

(c) DATA COLLECTION.—The Commissioner shall collect data for purposes of carrying out the Commissioner's duties, including for purposes of promoting quality

and value, protecting consumers, and addressing disparities in health and health care and may share such data with the Secretary of Health and Human Services.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—In the case that the Commissioner determines that a QHBP offering entity violates a requirement of this title, the Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph, with respect to a qualified health benefits plan offered by a QHBP offering entity, are—

(A) civil money penalties of not more than the amount that would be applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act;

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the entity under the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the requirements of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 208 and 241(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management pursuant to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 4728).

SEC. 143. CONSULTATION AND COORDINATION.

(a) CONSULTATION.—In carrying out the Commissioner's duties under this division, the Commissioner, as appropriate, shall consult with at least with the following:

(1) The National Association of Insurance Commissioners, State attorneys general, and State insurance regulators, including concerning the standards for insured qualified health benefits plans under this title and enforcement of such standards.

(2) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of title II and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(3) Other appropriate Federal agencies.

(4) Indian tribes and tribal organizations.

(5) The National Association of Insurance Commissioners for purposes of using model guidelines established by such association for purposes of subtitles B and D.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner, in coordination with such entities, shall seek to achieve uniform standards that adequately protect consumers in a manner that does not unreasonably affect employers and insurers.

SEC. 144. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Qualified Health Benefits Plan Ombudsman who shall have exper-

tise and experience in the fields of health care and education of (and assistance to) individuals.

(b) DUTIES.—The Qualified Health Benefits Plan Ombudsman shall, in a linguistically appropriate manner—

(1) receive complaints, grievances, and requests for information submitted by individuals;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant information needed to seek an appeal of a decision or determination;

(B) assistance to such individuals with any problems arising from disenrollment from such a plan;

(C) assistance to such individuals in choosing a qualified health benefits plan in which to enroll; and

(D) assistance to such individuals in presenting information under subtitle C (relating to affordability credits);

(3) consult with educated patients and consumer advocates (described in section 123(a)(5)); and

(4) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 151. RELATION TO OTHER REQUIREMENTS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan), and in the case of employment-based health plans, the requirements of this title do not supercede any requirements applicable under titles XXII and XXVII of the Public Health Service Act, parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

(b) COVERAGE OFFERED THROUGH EXCHANGE.—

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange—

(A) the requirements of this title do not supercede any requirements (including requirements relating to genetic information nondiscrimination and mental health) applicable under title XXVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

(B) individual rights and remedies under State laws shall apply.

(2) CONSTRUCTION.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws with respect to any requirement referred to in paragraph (1)(A).

SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsequent regulations consistent with this Act, all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services.

(b) IMPLEMENTATION.—To implement the requirement set forth in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including

insurance coverage and public health activities) covered by this Act are provided (whether directly or through contractual, licensing, or other arrangements) without regard to personal characteristics extraneous to the provision of high quality health care or related services.

SEC. 153. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee (or any person acting pursuant to a request of the employee)—

(1) 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 Act or any order, rule, or regulation promulgated under this Act;

(2) testified or is about to testify in a proceeding concerning such violation;

(3) assisted or participated or is about to assist or participate in such a proceeding; or

(4) 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 Act or any order, rule, or regulation promulgated under this Act.

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of subsection (a) may bring an action governed by the rules, procedures, legal burdens of proof, and remedies set forth in section 40(b) of the Consumer Product Safety Act (15 U.S.C. 2087(b)).

(c) EMPLOYER DEFINED.—As used in this section, the term "employer" means any person (including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees) engaged in profit or nonprofit business or industry whose activities are governed by this Act, and any agent, contractor, subcontractor, grantee, or consultant of such person.

(d) RULE OF CONSTRUCTION.—The rule of construction set forth in section 20109(h) of title 49, United States Code, shall also apply to this section.

SEC. 154. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

Nothing in this division shall be construed to alter or supercede any statutory or other obligation to engage in collective bargaining over the terms and conditions of employment related to health care.

SEC. 155. SEVERABILITY.

If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, the remainder of the provisions of this Act and the application of the provision to any other person or circumstance shall not be affected.

SEC. 156. RULE OF CONSTRUCTION REGARDING HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii 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)), and such exemption shall also apply with respect to the provisions of this division, and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate officials of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 157. INCREASING MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS.

(a) STUDY.—The Commissioner shall conduct a study on methods that QHBP offering entities can use to encourage increased meaningful use of electronic health records by health care providers, including—

(1) qualified health benefits plans offering higher reimbursement rates for such meaningful use; and

(2) promoting the use by health care providers of low-cost available electronic health record software packages, such as software made available to health care providers by the Veterans Administration.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commissioner shall submit to the Congress a report containing—

(1) the results of the study under subsection (a); and

(2) recommendations concerning whether qualified health benefits plans should increase reimbursement rates to health care providers to increase meaningful use of electronic health records by such providers.

(c) REQUIREMENTS.—

(1) IN GENERAL.—Not later than one year after the date the report is submitted to the Congress under subsection (b), if, under subsection (b)(2), the Commissioner recommends increased reimbursement rates, the Commissioner shall require that qualified health benefits plans increase reimbursement rates for health care providers that show meaningful use of electronic health records.

(2) COST LIMITATION.—An increase in rates under paragraph (1) shall not result in any increase in affordability premium or cost-sharing credits under subtitle C of title II of this division.

SEC. 158. PRIVATE RIGHT OF CONTRACT WITH HEALTH CARE PROVIDERS.

Nothing in this Act shall be construed to preclude any participant or beneficiary in a group health plan from entering into any contract or arrangement for health care with any health care provider.

Subtitle G—Early Investments

SEC. 161-163. [*For sections 161 through 163, see the text of H.R.3200, as introduced.***]**

SEC. 164. REINSURANCE PROGRAM FOR RETIREES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a temporary reinsurance program (in this section referred to as the "reinsurance program") to provide reimbursement to assist participating employment-based plans with the cost of providing health benefits to retirees and to eligible spouses, surviving spouses and dependents of such retirees.

(2) DEFINITIONS.—For purposes of this section:

(A) The term "eligible employment-based plan" means a group health benefits plan that—

(i) is maintained by one or more employers, former employers or employee associations, or a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan, and

(ii) provides health benefits to retirees.

(B) 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.

(C) The term "participating employment-based plan" means an eligible employment-based plan that is participating in the reinsurance program.

(D) The term "retiree" means, with respect to a participating employment-benefit plan, an individual who—

(i) is 55 years of age or older;

(ii) is not eligible for coverage under title XVIII of the Social Security Act; and

(iii) is not an active employee of an employer maintaining the plan or of any employer that makes or has made substantial contributions to fund such plan.

(E) The term "Secretary" means Secretary of Health and Human Services.

(b) PARTICIPATION.—To be eligible to participate in the reinsurance program, an eligible employment-based plan shall submit 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.

(c) PAYMENT.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—Under the reinsurance program, 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.—Each claim 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 appropriate employment based health benefits provided to a retiree or to the spouse, surviving spouse, or dependent of a retiree. In determining the amount of any 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 benefits. For purposes of calculating the amount of any claim, the costs paid by the retiree or by the spouse, surviving spouse, or dependent of the retiree in the form of deductibles, co-payments, and co-insurance shall be included along with the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS AND LIMIT.—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 exceeds $15,000, but is less than $90,000. Such amounts shall be adjusted each year based on the percentage increase in the medical care component of the Consumer Price Index (rounded to the nearest multiple of $1,000) for the year involved.

(3) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower the costs borne directly by the participants and beneficiaries for health benefits provided under such plan in the form of premiums, co-payments, deductibles, co-insurance, or other out-of-pocket costs. Such payments shall not be used to reduce the costs of an employer maintaining the participating employment-based plan. The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such plans.

(4) APPEALS AND PROGRAM PROTECTIONS.—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.

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

(d) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the "Retiree Reserve Trust Fund" (referred to in this section as the "Trust Fund"), that shall consist of such amounts as may be appropriated or credited to the Trust Fund as provided for in this subsection to enable the Secretary to carry out the reinsurance program. Such amounts shall remain available until expended.

(B) FUNDING.—There are hereby appropriated to the Trust Fund, out of any moneys in the Treasury not otherwise appropriated, an amount requested by the Secretary as necessary to carry out this section, except that the total of all such amounts requested shall not exceed $10,000,000,000.

(C) APPROPRIATIONS FROM THE TRUST FUND.—

(i) IN GENERAL.—Amounts in the Trust Fund are appropriated to provide funding to carry out the reinsurance program and shall be used to carry out such program.

(ii) BUDGETARY IMPLICATIONS.—Amounts appropriated under clause (i), and outlays flowing from such appropriations, shall not be taken into account for purposes of any budget enforcement procedures including allocations under section 302(a) and (b) of the Balanced Budget and

Emergency Deficit Control Act and budget resolutions for fiscal years during which appropriations are made from the Trust Fund.

(iii) LIMITATION TO AVAILABLE FUNDS.—The Secretary has the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under the reinsurance program in order to ensure that expenditures under the reinsurance program do not exceed the funds available under this subsection.

SEC. 165. PROHIBITION AGAINST POST-RETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 714 the following new section:

"SEC. 715. PROTECTION AGAINST POST-RETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

"(a) IN GENERAL.—Every group health plan shall contain a provision which expressly bars the plan, or any fiduciary of the plan, from reducing the benefits provided under the plan to a retired participant, or beneficiary of such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement unless such reduction is also made with respect to active participants.

"(b) NO REDUCTION.—Notwithstanding that a group health plan described in subsection (a) may contain a provision reserving the general power to amend or terminate the plan or a provision specifically authorizing the plan to make post-retirement reductions in retiree health benefits, it shall be prohibited for any group health plan, whether through amendment or otherwise, to reduce the benefits provided to a retired participant or his or her beneficiary under the terms of the plan if such reduction of benefits occurs after the date the participant retired for purposes of the plan and reduces benefits that were provided to the participant, or his or her beneficiary, as of the date the participant retired unless such reduction is also made with respect to active participants.".

(b) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 714 the following new item:

"Sec. 715. Protection against post-retirement reduction of retiree health benefits.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 166. LIMITATIONS ON PREEXISTING CONDITION EXCLUSIONS IN GROUP HEALTH PLANS IN ADVANCE OF APPLICABILITY OF NEW PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

(a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking "6-month period" and inserting "30-day period".

(2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 701(a)(2) of such Act (29 U.S.C. 1181(a)(2)) is amended by striking "12 months" and inserting "3 months", and by striking "18 months" and inserting "9 months".

(3) INAPPLICABILITY OF INTERIM LIMITATIONS UPON APPLICABILITY OF TOTAL PROHIBITION OF EXCLUSION.—Section 701 of such Act shall cease to be effective in the case of any group health plan as of the date on which such plan becomes subject to the requirements of section 111 of this Act (relating to prohibiting preexisting condition exclusions).

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by paragraphs (1) and (2) of subsection (a) shall apply with respect to group health plans for plan years beginning after the end of the 6th calendar month following the date of the enactment of this Act.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by paragraphs (1) and (2) of subsection (a) shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) 3 years after the date of the enactment of this Act.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by the amendments made by paragraphs (1) and (2) of subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SEC. 167. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) IN GENERAL.—In the case of any individual who is, under a COBRA continuation coverage provision, covered under COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated under the terms of such provision for any reason other than the expiration of a period of a specified number of months shall, notwithstanding such provision and subject to subsection (b), extend to the earlier of the date on which such individual becomes eligible for coverage under an employment-based health plan or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

(2) NOTICE.—As soon as practicable after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide or administer the COBRA continuation coverage involved, provide rules setting forth the form and manner in which prompt notice to individuals of the continued availability of COBRA continuation coverage to such individuals under paragraph (1).

(b) CONTINUED EFFECT OF OTHER TERMINATING EVENTS.—Notwithstanding subsection (a), any required period of COBRA continuation coverage which is extended under such subsection shall terminate upon the occurrence, prior to the date of termination otherwise provided in such subsection, of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of a specified number of months.

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provision of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section solely by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired.

(d) DEFINITIONS.—For purposes of this section—

(1) COBRA CONTINUATION COVERAGE.—The term "COBRA continuation coverage" means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 905a of title 5, United States Code, or under a State program that provides comparable continuation coverage. Such term does not include coverage under a health flexible spending arrangement under a cafeteria plan within the meaning of section 125 of the Internal Revenue Code of 1986.

(2) COBRA CONTINUATION PROVISION.—The term "COBRA continuation provision" means the provisions of law described in paragraph (1).

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE; OUTLINE OF DUTIES; DEFINITIONS.

(a) ESTABLISHMENT.—There is established within the Health Choices Administration and under the direction of the Commissioner a Health Insurance Exchange in order to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 143(b), the Commissioner shall—

(1) under section 204 establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under section 203, and including with respect to oversight and enforcement;

(2) under section 205 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 202; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishment of a risk pooling mechanism under section 206 and consumer protections under subtitle D of title I.

(c) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN DEFINED.—In this division, the term "Exchange-participating health benefits plan" means a qualified health benefits plan that is offered through the Health Insurance Exchange.

SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS.

(a) ACCESS TO COVERAGE.—In accordance with this section, all individuals are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Health Insurance Exchange unless such individuals are enrolled in another qualified health benefits plan or other acceptable coverage.

(b) DEFINITIONS.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term "Exchange-eligible individual" means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term "Exchange-eligible employer" means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms "employer", "employee", "full-time employee", and "part-time employee" have the meanings given such terms by the Commissioner for purposes of this division.

(c) TRANSITION.—Individuals and employers shall only be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following transition schedule:

(1) FIRST YEAR.—In Y1 (as defined in section 100(c))—

(A) individuals described in subsection (d)(1), including individuals described in paragraphs (3), (4), and (5) of subsection (d); and

(B) smallest employers described in subsection (e)(1).

(2) SECOND YEAR.—In Y2—

(A) individuals and employers described in paragraph (1); and

(B) smaller employers described in subsection (e)(2).

(3) THIRD YEAR.—In Y3—

(A) individuals and employers described in paragraph (2);

(B) larger employers described in subsection (e)(3); and

(C) largest employers as permitted by the Commissioner under subsection (e)(4).

(4) FOURTH AND SUBSEQUENT YEARS.—In Y4 and subsequent years—

(A) individuals and employers described in paragraph (3); and

(B) largest employers as permitted by the Commissioner under subsection (e)(4).

(d) INDIVIDUALS.—

(1) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who—

(A) is not enrolled in coverage described in subparagraphs (C) through (F) of paragraph (2); and

(B) is not enrolled in coverage as a full-time employee (or as a dependent of such an employee) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 312.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirements of section 312, such individual shall be deemed a full-time employee described in such subparagraph.

(2) ACCEPTABLE COVERAGE.—For purposes of this division, the term "acceptable coverage" means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 102) or under a current group health plan (described in subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (z), or (aa) of section 1902 of such Act

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Commissioner in coordination with the Secretary of Treasury to be not less than a level specified by the Commissioner and Secretary of Veteran's Affairs, in coordination with the Secretary of Treasury, based on the individual's priority for services as provided under section 1705(a) of such title.

(G) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this paragraph.

The Commissioner shall make determinations under this paragraph in coordination with the Secretary of the Treasury.

(3) TREATMENT OF CERTAIN NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—An individual who is a non-traditional Medicaid eligible individual (as defined in section 205(e)(4)(C)) in a State may be an Exchange-eligible individual if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the 6 months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual has chosen to enroll in an Exchange-participating health benefits plan, the individual is not also eligible for medical assistance under Medicaid.

(4) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under this subsection (including as an employee or dependent of an employee of an Exchange-eligible employer) and enrolls under an Exchange-participating health benefits plan through the Health Insurance Exchange, the individual shall continue to be treated as an Exchange-eligible individual until the individual is no longer enrolled with an Exchange-participating health benefits plan.

(B) EXCEPTIONS.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to an individual once the individual becomes eligible for coverage—

(I) under part A of the Medicare program;

(II) under the Medicaid program as a Medicaid eligible individual, except as permitted under paragraph (3) or clause (ii); or

(III) in such other circumstances as the Commissioner may provide.

(ii) TRANSITION PERIOD.—In the case described in clause (i)(II), the Commissioner shall permit the individual to continue treatment under subparagraph (A) until such limited time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual's access to health care.

(5) ADVERSELY AFFECTED RETIREE HEALTH BENEFITS GROUP PARTICIPANTS AND BENEFICIARIES.—

(A) IN GENERAL.—Beginning in Y1, an individual who is a participant or beneficiary in an adversely affected retiree health benefits group who does not have coverage described in paragraph (2)(C) is an Exchange eligible individual, whether or not such an individual has other acceptable coverage.

(B) ADVERAGE AFFECTED RETIREE HEALTH BENEFIT GROUP DEFINED.—In this paragraph, the term "adversely affected retiree health benefits group" means the retired participants and their beneficiaries of a group health plan that cancelled or substantially reduced the amount, type, level, or form of health benefit or option provided prior January 1, 2008.

(e) EMPLOYERS.—

(1) SMALLEST EMPLOYERS.—Subject to paragraph (5), smallest employers described in this paragraph are employers with 15 or fewer employees.

(2) SMALLER EMPLOYERS.—Subject to paragraph (5), smaller employers described in this paragraph are employers that are not smallest employers described in paragraph (1) and that have 25 or fewer employees.

(3) LARGER EMPLOYERS.—Subject to paragraph (5), larger employers described in this paragraph are employers that are not smallest employers described in paragraph (1) or smaller employers described in paragraph (2) and that have 50 or fewer employees.

(4) LARGEST EMPLOYERS.—

(A) IN GENERAL.—Beginning with Y3, the Commissioner may permit employers not described in paragraphs (1) (2), or (3) to be Exchange-eligible employers.

(B) PHASE-IN.—In applying subparagraph (A), the Commissioner may phase-in the application of such subparagraph based on the number of full-time employees of an employer and such other considerations as the Commissioner deems appropriate.

(5) CONTINUING ELIGIBILITY.—Once an employer is permitted to be an Exchange-eligible employer under this subsection and enrolls employees through the Health Insurance Exchange, the employer shall continue to be treated as an Exchange-eligible employer for each subsequent plan year regardless of the number of employees involved unless and until the employer meets the requirement of section 311(a) through paragraph (1) of such section by offering a group health plan and not through offering Exchange-participating health benefits plan.

(6) EMPLOYER PARTICIPATION AND CONTRIBUTIONS.—

(A) SATISFACTION OF EMPLOYER RESPONSIBILITY.—For any year in which an employer is an Exchange-eligible employer, such employer may meet the requirements of section 312 with respect to employees of such employer by offering such employees the option of enrolling with Exchange-participating health benefits plans through the Health Insurance Exchange consistent with the provisions of subtitle B of title III.

(B) EMPLOYEE CHOICE.—Any employee offered Exchange-participating health benefits plans by the employer of such employee under subparagraph (A) may choose coverage under any such plan. That choice includes, with respect to family coverage, coverage of the dependents of such employee.

(7) AFFILIATED GROUPS.—Any employer which is part of a group of employers who are 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, for purposes of this subtitle, as a single employer.

(8) OTHER COUNTING RULES.—The Commissioner shall establish rules relating to how employees are counted for purposes of carrying out this subsection.

(9) TREATMENT OF MULTIEMPLOYER PLANS.—The plan sponsor of a group health plan (as defined in section 733(a) of the Employee Retirement Income Security Act of 1974) that is multiemployer plan (as defined in section 3(37) of such Act) may obtain health insurance coverage with respect to participants in the plan through the Exchange to the same extent as an employer not described in paragraph (1) or (2) is permitted by the Commissioner to obtain health insurance coverage through the Exchange as an Exchange-eligible employer

(f) SPECIAL SITUATION AUTHORITY.—The Commissioner shall have the authority to establish such rules as may be necessary to deal with special situations with regard to uninsured individuals and employers participating as Exchange-eligible individuals and employers, such as transition periods for individuals and employers who gain, or lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

(g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The Commissioner shall provide for periodic surveys of Exchange-eligible individuals and employers concerning satisfaction of such individuals and employers with the Health Insurance Exchange and Exchange-participating health benefits plans.

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a study of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not eligible and enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

(2) ITEMS INCLUDED IN STUDY.—Such study also shall examine—

(A) the terms, conditions, and affordability of group health coverage offered by employers and QHBP offering entities outside of the Exchange compared to Exchange-participating health benefits plans; and

(B) the affordability-test standard for access of certain employed individuals to coverage in the Health Insurance Exchange.

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress on the study conducted under this subsection and shall include in such report recommendations regarding changes in standards for Exchange eligibility for for individuals and employers.

SEC. 203. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title I and this section.

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The Commissioner may not enter into a contract with a QHBP offering entity under section 204(c) for the offering of an Exchange-participating health benefits plan in a service area unless the following requirements are met:

(1) REQUIRED OFFERING OF BASIC PLAN.—The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF ENHANCED PLAN.—If and only if the entity offers a basic plan for such service area, the entity may offer one enhanced plan for such area.

(3) OPTIONAL OFFERING OF PREMIUM PLAN.—If and only if the entity offers an enhanced plan for such service area, the entity may offer one premium plan for such area.

(4) OPTIONAL OFFERING OF PREMIUM-PLUS PLANS.—If and only if the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area.

All such plans may be offered under a single contract with the Commissioner.

(c) SPECIFICATION OF BENEFIT LEVELS FOR PLANS.—

(1) IN GENERAL.—The Commissioner shall establish the following standards consistent with this subsection and title I:

(A) BASIC, ENHANCED, AND PREMIUM PLANS.—Standards for 3 levels of Exchange-participating health benefits plans: basic, enhanced, and premium (in this division referred to as a "basic plan", "enhanced plan", and "premium plan", respectively).

(B) PREMIUM-PLUS PLAN BENEFITS.—Standards for additional benefits that may be offered, consistent with this subsection and subtitle C of title I, under a premium plan (such a plan with additional benefits referred to in this division as a "premium-plus plan") .

(2) BASIC PLAN.—

(A) IN GENERAL.—A basic plan shall offer the essential benefits package required under title I for a qualified health benefits plan.

(B) TIERED COST-SHARING FOR AFFORDABLE CREDIT ELIGIBLE INDIVIDUALS.—In the case of an affordable credit eligible individual (as defined in section 242(a)(1)) enrolled in an Exchange-participating health benefits plan, the benefits under a basic plan are modified to provide for the reduced

cost-sharing for the income tier applicable to the individual under section 244(c).

(3) ENHANCED PLAN.—A enhanced plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title I consistent with section 123(b)(5)(A).

(4) PREMIUM PLAN.—A premium plan shall offer, in addition to the level of benefits under the basic plan, a lower level of cost-sharing as provided under title I consistent with section 123(b)(5)(B).

(5) PREMIUM-PLUS PLAN.—A premium-plus plan is a premium plan that also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner. The portion of the premium that is attributable to such additional benefits shall be separately specified.

(6) RANGE OF PERMISSIBLE VARIATION IN COST-SHARING.—The Commissioner shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan, except with respect to any benefit for which there is no cost-sharing permitted under the essential benefits package. Such variation shall permit a variation of not more than plus (or minus) 10 percent in cost-sharing with respect to each benefit category specified under section 122.

(d) TREATMENT OF STATE BENEFIT MANDATES.—Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in affordability premium credits under subtitle C as a result of an increase in premium in basic plans as a result of application of such requirement.

SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.

(a) CONTRACTING DUTIES.—In carrying out section 201(b)(1) and consistent with this subtitle:

(1) OFFERING ENTITY AND PLAN STANDARDS.—The Commissioner shall—

(A) establish standards necessary to implement the requirements of this title and title I for—

(i) QHBP offering entities for the offering of an Exchange-participating health benefits plan; and

(ii) for Exchange-participating health benefits plans; and

(B) certify QHBP offering entities and qualified health benefits plans as meeting such standards and requirements of this title and title I for purposes of this subtitle.

(2) SOLICITING AND NEGOTIATING BIDS; CONTRACTS.—The Commissioner shall—

(A) solicit bids from QHBP offering entities for the offering of Exchange-participating health benefits plans;

(B) based upon a review of such bids, negotiate with such entities for the offering of such plans; and

(C) enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this title) negotiated between the Commissioner and such entities.

(3) FAR NOT APPLICABLE.—The provisions of the Federal Acquisition Regulation shall not apply to contracts between the Commissioner and QHBP offering entities for the offering of Exchange-participating health benefits plans under this title.

(b) STANDARDS FOR QHBP OFFERING ENTITIES TO OFFER EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—The standards established under subsection (a)(1)(A) shall require that, in order for a QHBP offering entity to offer an Exchange-participating health benefits plan, the entity must meet the following requirements:

(1) LICENSED.—The entity shall be licensed to offer health insurance coverage under State law for each State in which it is offering such coverage.

(2) DATA REPORTING.—The entity shall provide for the reporting of such information as the Commissioner may specify, including information necessary to administer the risk pooling mechanism described in section 206(b) and information to address disparities in health and health care.

(3) IMPLEMENTING AFFORDABILITY CREDITS.—The entity shall provide for implementation of the affordability credits provided for enrollees under subtitle C, including the reduction in cost-sharing under section 244(c).

(4) ENROLLMENT.—The entity shall accept all enrollments under this subtitle, subject to such exceptions (such as capacity limitations) in accordance with the requirements under title I for a qualified health benefits plan. The entity shall notify the Commissioner if the entity projects or anticipates reaching such a capacity limitation that would result in a limitation in enrollment.

(5) RISK POOLING PARTICIPATION.—The entity shall participate in such risk pooling mechanism as the Commissioner establishes under section 206(b).

(6) ESSENTIAL COMMUNITY PROVIDERS.—With respect to the basic plan offered by the entity, the entity shall contract for outpatient services with covered entities (as defined in section 340B(a)(4) of the Public Health Service Act, as in effect as of July 1, 2009). The Commissioner shall specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act.

(7) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS.—The entity shall provide for culturally and linguistically appropriate communication and health services.

(8) ADDITIONAL REQUIREMENTS.—The entity shall comply with other applicable requirements of this title, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums and related grace periods and which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

(c) CONTRACTS.—

(1) BID APPLICATION.—To be eligible to enter into a contract under this section, a QHBP offering entity shall submit to the Commissioner a bid at such time, in such manner, and containing such information as the Commissioner may require.

(2) TERM.—Each contract with a QHBP offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(3) ENFORCEMENT OF NETWORK ADEQUACY.—In the case of a health benefits plan of a QHBP offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 115; and

(B) an individual enrolled in such plan receives an item or service from a provider that is not within such network;

then any cost-sharing for such item or service shall be equal to the amount of such cost-sharing that would be imposed if such item or service was furnished by a provider within such network.

(4) OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES.—The Commissioner shall establish processes, in coordination with State insurance regulators, to oversee, monitor, and enforce applicable requirements of this title with respect to QHBP offering entities offering Exchange-participating health benefits plans and such plans, including the marketing of such plans. Such processes shall include the following:

(A) GRIEVANCE AND COMPLAINT MECHANISMS.—The Commissioner shall establish, in coordination with State insurance regulators, a process under which Exchange-eligible individuals and employers may file complaints concerning violations of such standards.

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 142(c).

(C) TERMINATION.—

(i) IN GENERAL.—The Commissioner may terminate a contract with a QHBP offering entity under this section for the offering of an Exchange-participating health benefits plan if such entity fails to comply with the applicable requirements of this title. Any determination by the Commissioner to terminate a contract shall be made in accordance with formal investigation and compliance procedures established by the Commissioner under which—

(I) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to

correct the deficiencies that were the basis of the Commissioner's determination; and

(II) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(ii) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Clause (i) shall not apply if the Commissioner determines that a delay in termination, resulting from compliance with the procedures specified in such clause prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under the qualified health benefits plan of the QHBP offering entity.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle E of title I with respect to an entity for a violation of such a requirement.

SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(1) OUTREACH.—The Commissioner shall conduct outreach activities consistent with subsection (c), including through use of appropriate entities as described in paragraph (4) of such subsection, to inform and educate individuals and employers about the Health Insurance Exchange and Exchange-participating health benefits plan options. Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, and individuals with other cognitive impairments.

(2) ELIGIBILITY.—The Commissioner shall make timely determinations of whether individuals and employers are Exchange-eligible individuals and employers (as defined in section 202).

(3) ENROLLMENT.—The Commissioner shall establish and carry out an enrollment process for Exchange-eligible individuals and employers, including at community locations, in accordance with subsection (b).

(b) ENROLLMENT PROCESS.—

(1) IN GENERAL.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

(A) OPEN ENROLLMENT PERIOD.—The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll in an Exchange-participating health benefits plan for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be during September through November of each year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be less than 30 days.

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

(ii) experiences a change in marital or other dependent status;

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(C) ENROLLMENT INFORMATION.—The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(3) AUTOMATIC ENROLLMENT FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such process may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) SUBSIDIZED INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is an Exchange-eligible individual who is either of the following:

(i) AFFORDABILITY CREDIT ELIGIBLE INDIVIDUALS.—The individual—

(I) has applied for, and been determined eligible for, affordability credits under subtitle C;

(II) has not opted out from receiving such affordability credit; and

(III) does not otherwise enroll in another Exchange-participating health benefits plan.

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) and who does not otherwise enroll in another Exchange-participating health benefits plan.

(4) DIRECT PAYMENT OF PREMIUMS TO PLANS.—Under the enrollment process, individuals enrolled in an Exchange-partcipating health benefits plan shall pay such plans directly, and not through the Commissioner or the Health Insurance Exchange.

(c) COVERAGE INFORMATION AND ASSISTANCE.—

(1) COVERAGE INFORMATION.—The Commissioner shall provide for the broad dissemination of information on Exchange-participating health benefits plans offered under this title. Such information shall be provided in a comparative manner, and shall include information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction.

(2) CONSUMER ASSISTANCE WITH CHOICE.—To provide assistance to Exchange-eligible individuals and employers, the Commissioner shall—

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet website through which individuals may obtain information on coverage under Exchange-participating health benefits plans and file complaints;

(B) develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities;

(C) assist Exchange-eligible individuals in selecting Exchange-participating health benefits plans and obtaining benefits through such plans; and

(D) ensure that the Internet website described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 133(a)(2)).

(3) USE OF OTHER ENTITIES.—In carrying out this subsection, the Commissioner may work with other appropriate entities to facilitate the dissemination of information under this subsection and to provide assistance as described in paragraph (2).

(d) SPECIAL DUTIES RELATED TO MEDICAID AND CHIP.—

(1) COVERAGE FOR CERTAIN NEWBORNS.—

(A) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage, for the period of time beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

(i) to be a non-traditional Medicaid eligible individual (as defined in subsection (e)(5)) for purposes of this division and Medicaid; and

(ii) to have elected to enroll in Medicaid through the application of paragraph (3).

(B) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in subparagraph (A) who at the end of the period referred to in such subparagraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such time as the child obtains such coverage or the State otherwise makes a determination of the child's eligibility for medical assistance under its Medicaid plan pursuant to section 1943(c)(1) of the Social Security Act) to be a traditional Medicaid eligible individual described in section 1902(l)(1)(B) of such Act.

(2) CHIP TRANSITION.—A child who, as of the day before the first day of Y1, is eligible for child health assistance under title XXI of the Social Security Act (including a child receiving coverage under an arrangement described in section 2101(a)(2) of such Act) is deemed as of such first day to be an Exchange-eligible individual unless the individual is a traditional Medicaid eligible individual as of such day.

(3) AUTOMATIC ENROLLMENT OF MEDICAID ELIGIBLE INDIVIDUALS INTO MEDICAID.—The Commissioner shall provide for a process under which an individual who is described in section 202(d)(3) and has not elected to enroll in an Exchange-participating health benefits plan is automatically enrolled under Medicaid.

(4) NOTIFICATIONS.—The Commissioner shall notify each State in Y1 and for purposes of section 1902(gg)(1) of the Social Security Act (as added by section 1703(a)) whether the Health Insurance Exchange can support enrollment of children described in paragraph (2) in such State in such year.

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—

(A) CHOICE FOR LIMITED EXCHANGE-ELIGIBLE INDIVIDUALS.—As part of the enrollment process under subsection (b), the Commissioner shall provide the option, in the case of an Exchange-eligible individual described in section 202(d)(3), for the individual to elect to enroll under Medicaid instead of under an Exchange-participating health benefits plan. Such an individual may change such election during an enrollment period under subsection (b)(2).

(B) MEDICAID ENROLLMENT OBLIGATION.—An Exchange eligible individual may apply, in the manner described in section 241(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4). In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(2) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—In the case of a non-traditional Medicaid eligible individual described in section 202(d)(3) who elects to enroll under Medicaid under paragraph (1)(A), the Commissioner shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding under paragraph (4).

(3) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State (each in this division referred to as a "Medicaid memorandum of understanding") with respect to coordinating enrollment of individuals in Exchange-participating health benefits plans and under the State's Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or vitiate any requirement of a State Medicaid plan.

(4) MEDICAID ELIGIBLE INDIVIDUALS.—For purposes of this division:

(A) MEDICAID ELIGIBLE INDIVIDUAL.—The term "Medicaid eligible individual" means an individual who is eligible for medical assistance under Medicaid.

(B) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term "traditional Medicaid eligible individual" means a Medicaid eligible individual other than an individual who is—

(i) a Medicaid eligible individual by reason of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(ii) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(C) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term "non-traditional Medicaid eligible individual" means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

(f) EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

SEC. 206. OTHER FUNCTIONS.

(a) COORDINATION OF AFFORDABILITY CREDITS.—The Commissioner shall coordinate the distribution of affordability premium and cost-sharing credits under subtitle C to QHBP offering entities offering Exchange-participating health benefits plans.

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

(c) SPECIAL INSPECTOR GENERAL FOR THE HEALTH INSURANCE EXCHANGE.—

(1) ESTABLISHMENT; APPOINTMENT.—There is hereby established the Office of the Special Inspector General for the Health Insurance Exchange, to be headed by a Special Inspector General for the Health Insurance Exchange (in this subsection referred to as the "Special Inspector General") to be appointed by the President, by and with the advice and consent of the Senate. The nomination of an individual as Special Inspector General shall be made as soon as practicable after the establishment of the program under this subtitle.

(2) DUTIES.—The Special Inspector General shall—

(A) conduct, supervise, and coordinate audits, evaluations and investigations of the Health Insurance Exchange to protect the integrity of the Health Insurance Exchange, as well as the health and welfare of participants in the Exchange;

(B) report both to the Commissioner and to the Congress regarding program and management problems and recommendations to correct them;

(C) have other duties (described in paragraphs (2) and (3) of section 121 of division A of Public Law 110–343) in relation to the duties described in the previous subparagraphs; and

(D) have the authorities provided in section 6 of the Inspector General Act of 1978 in carrying out duties under this paragraph.

(3) APPLICATION OF OTHER SPECIAL INSPECTOR GENERAL PROVISIONS.—The provisions of subsections (b) (other than paragraphs (1) and (3)), (d) (other than paragraph (1)), and (e) of section 121 of division A of the Emergency Economic Stabilization Act of 2009 (Public Law 110–343) shall apply to the Special Inspector General under this subsection in the same manner as such provisions apply to the Special Inspector General under such section.

(4) REPORTS.—Not later than one year after the confirmation of the Special Inspector General, and annually thereafter, the Special Inspector General shall submit to the appropriate committees of Congress a report summarizing the activities of the Special Inspector General during the one year period ending on the date such report is submitted.

(5) TERMINATION.—The Office of the Special Inspector General shall terminate five years after the date of the enactment of this Act.

(d) ASSISTANCE FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—The Commissioner, in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers counseling and technical assistance with respect to the provision of health insurance to employees of such employers through the Health Insurance Exchange.

(2) DUTIES.—The program established under paragraph (1) shall include the following services:

(A) Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options.

(B) Distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health Insurance Exchange, including standardized comparative information on the health plans available under the Health Insurance Exchange.

(C) Distribution of information to small employers with respect to available affordability credits or other financial assistance.

(D) Referrals to appropriate entities of complaints and questions relating to the Health Insurance Exchange.

(E) Enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange.

(F) Responses to questions relating to the Health Insurance Exchange and the program established under paragraph (1).

(3) AUTHORITY TO PROVIDE SERVICES DIRECTLY OR BY CONTRACT.—The Commissioner may provide services under paragraph (2) directly or by contract with nonprofit entities that the Commissioner determines capable of carrying out such services.

(4) SMALL EMPLOYER DEFINED.—In this subsection, the term "small employer" means an employer with less than 100 employees.

SEC. 207. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE TRUST FUND.—There is created within the Treasury of the United States a trust fund to be known as the "Health Insurance Exchange Trust Fund" (in this section referred to as the "Trust Fund"), consisting of such amounts as may be appropriated or credited to the Trust Fund under this section or any other provision of law.

(b) PAYMENTS FROM TRUST FUND.—The Commissioner shall pay from time to time from the Trust Fund such amounts as the Commissioner determines are necessary to make payments to operate the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(c) TRANSFERS TO TRUST FUND.—

(1) DEDICATED PAYMENTS.—There is hereby appropriated to the Trust Fund amounts equivalent to the following:

(A) TAXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirement of health insurance coverage for individuals).

(B) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 3111(c) of the Internal Revenue Code of 1986 (relating to employers electing to not provide health benefits).

(C) EXCISE TAX ON FAILURES TO MEET CERTAIN HEALTH COVERAGE REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to an amount of payments made from the Trust Fund under subsection (b) plus such amounts as are necessary reduced by the amounts deposited under paragraph (1).

(d) APPLICATION OF CERTAIN RULES.—Rules similar to the rules of subchapter B of chapter 98 of the Internal Revenue Code of 1986 shall apply with respect to the Trust Fund.

SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange,

then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States). The Commissioner shall approve a State-based Health Insurance Exchange if it meets the requirements for approval under subsection (b).

(b) REQUIREMENTS FOR APPROVAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(1) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(A) negotiating and contracting with QHBP offering entities for the offering of Exchange-participating health benefits plan, which satisfy the standards and requirements of this title and title I;

(B) enrolling Exchange-eligible individuals and employers in such State in such plans;

(C) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(D) administering affordability credits under subtitle B using the same methodologies (and at least the same income verification methods) as would otherwise apply under such subtitle and at a cost to the Federal Govern-

ment which does exceed the cost to the Federal Government if this section did not apply; and

(E) enforcement activities consistent with federal requirements.

(2) There is no more than one Health Insurance Exchange operating with respect to any one State.

(3) The State provides assurances satisfactory to the Commissioner that approval of such an Exchange will not result in any net increase in expenditures to the Federal Government.

(4) The State provides for reporting of such information as the Commissioner determines and assurances satisfactory to the Commissioner that it will vigorously enforce violations of applicable requirements.

(5) Such other requirements as the Commissioner may specify.

(c) CEASING OPERATION.—

(1) IN GENERAL.—A State-based Health Insurance Exchange may, at the option of each State involved, and only after providing timely and reasonable notice to the Commissioner, cease operation as such an Exchange, in which case the Health Insurance Exchange shall operate, instead of such State-based Health Insurance Exchange, with respect to such State (or States).

(2) TERMINATION; HEALTH INSURANCE EXCHANGE RESUMPTION OF FUNCTIONS.—The Commissioner may terminate the approval (for some or all functions) of a State-based Health Insurance Exchange under this section if the Commissioner determines that such Exchange no longer meets the requirements of subsection (b) or is no longer capable of carrying out such functions in accordance with the requirements of this subtitle. In lieu of terminating such approval, the Commissioner may temporarily assume some or all functions of the State-based Health Insurance Exchange until such time as the Commissioner determines the State-based Health Insurance Exchange meets such requirements of subsection (b) and is capable of carrying out such functions in accordance with the requirements of this subtitle.

(3) EFFECTIVENESS.—The ceasing or termination of a State-based Health Insurance Exchange under this subsection shall be effective in such time and manner as the Commissioner shall specify.

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

(A) may not be performed by a State-based Health Insurance Exchange under this section; or

(B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(e) REFERENCES.—In the case of a State-based Health Insurance Exchange, except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to the Commissioner in the area in which the State-based Health Insurance Exchange operates shall be deemed a reference to the State-based Health Insurance Exchange and the head of such Exchange, respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be assistance provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 209. PARTICIPATION OF SMALL EMPLOYER BENEFIT ARRANGEMENTS.

(a) IN GENERAL.—The Commissioner may enter into contracts with small employer benefit arrangements to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an arrangement under Exchange participating health benefits plans.

(b) SMALL EMPLOYER BENEFIT ARRANGEMENT DEFINED.—In this section, the term "small employer benefit arrangement" means a not-for-profit agricultural or other cooperative that—

(1) consists solely of its members and is operated for the primary purpose of providing affordable employee benefits to its members;

(2) only has as members small employers in the same industry or line of business;

(3) has no member that has more than a 5 percent voting interest in the cooperative; and

(4) is governed by a board of directors elected by its members.

Subtitle B—Public Health Insurance Option

SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with Y1, the Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the "public health insurance option") that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without comprimising quality or access to care.

(b) OFFERING AS AN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—

(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

(A) shall offer basic, enhanced, and premium plans; and

(B) may offer premium-plus plans.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option 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. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1808(c)(2) of the Social Security Act.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce disparities in health and health care based on race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation as determined appropriate by the Secretary, but only if the data collection is conducted on a voluntary basis and consistent with the standards, including privacy protections, established pursuant to section 1709 of the Public Health Service Act.

(f) TREATMENT OF PUBLIC HEALTH INSURANCE OPTION.—With respect to the public health insurance option, the Secretary shall be treated as a QHBP offering entity offering an Exchange-participating health benefits plan.

(g) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

SEC. 222. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—

(1) IN GENERAL.—The Secretary shall establish geographically-adjusted premium rates for the public health insurance option in a manner—

(A) that complies with the premium rules established by the Commissioner under section 113 for Exchange-participating health benefit plans; and

(B) at a level sufficient to fully finance the costs of—

(i) health benefits provided by the public health insurance option; and

(ii) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall include an appropriate amount for a contingency margin.

(b) ACCOUNT.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States an Account for the receipts and disbursements attributable to the operation of the public health insurance option, including the start-up funding under paragraph (2). Section 1854(g) of the Social Security Act shall apply to receipts described in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

(2) START-UP FUNDING.—

(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under subparagraph (A) to the Treasury in an amortized manner over the 10-year period beginning with Y1.

(C) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) RATES ESTABLISHED BY SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish payment rates for the public health insurance option for services and health care providers consistent with this section and may change such payment rates in accordance with section 224.

(2) INITIAL PAYMENT RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B) and subsection (b)(1), during Y1, Y2, and Y3, the Secretary shall base the payment rates under this section for services and providers described in paragraph (1) on the payment rates for similar services and providers under parts A and B of Medicare.

(B) EXCEPTIONS.—

(i) PRACTITIONERS' SERVICES.—Payment rates for practitioners' services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this paragraph shall be not less than 1 percent.

(ii) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this subtitle.

(3) FOR NEW SERVICES.—The Secretary shall modify payment rates described in paragraph (2) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(4) PRESCRIPTION DRUGS.—Payment rates under this section for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(1) INITIAL INCENTIVE PERIOD.—

(A) IN GENERAL.—The Secretary shall provide, in the case of services described in subparagraph (B) furnished during Y1, Y2, and Y3, for payment rates that are 5 percent greater than the rates established under subsection (a).

(B) SERVICES DESCRIBED.—The services described in this subparagraph are items and professional services, under the public health insurance option by a physician or other health care practitioner who participates in both Medicare and the public health insurance option.

(C) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in

Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subparagraph (A).

(2) SUBSEQUENT PERIODS.— Beginning with Y4 and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care consistent with section 221(a). Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subsection (a)(2) and paragraph (1) of this subsection were continued.

(3) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary.

(c) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this section but not to the specific methodology for establishing such rates or the calculation of such rates.

(d) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the provisions of section 221(a) and the amounts paid for similar health care providers and services under other Exchange-participating health benefits plans.

(e) CONSTRUCTION.—Nothing in this subtitle shall be construed as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services, such as the initiatives provided for under section 224.

(f) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 224.

SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(a) IN GENERAL.—For plan years beginning with Y1, the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.

(b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficent and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

(2) promotes care that is integrated, patient-centered, quality, and efficient.

(c) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

(d) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

SEC. 225. PROVIDER PARTICIPATION.

(a) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

(b) LICENSURE OR CERTIFICATION.—The Secretary shall not allow a health care provider to participate in the public health insurance option unless such provider is appropriately licensed, certified, or otherwise permitted to practice under State law.

(c) PAYMENT TERMS FOR PROVIDERS.—

(1) PHYSICIANS.—The Secretary shall provide for the annual participation of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment rate described in section 223 for such physicians) that exceed the ratio permitted under section 1848(g)(2)(C) of the Social Security Act.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual or other basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment shall only be available if the provider agrees to accept the payment rate established under section 223 (without regard to cost-sharing) as the payment in full.

(d) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from participation under the public health insurance option a health care provider that is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act).

SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVISIONS.

Provisions of law (other than criminal law provisions) identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as the False Claims Act (31 U.S.C. 3729 et seq.), shall also apply to the public health insurance option.

SEC. 227. SENSE OF THE HOUSE REGARDING ENROLLMENT OF MEMBERS IN THE PUBLIC OPTION.

It is the sense of the House of Representatives that Members who vote in favor of the establishment of a public, Federal Government run health insurance option, and senior members of the President's administration, are urged to forgo their right to participate in the Federal Employees Health Benefits Program (FEHBP) and agree to enroll under that public option.

Subtitle C—Individual Affordability Credits

SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, in the case of an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

(A) an affordability premium credit under section 243 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 244 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

(2) the Commissioner shall pay the QHBP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate amount of affordability credits for all affordable credit eligible individuals enrolled in such plan.

(b) APPLICATION.—

(1) IN GENERAL.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to eligibility of an individual for affordability credits under this subtitle.The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible individuals. In carrying this subtitle, the Commissioner shall establish effective methods that ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) USE OF STATE MEDICAID AGENCIES.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards

as used by the Commissioner, under the Medicaid memorandum of understanding (as defined in section 205(c)(4))—

(A) the State Medicaid agency is authorized to conduct such determinations for any Exchange-eligible individual who requests such a determination; and

(B) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(3) MEDICAID SCREEN AND ENROLL OBLIGATION.—In the case of an application made under paragraph (1), there shall be a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the Medicaid memorandum of understanding, shall provide for the enrollment of the individual under the State Medicaid plan in accordance with the Medicaid memorandum of understanding. In the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise apply if the individual had directly applied for medical assistance to the State Medicaid agency.

(c) USE OF AFFORDABILITY CREDITS.—

(1) IN GENERAL.—In Y1 and Y2 an affordable credit eligible individual may use an affordability credit only with respect to a basic plan.

(2) FLEXIBILITY IN PLAN ENROLLMENT AUTHORIZED.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability credit to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordable credit amount otherwise applicable if the individual had enrolled in a basic plan.

(d) ACCESS TO DATA.—In carrying out this subtitle, the Commissioner shall request from the Secretary of the Treasury consistent with section 6103 of the Internal Revenue Code of 1986 such information as may be required to carry out this subtitle.

(e) NO CASH REBATES.—In no case shall an affordable credit eligible individual receive any cash payment as a result of the application of this subtitle.

SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.

(a) DEFINITION.—

(1) IN GENERAL.—For purposes of this division, the term "affordable credit eligible individual" means, subject to subsection (b), an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)—

(A) who is enrolled under an Exchange-participating health benefits plan and is not enrolled under such plan as an employee (or dependent of an employee) through an employer qualified health benefits plan that meets the requirements of section 312;

(B) with family income below 400 percent of the Federal poverty level for a family of the size involved; and

(C) who is not a Medicaid eligible individual, other than an individual described in section 202(d)(3) or an individual during a transition period under section 202(d)(4)(B)(ii).

(2) TREATMENT OF FAMILY.—Except as the Commissioner may otherwise provide, members of the same family who are affordable credit eligible individuals shall be treated as a single affordable credit individual eligible for the applicable credit for such a family under this subtitle.

(b) LIMITATIONS ON EMPLOYEE AND DEPENDENT DISQUALIFICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the term "affordable credit eligible individual" does not include a full-time employee of an employer if the employer offers the employee coverage (for the employee and dependents) as a full-time employee under a group health plan if the coverage and employer contribution under the plan meet the requirements of section 312.

(2) EXCEPTIONS.—

(A) FOR CERTAIN FAMILY CIRCUMSTANCES.—The Commissioner shall establish such exceptions and special rules in the case described in paragraph (1) as may be appropriate in the case of a divorced or separated individual or such a dependent of an employee who would otherwise be an affordable credit eligible individual.

(B) FOR UNAFFORDABLE EMPLOYER COVERAGE.—For years beginning with Y2, in the case of full-time employees for which the cost of the em-

ployee premium (plus, to the extent specified by the Commissioner, out-of-pocket cost-sharing for such year or the preceding year) for coverage under a group health plan would exceed 11 percent of current family income (determined by the Commissioner on the basis of verifiable documentation and without regard to section 245), paragraph (1) shall not apply.

(c) INCOME DEFINED.—

(1) IN GENERAL.—In this title, the term "income" means modified adjusted gross income (as defined in section 59B of the Internal Revenue Code of 1986).

(2) STUDY OF INCOME DISREGARDS.—The Commissioner shall conduct a study that examines the application of income disregards for purposes of this subtitle. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) CLARIFICATION OF TREATMENT OF AFFORDABILITY CREDITS.—Affordabilty credits under this subtitle shall not be treated, for purposes of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to be a benefit provided under section 403 of such title.

SEC. 243. AFFORDABLE PREMIUM CREDIT.

(a) IN GENERAL.—The affordability premium credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in an amount equal to the amount (if any) by which the premium for the plan (or, if less, the reference premium amount specified in subsection (c)), exceeds the affordable premium amount specified in subsection (b) for the individual.

(b) AFFORDABLE PREMIUM AMOUNT.—

(1) IN GENERAL.—The affordable premium amount specified in this subsection for an individual for monthly premium in a plan year shall be equal to 1/12 of the product of—

(A) the premium percentage limit specified in paragraph (2) for the individual based upon the individual's family income for the plan year; and

(B) the individual's family income for such plan year.

(2) PREMIUM PERCENTAGE LIMITS BASED ON TABLE.—The Commissioner shall establish premium percentage limits so that for individuals whose family income is within an income tier specified in the table in subsection (d) such percentage limits shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier.

(c) REFERENCE PREMIUM AMOUNT.—The reference premium amount specified in this subsection for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium levels. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) TABLE OF PREMIUM PERCENTAGE LIMITS AND ACTUARIAL VALUE PERCENTAGES BASED ON INCOME TIER.—

(1) IN GENERAL.—For purposes of this subtitle, the table specified in this subsection is as follows:

In the case of family income (expressed as a percent of FPL) within the following income tier:	The initial premium percentage is—	The final premium percentage is—	The actuarial value percentage is—
133% through 150%	1.5%	3%	97%
150% through 200%	3%	5%	93%
200% through 250%	5%	7%	85%
250% through 300%	7%	9%	78%
300% through 350%	9%	10%	72%
350% through 400%	10%	11%	70%

(2) SPECIAL RULES.—For purposes of applying the table under paragraph (1)—

(A) FOR LOWEST LEVEL OF INCOME.—In the case of an individual with income that does not exceed 133 percent of FPL, the individual shall be considered to have income that is 133% of FPL.

(B) APPLICATION OF HIGHER ACTUARIAL VALUE PERCENTAGE AT TIER TRANSITION POINTS.—If two actuarial value percentages may be determined with respect to an individual, the actuarial value percentage shall be the higher of such percentages.

SEC. 244. AFFORDABILITY COST-SHARING CREDIT.

(a) IN GENERAL.—The affordability cost-sharing credit under this section for an affordable credit eligible individual enrolled in an Exchange-participating health benefits plan is in the form of the cost-sharing reduction described in subsection (b) provided under this section for the income tier in which the individual is classified based on the individual's family income.

(b) COST-SHARING REDUCTIONS.—The Commissioner shall specify a reduction in cost-sharing amounts and the annual limitation on cost-sharing specified in section 122(c)(2)(B) under a basic plan for each income tier specified in the table under section 243(d), with respect to a year, in a manner so that, as estimated by the Commissioner, the actuarial value of the coverage with such reduced cost-sharing amounts (and the reduced annual cost-sharing limit) is equal to the actuarial value percentage (specified in the table under section 243(d) for the income tier involved) of the full actuarial value if there were no cost-sharing imposed under the plan.

(c) DETERMINATION AND PAYMENT OF COST-SHARING AFFORDABILITY CREDIT.—In the case of an affordable credit eligible individual in a tier enrolled in an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner shall provide for payment to the offering entity of an amount equivalent to the increased actuarial value of the benefits under the plan provided under section 203(c)(2)(B) resulting from the reduction in cost-sharing described in subsection (b).

SEC. 245. INCOME DETERMINATIONS.

(a) IN GENERAL.—In applying this subtitle for an affordability credit for an individual for a plan year, the individual's income shall be the income (as defined in section 242(c)) for the individual for the most recent taxable year (as determined in accordance with rules of the Commissioner). The Federal poverty level applied shall be such level in effect as of the date of the application.

(b) PROGRAM INTEGRITY; INCOME VERIFICATION PROCEDURES.—

(1) PROGRAM INTEGRITY.—The Commissioner shall take such steps as may be appropriate to ensure the accuracy of determinations and redeterminations under this subtitle.

(2) INCOME VERIFICATION.—

(A) IN GENERAL.—Upon an initial application of an individual for an affordability credit under this subtitle (or in applying section 242(b)) or upon an application for a change in the affordability credit based upon a significant change in family income described in subparagraph (A)—

(i) the Commissioner shall request from the Secretary of the Treasury the disclosure to the Commissioner of such information as may be permitted to verify the information contained in such application; and

(ii) the Commissioner shall use the information so disclosed to verify such information.

(B) ALTERNATIVE PROCEDURES.—The Commissioner shall establish procedures for the verification of income for purposes of this subtitle if no income tax return is available for the most recent completed tax year.

(c) SPECIAL RULES.—

(1) CHANGES IN INCOME AS A PERCENT OF FPL.—In the case that an individual's income (expressed as a percentage of the Federal poverty level for a family of the size involved) for a plan year is expected (in a manner specified by the Commissioner) to be significantly different from the income (as so expressed) used under subsection (a), the Commissioner shall establish rules requiring an individual to report, consistent with the mechanism established under paragraph (2), significant changes in such income (including a significant change in family composition) to the Commissioner and requiring the substitution of such income for the income otherwise applicable.

(2) REPORTING OF SIGNIFICANT CHANGES IN INCOME.—The Commissioner shall establish rules under which an individual determined to be an affordable credit eligible individual would be required to inform the Commissioner when there is a significant change in the family income of the individual (expressed as a percentage of the FPL for a family of the size involved) and of the information regarding such change. Such mechanism shall provide for guidelines that specify the circumstances that qualify as a significant change, the verifiable information required to document such a change, and the process for submission of such information. If the Commissioner receives new information from an individual regarding the family income of the individual,the Commissioner shall provide for a redetermination of the individual's eligibility to be an affordable credit eligible individual.

(3) TRANSITION FOR CHIP.—In the case of a child described in section 202(d)(2), the Commissioner shall establish rules under which the family in-

come of the child is deemed to be no greater than the family income of the child as most recently determined before Y1 by the State under title XXI of the Social Security Act.

(4) STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.—The Commissioner shall examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Commissioner determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than the first day of Y2, the Commissioner shall submit to Congress a report on such study and shall include such recommendations as the Commissioner determines appropriate.

(d) PENALTIES FOR MISREPRESENTATION.—In the case of an individual intentionally misrepresents family income or the individual fails (without regard to intent) to disclose to the Commissioner a significant change in family income under subsection (c) in a manner that results in the individual becoming an affordable credit eligible individual when the individual is not or in the amount of the affordability credit exceeding the correct amount—

(1) the individual is liable for repayment of the amount of the improper affordability credit; ;and

(2) in the case of such an intentional misrepresentation or other egregious circumstances specified by the Commissioner, the Commissioner may impose an additional penalty.

SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED ALIENS.

Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States.

Subtitle D—State Innovation

SEC. 251. WAIVER OF ERISA LIMITATION; APPLICATION INSTEAD OF STATE SINGLE PAYER SYSTEM.

(a) IN GENERAL.—A State may request from the Secretary, and the Secretary must grant except under extraordinary circumstances, a waiver of application of section 514 of the Employee Retirement Income Security Act of 1974 with respect to a state single payer system enacted into law by such State that would be structured and operate in a manner consistent with this subtitle. The Secretary shall provide for the revocation of any waiver granted under this section upon a determination made by the Secretary that the requirements of the preceding sentence are no longer being met.

(b) EFFECT OF WAIVER.—During any period for which a waiver under subsection (a) is in effect—

(1) the provisions of section 514 of the Employee Retirement Income Security Act of 1974 shall not apply with respect to the State single payer system; and

(2) the State single payer system shall operate in the State instead of the public health insurance option or the National Health Exchange.

(c) CONSTRUCTION.—Nothing in this subtitle shall be construed to limit or otherwise affect the transfer and allocation under this Act of funds to States with single payer systems.

SEC. 252. REQUIREMENTS.

A State single payer system shall—

(1)) provide benefits that meet or exceed the standards of coverage and quality of care set forth in this Act; and

(2) ensure that the cost to the Federal Government resulting from the waiver granted under section 261 is neither substantially greater nor substantially less than would have been the case in the absence of such waiver, except that:

(A) the State may seek and benefit from planning and start-up funds with respect to the system; and

(B) nothing in this paragraph shall be construed to preclude allowance for normal variations in population demographics, health status, and other factors exogenous to the health care system that may affect differences in costs.

SEC. 253. DEFINITIONS.

(a) STATE SINGLE PAYER SYSTEM.—The term "State single payer system" means, in connection with a State, a non-profit program of the State for providing health care—

(1) in which a single agency of the State is responsible for financing health care benefits for all residents of the State and for the administration or supervision of the administration of the program;

(2) under which private insurance duplicating the benefits provided in the single payer program is prohibited;

(3) which provides comprehensive health benefits to all residents of the State, and provides measures to assure free choice of providers for covered services, to promote quality, and to help resolve complaints and disputes between consumers and providers; and

(4) under which participation by health maintenance organizations is limited to non-profit health maintenance organizations that own their own delivery facilities and employ physicians on salary, and funding is limited to services that the health maintenance organizations actually deliver; and

(5) which may be maintained by such State together one or more other States in a geographic region.

(b) SECRETARY.—The term "Secretary" means the Secretary of Labor, acting in consultation with the Secretary of Health and Human Services.

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

SEC. 301. INDIVIDUAL RESPONSIBILITY.

For an individual's responsibility to obtain acceptable coverage, see section 59B of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) IN GENERAL.—An employer meets the requirements of this section if such employer does all of the following:

(1) OFFER OF COVERAGE.—The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 102(b))) in accordance with section 312.

(2) CONTRIBUTION TOWARDS COVERAGE.—If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 312.

(3) CONTRIBUTION IN LIEU OF COVERAGE.—Beginning with Y2, if an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Health Insurance Exchange with respect to each such employee in accordance with section 313.

(b) HARDSHIP EXEMPTION.—Notwithstanding any other provision of this part, an employer may, in a form and manner which shall be prescribed by the Secretary, apply to the Secretary for a waiver from the health coverage participation requirements of this part for any 2-year period. The Secretary shall grant the waiver within 30 days after submission of the application if the application reasonably demonstrates to the Secretary that meeting the requirements of this part would result in job losses that would negatively impact the employer or the community in which the employer is located.

SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARDS EMPLOYEE AND DEPENDENT COVERAGE.

(a) IN GENERAL.—An employer meets the requirements of this section with respect to an employee if the following requirements are met:

(1) OFFERING OF COVERAGE.—The employer offers the coverage described in section 311(1) either through an Exchange-participating health benefits plan or other than through such a plan.

(2) EMPLOYER REQUIRED CONTRIBUTION.—The employer timely pays to the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.

(3) PROVISION OF INFORMATION.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section.

(4) AUTOENROLLMENT OF EMPLOYEES.—The employer provides for autoenrollment of the employee in accordance with subsection (c).

(b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH MINIMUM EMPLOYER CONTRIBUTION.—

(1) FULL-TIME EMPLOYEES.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee's spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986) under a qualified health benefits plan (or current employment-based health plan) is equal to—

(A) in case of individual coverage, not less than 72.5 percent of the applicable premium (as defined in section 4980B(f)(4) of such Code, subject to paragraph (2)) of the lowest cost plan offered by the employer that is a qualified health benefits plan (or is such current employment-based health plan); and

(B) in the case of family coverage which includes coverage of such spouse and children, not less 65 percent of such applicable premium of such lowest cost plan.

(2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium of the lowest cost plan with respect to coverage of an employee under an Exchange-participating health benefits plan is the reference premium amount under section 243(c) for individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

(3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYEES OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contribution under this subsection with respect to a full-time employee that reflects the proportion of—

(A) the average weekly hours of employment of the employee by the employer, to

(B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

(4) SALARY REDUCTIONS NOT TREATED AS EMPLOYER CONTRIBUTIONS.—For purposes of this section, any contribution on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer.

(c) AUTOMATIC ENROLLMENT FOR EMPLOYER SPONSORED HEALTH BENEFITS.—

(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll suchs employee into the employment-based health benefits plan for individual coverage under the plan option with the lowest applicable employee premium.

(2) OPT-OUT.—In no case may an employer automatically enroll an employee in a plan under paragraph (1) if such employee makes an affirmative election to opt out of such plan or to elect coverage under an employment-based health benefits plan offered by such employer. An employer shall provide an employee with a 30-day period to make such an affirmative election before the employer may automatically enroll the employee in such a plan.

(3) NOTICE REQUIREMENTS.—

(A) IN GENERAL.—Each employer described in paragraph (1) who automatically enrolls an employee into a plan as described in such paragraph shall provide the employees, within a reasonable period before the beginning of each plan year (or, in the case of new employees, within a reasonable period before the end of the enrollment period for such a new employee), written notice of the employees' rights and obligations relating to

the automatic enrollment requirement under such paragraph. Such notice must be comprehensive and understood by the average employee to whom the automatic enrollment requirement applies.

(B) INCLUSION OF SPECIFIC INFORMATION.—The written notice under subparagraph (A) must explain an employee's right to opt out of being automatically enrolled in a plan and in the case that more than one level of benefits or employee premium level is offered by the employer involved, the notice must explain which level of benefits and employee premium level the employee will be automatically enrolled in the absence of an affirmative election by the employee.

SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COVERAGE.

(a) IN GENERAL.—A contribution is made in accordance with this section with respect to an employee if such contribution is equal to an amount equal to 8 percent of the average wages paid by the employer during the period of enrollment (determined by taking into account all employees of the employer and in such manner as the Commissioner provides, including rules providing for the appropriate aggregation of related employers). Any such contribution—

(1) shall be paid to the Health Choices Commissioner for deposit into the Health Insurance Exchange Trust Fund, and

(2) shall not be applied against the premium of the employee under the Exchange-participating health benefits plan in which the employee is enrolled.

(b) SPECIAL RULES FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—In the case of any employer who is a small employer for any calendar year, subsection (a) shall be applied by substituting the applicable percentage determined in accordance with the following table for "8 percent":

If the annual payroll of such employer for the preceding calendar year:	The applicable percentage is:
Does not exceed $250,000	0 percent
Exceeds $250,000, but does not exceed $300,000	2 percent
Exceeds $300,000, but does not exceed $350,000	4 percent
Exceeds $350,000, but does not exceed $400,000	6 percent

(2) SMALL EMPLOYER.—For purposes of this subsection, the term "small employer" means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $400,000.

(3) ANNUAL PAYROLL.—For purposes of this paragraph, the term "annual payroll" means, with respect to any employer for any calendar year, the aggregate wages paid by the employer during such calendar year.

(4) AGGREGATION RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

SEC. 314. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are undertaking any actions to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plan (within the meaning of section 102(b)) offered by the employer and instead to enroll in an Exchange-participating health benefits plan. An employer violating such standards shall be treated as not meeting the requirements of this section.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"(a) IN GENERAL.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

"(b) TIME AND MANNER.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

"SEC. 802. TREATMENT OF COVERAGE RESULTING FROM ELECTION.

"(a) IN GENERAL.—If an employer makes an election to the Secretary under section 801—

"(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 733(a)) for purposes of this title, subject to section 151 of the America's Affordable Health Choices Act of 2009, and

"(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

"(b) PERIODIC INVESTIGATIONS TO DISCOVER NONCOMPLIANCE.—The Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to such sampling of plans so as to discover noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall take such timely enforcement action as appropriate to achieve compliance.

"(c) RECORDKEEPING.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of the trade or business in which the employer is engaged, has engaged for the performance of labor or services.

"SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

"For purposes of this part, the term 'health coverage participation requirements' means the requirements of part 1 of subtitle B of title III of division A of America's Affordable Health Choices Act of 2009 (as in effect on the date of the enactment of such Act).

"SEC. 804. RULES FOR APPLYING REQUIREMENTS.

"(a) AFFILIATED GROUPS.—In the case of any employer which is part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election under section 801 shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

"(b) SEPARATE ELECTIONS.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

"(1) separate lines of business, and

"(2) full-time employees and employees who are not full-time employees.

"SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.

"The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

"SEC. 806. REGULATIONS.

"The Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part, in accordance with section 324(a) of the America's Affordable Health Choices Act of 2009. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.".

(b) ENFORCEMENT OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(6), by striking "paragraph" and all that follows through "subsection (c)" and inserting "paragraph (2), (4), (5), (6), (7), (8), (9), (10), or (11) of subsection (c)"; and

(2) in subsection (c), by redesignating the second paragraph (10) as paragraph (12) and by inserting after the first paragraph (10) the following new paragraph:

"(11) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—

"(A) CIVIL PENALTIES.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) is in effect) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

"(B) HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For purposes of this paragraph, the term 'health coverage participation requirements' has the meaning provided in section 803.

"(C) LIMITATIONS ON AMOUNT OF PENALTY.—

"(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

"(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

"(I) such failure was due to reasonable cause and not to willful neglect, and

"(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty assessed under subparagraph (A) for failures during any 1-year period shall not exceed the amount equal to the lesser of—

"(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding 1-year period for group health plans, or

"(II) $500,000.

"(D) ADVANCE NOTIFICATION OF FAILURE PRIOR TO ASSESSMENT.—Before a reasonable time prior to the assessment of any penalty under this paragraph with respect to any failure by an employer, the Secretary shall inform the employer in writing of such failure and shall provide the employer information regarding efforts and procedures which may be undertaken by the employer to correct such failure.

"(E) COORDINATION WITH EXCISE TAX.—Under regulations prescribed in accordance with section 324 of the America's Affordable Health Choices Act of 2009, the Secretary and the Secretary of the Treasury shall coordinate the assessment of penalties under this section in connection with failures to satisfy health coverage participation requirements with the imposition of excise taxes on such failures under section 4980H(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failures.

"(F) DEPOSIT OF PENALTY COLLECTED.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous receipts in the Treasury of the United States.".

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 734 the following new items:

"PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

"Sec. 801. Election of employer to be subject to national health coverage participation requirements.
"Sec. 802. Treatment of coverage resulting from election.
"Sec. 803. Health coverage participation requirements.
"Sec. 804. Rules for applying requirements.
"Sec. 805. Termination of election in cases of substantial noncompliance.
"Sec. 806. Regulations.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

[For sections 322 and 323, see text of bill as introduced on June 14, 2009.]

SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(a) ASSURING COORDINATION.—The officers consisting of the Secretary of Labor, the Secretary of the Treasury, the Secretary of Health and Human Services, and the Health Choices Commissioner shall ensure, through the execution of an interagency memorandum of understanding among such officers, that—

(1) regulations, rulings, and interpretations issued by such officers relating to the same matter over which two or more of such officers have responsibility under subpart B of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, section 4980H of the Internal Revenue Code of 1986, and section 2793 of the Public Health Service Act are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such officers in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(b) MULTIEMPLOYER PLANS.—In the case of a group health plan that is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974), the regulations prescribed in accordance with subsection (a) by the officers referred to in subsection (a) shall provide for the application of the health coverage participation requirements to the plan sponsor and contributing sponsors of such plan.

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

[For division B, see text of bill as introduced on July 14, 2009.]

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

(a) TABLE OF CONTENTS.—The table of contents of this division is as follows:

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

[For section 2002 and titles I through IV of division C, see text of bill as introduced on July 14, 2009.]

TITLE V—OTHER PROVISIONS

[For subtitles A through C of title V of division C, see text of bill as introduced on July 14, 2009.]

Subtitle D—Grants for Comprehensive Programs to Provide Education to Nurses and Create a Pipeline to Nursing

SEC. 2531. ESTABLISHMENT OF GRANT PROGRAM.

(a) PURPOSES.—It is the purpose of this section to authorize grants to—

(1) address the projected shortage of nurses by funding comprehensive programs to create a career ladder to nursing (including Certified Nurse Assistants, Licensed Practical Nurses, Licensed Vocational Nurses, and Registered Nurses) for incumbent ancillary health care workers;

(2) increase the capacity for educating nurses by increasing both nurse faculty and clinical opportunities through collaborative programs between staff nurse organizations, health care providers, and accredited schools of nursing; and

(3) provide training programs through education and training organizations jointly administered by health care providers and health care labor organizations or other organizations representing staff nurses and frontline health care workers, working in collaboration with accredited schools of nursing and academic institutions.

(b) GRANTS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor (referred to in this section as the "Secretary") shall establish a partnership grant program to award grants to eligible entities to carry out comprehensive programs to provide education to nurses and create a pipeline to nursing for incumbent ancillary health care workers who wish to advance their careers, and to otherwise carry out the purposes of this section.

(c) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall be—

(1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer and that carries out activities using labor management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)(6));

(2) an entity that operates a training program that is jointly administered by—

(A) one or more health care providers or facilities, or a trade association of health care providers; and

(B) one or more organizations which represent the interests of direct care health care workers or staff nurses and in which the direct care health care workers or staff nurses have direct input as to the leadership of the organization;

(3) a State training partnership program that consists of nonprofit organizations that include equal participation from industry, including public or private employers, and labor organizations including joint labor-management training programs, and which may include representatives from local governments, worker investment agency one-stop career centers, community-based organizations, community colleges, and accredited schools of nursing; or

(4) a school of nursing (as defined in section 801 of the Public Health Service Act (42 U.S.C. 296)).

(d) ADDITIONAL REQUIREMENTS FOR HEALTH CARE EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligible for a grant under this section, a health care employer described in subsection (c) shall demonstrate that it—

(1) has an established program within their facility to encourage the retention of existing nurses;

(2) provides wages and benefits to its nurses that are competitive for its market or that have been collectively bargained with a labor organization; and

(3) supports programs funded under this section through 1 or more of the following:

(A) The provision of paid leave time and continued health coverage to incumbent health care workers to allow their participation in nursing career ladder programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.

(B) Contributions to a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work full- or part-time in a faculty position.

(D) The provision of paid release time for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced nursing degrees, specialty training, or certification program.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(e) OTHER REQUIREMENTS.—

(1) MATCHING REQUIREMENT.—

(A) IN GENERAL.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in subparagraph (A) may be in cash or in kind (including paid release time), fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) REQUIRED COLLABORATION.—Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs or specialty training or certification programs.

(f) USE OF FUNDS.—Amounts awarded to an entity under a grant under this section shall be used for the following:

(1) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English -as-a-second language education, GED education, pre-college counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preference for dedicated cohort classes in community colleges, universities, accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs that assist newly graduated nurses in adjusting to working at the bedside to ensure their retention postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incumbent health care workers to participate in these programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that—

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually evaluate, and submit to the Secretary a report on, the activities carried out under the grant and the outcomes of such activities. Such outcomes may include—

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increasing number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of nurse faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

[For subtitle E of title V of division C, see text of bill as introduced on July 14, 2009.]

Subtitle F—Standards for Accessibility to Medical Equipment for Individuals With Disabilities.

SEC. 2541. ACCESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

"SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

"(a) STANDARDS.—Not later than 9 months after the date of enactment of the America's Affordable Health Choices Act of 2009, the Architectural and Transportation Barriers Compliance Board shall issue guidelines setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The guidelines shall ensure that such equipment is accessible to, and usable by, individuals with disabilities, including provisions to ensure independent entry to, use

of, and exit from the equipment by such individuals to the maximum extent possible.

"(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The guidelines issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.

"(c) INTERIM STANDARDS.—Until the date on which final regulations are issued under subsection (d), purchases of examination tables, weight scales, and mammography equipment and used in (or in conjunction with) medical settings described in subsection (a), shall adhere to the following interim accessibility requirements:

"(1) Examination tables shall be height-adjustable between a range of at least 18 inches to 37 inches.

"(2) Weight scales shall be capable of weighing individuals who remain seated in a wheelchair or other personal mobility aid.

"(3) Mammography machines and equipment shall be capable of being used by individuals in a standing, seated, or recumbent position, including individuals who remain seated in a wheelchair or other personal mobility aid.

"(d) REGULATIONS.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

"(1) prescribe regulations in an accessible format as necessary to carry out the provisions of such Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

"(2) ensure that health care providers and health care plans covered by the America's Affordable Health Choices Act of 2009 meet the requirements of the Americans with Disabilities Act and section 504, including provisions ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

"(e) REVIEW AND AMEND.—The Architectural and Transportation Barriers Compliance Board shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (d).".

Subtitle G—Other Grant Programs

SEC. 2551. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education, in consultation with the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention, may make demonstration grants to eligible local education agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies that demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the agency, in part by providing information on current ratios of students to school nurses.

(3) MATCHING FUNDS.—The Secretary of Education may require recipients of grants under this subsection to provide matching funds from non-Federal sources, and shall permit the recipients to match funds in whole or in part with in-kind contributions.

(b) REPORT.—Not later than 24 months after the date on which assistance is first made available to local educational agencies under this section, the Secretary of Education shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

(c) DEFINITIONS.—For purposes of this section:

(1) The terms "elementary school", "local educational agency", and "secondary school" have the meanings given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term "eligible local educational agency" means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students to every school nurse.

(3) The term "high-need local educational agency" means a local educational agency—

(A) that serves not fewer than 10,000 children from families with incomes below the poverty line; or

(B) for which not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(4) The term "nurse" means a licensed nurse, as defined under State law.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

SEC. 2552. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

(1) IN GENERAL.—For purposes of this section, the Secretary of Labor shall award wellness grants as determined under this section. Wellness program grants shall be awarded to qualified employers for any plan year in an amount equal to 50 percent of the costs paid or incurred by the employer in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(2) LIMITATION.—The amount of the grant allowed under paragraph (1) for any plan year shall not exceed the sum of—

(A) the product of $200 and the number of employees of the employer not in excess of 200 employees; plus

(B) the product of $100 and the number of employees of the employer in excess of 200 employees.

The wellness grants awarded to an employer under this section shall be for up to 3 years and shall not exceed $50,000.

(b) QUALIFIED WELLNESS PROGRAM.—For purposes of this section:

(1) QUALIFIED WELLNESS PROGRAM.—The term "qualified wellness program" means a program that —

(A) includes any 3 wellness components described in subsection (c); and

(B) is be certified by the Secretary of Labor, in coordination with the Health Choices Commissioner and the Director of the Center for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

(i) is newly established or in existence on the date of enactment of this Act but not yet meeting the requirements of this section;

(ii) is consistent with evidenced-based researched and best practices, as identified by persons with expertise in employer health promotion and wellness programs;

(iii) includes multiple, evidenced-based strategies which are based on the existing and emerging research and careful scientific reviews, including the Guide to Community Preventative Services, the Guide to Clinical Preventative Services, and the National Registry for Effective Programs, and

(iv) includes strategies which focus on prevention and support for employee populations at risk of poor health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretary of Labor, in consultation with other appropriate agencies shall establish procedures for periodic review, evaluation, and update of the programs under this subsection.

(3) HEALTH LITERACY/ACCESSIBILITY.—The Secretary of Labor shall, as part of the certification process: —

(A) ensure that employers make the programs culturally competent. physically and programmatically accessible (including for individuals with

disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with low literacy skills, limited English and from under-served populations; and

(C) require the Secretary of Labor, in consultation with Secretary of Health and Human Services, to compile and disseminate to employer health plans info on model health literacy curricula, instructional programs, and effective intervention strategies.

(c) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees.

(B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow up measures.

(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for the active engagement of employees in worksite wellness programs through worksite assessments and program planning, onsite delivery, evaluation, and improvement efforts.

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which provides for altering employee lifestyles to encourage healthy living through counseling, seminars, on-line programs, or self-help materials which provide technical assistance and problem solving skills. such component may include programs relating to—

(A) tobacco use;
(B) obesity;
(C) stress management;
(D) physical fitness;
(E) nutrition;
(F) substance abuse;
(G) depression; and
(H) mental health promotion (including anxiety).

(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

(A) ON-SITE POLICIES.—Policies and services at the worksite which promote a healthy lifestyle, including policies relating to—

(i) tobacco use at the worksite;

(ii) the nutrition of food available at the worksite through cafeterias and vending options;

(iii) minimizing stress and promoting positive mental health in the workplace; and

(iv) the encouragement of physical activity before, during, and after work hours.

(d) PARTICIPATION REQUIREMENT.—No grant shall be allowed under subsection (a) unless the Secretary of Labor in consultation with other appropriate agencies, certifies, as a part of any certification described in subsection (b), that each wellness program component of the qualified wellness program—

(1) shall be available to all employees of the employer;

(2) shall not mandate participation by employees; and

(3) shall not require participation by individual employees as a condition to obtain a premium discount, rebate, deductible reduction, or other financial reward.

(e) PRIVACY PROTECTIONS.—Any employee health information collected through participation in an employer wellness program shall be confidential and available only to appropriately trained health professions as defined by the Secretary of Labor. Employers or employees of the employer sponsoring a wellness program shall have no access to employee health data. All entities offering employer-sponsored wellness programs shall be considered "business associates" pursuant to the American Reinvestment and Recovery Act and must comply with privacy protections restricting the release of personal medical information.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) QUALIFIED EMPLOYER.—The term "qualified employer" means an employer that offers a qualified health benefits plan to every employee (including each employee required to be offered coverage under a qualified health benefits plan under subtitle B of title III of division A), and meets the health coverage participation requirements as defined in section 312.

(2) CERTAIN COSTS NOT INCLUDED.—Costs paid or incurred by an employer for food or health insurance shall not be taken into account under subsection (a).

(g) OUTREACH.—

(1) IN GENERAL.—The Secretary of the Labor, in conjunction with other appropriate agencies and members of the business community, shall institute an outreach program to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs according to recognized and promising practices and on how to measure the success of implemented programs.

(h) EFFECTIVE DATE.—This section shall take effect on January 1, 2013.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 2553. HEALTH PROFESSIONS TRAINING FOR DIVERSITY PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) is amended by adding at the end the following:

"(f) HEALTH PROFESSIONS TRAINING FOR DIVERSITY PROGRAM.—

"(1) IN GENERAL.—The Secretary shall make available 20 grants of no more than $1,000,000 annually to nonprofit organizations for the purposes of providing workforce development training program for those who are currently employed in the health care workforce.

"(2) ELIGIBILITY.—For the purposes of providing assistance and services under the program established in this subsection, grants are to be awarded to Area Health Education Centers or similar nonprofit organizations involved in the development and implementation of health care workforce development programs and that—

"(A) have a formal affiliation with a hospital or community health center, and institution of higher education as defined by section 101 of the Higher Education Act of 1965;

"(B) have a history of providing program services to minority populations; and

"(C) provide workforce development programs to low-income persons, veterans, or urban and rural underserved communities.".

Subtitle H—Long-term Care and Family Caregiver Support

SEC. 2561. LONG-TERM CARE AND FAMILY CAREGIVER SUPPORT.

(a) AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965.—

(1) PROMOTION OF DIRECT CARE WORKFORCE.—Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by inserting before the semicolon the following: ", and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and assisting States in developing a comprehensive state workforce development plans with respect to such workforce including efforts to systematically assess, track, and report on workforce adequacy and capacity".

(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL.—Section 202 of such Act (42 U.S.C. 3012) is amended by adding at the end the following new subsection:

"(g)(1) The Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel and pilot program to improve working conditions and training for long term care workers, including home health aides, certified nurse aides, and personal care attendants.

"(2) The Panel shall include representatives from—

"(A) relevant health care agencies and facilities (including personal or home care agencies, home health care agencies, nursing homes and residential care facilities);

"(B) the disability community;

"(C) the nursing community;

"(D) direct care workers (which may include unions and national organizations);

"(E) older individuals and family caregivers;

"(F) State and federal health care entities; and

"(G) experts in workforce development and adult learning.

"(3) Within one year after the establishment of the Panel, the Panel shall submit a report to the Assistant Secretary articulating core competencies for eligible personal or home care aides necessary to successfully provide long-term services and supports to eligible consumers, as well as recommended training curricula and resources.

"(4) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 states to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

"(5) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to each House of the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate.".

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1965.—Section 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking "$173,000,000" and all that follows through "2011", and inserting "and $250,000,000 for each of the fiscal years 2010, 2011, and 2012".

(c) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—There is authorized to be appropriated $10,000,000 for each of the fiscal years 2010, 2011, and 2012 for the operation of the National Clearinghouse for Long-Term Care Information established by the Secretary of Health and Human Services under section 6021(d) of Public Law 109-171.

Subtitle I—Online Resources

SEC. 2571. WEB SITE ON HEALTH CARE LABOR MARKET AND RELATED EDUCATIONAL AND TRAINING OPPORTUNITIES.

(a) IN GENERAL.—The Secretary of Labor, in consultation with the National Center for Health Workforce Analysis, shall establish and maintain a Web site to serve as a comprehensive source of information, searchable by workforce region, on the health care labor market and related educational and training opportunities.

(b) CONTENTS.—The Web site maintained under this section shall include the following:

(1) Information on the types of jobs that are currently or are projected to be in high demand in the health care field, including—

(A) salary information; and

(B) training requirements, such as requirements for educational credentials, licensure, or certification.

(2) Information on training and educational opportunities within each region for the type jobs described in paragraph (1), including by—

(A) type of provider or program (such as public, private nonprofit, or private for-profit);

(B) duration;

(C) cost (such as tuition, fees, books, laboratory expenses, and other mandatory costs);

(D) performance outcomes (such as graduation rates, job placement, average salary, job retention, and wage progression);

(E) Federal financial aid participation;

(F) average graduate loan debt;

(G) student loan default rates;

(H) average institutional grant aid provided;

(I) Federal and State accreditation information; and

(J) other information determined by the Secretary.

(3) A mechanism for searching and comparing training and educational options for specific health care occupations to facilitate informed career and education choices.

(4) Financial aid information, including with respect to loan forgiveness, loan cancellation, loan repayment, stipends, scholarships, and grants or other assistance authorized by this Act or other Federal or State programs.

(c) PUBLIC ACCESSIBILITY.—The Web site maintained under this section shall—

(1) be publicly accessible;

(2) be user friendly and convey information in a manner that is easily understandable; and

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2572. ONLINE HEALTH WORKFORCE TRAINING PROGRAMS.

Section 171 of the Workforce Investment Act of 1998 (29 U.S.C. 2916) (as amended by section 2553) is further amended by adding at the end the following:

"(g) ONLINE HEALTH WORKFORCE TRAINING PROGRAM.—

"(1) GRANT PROGRAM.—

"(A) IN GENERAL.—The Secretary shall award National Health Workforce Online Training Grants on a competitive basis to eligible entities to enable such entities to carry out training for individuals to attain or advance in health care occupations. An entity may leverage such grant with other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

"(B) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

"(i) an entity shall be an educational institution, community-based organization, non-profit organization, workforce investment board, or local or county government; and

"(ii) an entity shall provide online workforce training for individuals seeking to attain or advance in health care occupations, including nursing, nursing assistants, dentistry, pharmacy, health care management and administration, public health, health information systems analysis, medical assistants, and other health care practitioner and support occupations.

"(C) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

"(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

"(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

"(iii) conduct training for occupations with national or local shortages.

"(D) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

"(i) the number of participants;

"(ii) the services received by the participants;

"(iii) program completion rates;

"(iv) factors determined as significantly interfering with program participation or completion;

"(v) the rate of job placement; and

"(vi) other information as determined as needed by the Secretary.

"(E) OUTREACH.—Grantees under this paragraph shall conduct outreach activities to disseminate information about their program and results to workforce investment boards, local governments, educational institutions, and other workforce training organizations.

"(F) PERFORMANCE LEVELS.—The Secretary shall establish indicators of performance that will be used to evaluate the performance of grantees under this paragraph in carrying out the activities described in this paragraph. The Secretary shall negotiate and reach agreement with each grantee regarding the levels of performance expected to be achieved by the grantee on the indicators of performance.

"(G) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $50,000,000 for fiscal years 2011 through 2020.

"(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.—

"(A) DESCRIPTION OF GRANT.—The Secretary shall award one grant to an eligible postsecondary educational institution to provide the services described in this paragraph.

"(B) ELIGIBILITY.—To be eligible to receive a grant under this paragraph, a postsecondary educational institution shall—

"(i) have demonstrated the ability to disseminate research on best practices for implementing workforce investment programs; and

"(ii) be a national leader in producing cutting-edge research on technology related to workforce investment systems under subtitle B.

"(C) SERVICES.—The postsecondary educational institution that receives a grant under this paragraph shall use such grant—

"(i) to provide technical assistance to entities that receive grants under paragraph (1);

"(ii) to collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

"(iii) to disseminate the best practices identified by the National Health Workforce Online Training Grant Program to other workforce training organizations.

"(D) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection $1,000,000 for fiscal years 2011 through 2020.".