Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Provisions Relating to Title I

SEC. 10101. AMENDMENTS TO SUBTITLE A.

(a) Section 2711 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

"(a) PROHIBITION.—

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

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

"(B) except as provided in paragraph (2), annual limits on the dollar value of benefits for any participant or beneficiary.

"(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

"(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per ben-

eficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.".

(b) Section 2715(a) of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by striking "and providing to enrollees" and inserting "and providing to applicants, enrollees, and policyholders or certificate holders".

(c) Subpart II of part A of title XXVII of the Public Health Service Act, as added by section 1001(5), is amended by inserting after section 2715, the following:

"SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 1311(e)(3) of the Patient Protection and Affordable Care Act, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.".

(d) Section 2716 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended to read as follows:

"SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS.

"(a) IN GENERAL.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

"(b) RULES AND DEFINITIONS.—For purposes of this section—

"(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

"(2) HIGHLY COMPENSATED INDIVIDUAL.—The term 'highly compensated individual' has the meaning given such term by section 105(h)(5) of such Code.".

(e) Section 2717 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b), the following:

"(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

"(1) WELLNESS AND PREVENTION PROGRAMS.—A wellness and health promotion activity imple-

mented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

"(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

"(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

"(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

"(A) the lawful ownership or possession of a firearm or ammunition;

"(B) the lawful use of a firearm or ammunition; or

"(C) the lawful storage of a firearm or ammunition.

"(3) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain

records of individual ownership or possession of a firearm or ammunition.

"(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

"(A) the lawful ownership or possession of a firearm or ammunition; or

"(B) the lawful use or storage of a firearm or ammunition.

"(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

"(A) the lawful ownership or possession of a firearm or ammunition; or

"(B) the lawful use, possession, or storage of a firearm or ammunition.".

(f) Section 2718 of the Public Health Service Act, as added by section 1001(5), is amended to read as follows:

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

"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

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

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

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

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

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

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

"(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

"(B) REBATE AMOUNT.—

"(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

"(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

"(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

"(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

"(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

"(3) ENFORCEMENT.—The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

"(c) DEFINITIONS.—Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

"(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

"(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hos-

pital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.".

(g) Section 2719 of the Public Health Service Act, as added by section 1001(4) of this Act, is amended to read as follows:

"SEC. 2719. APPEALS PROCESS.

"(a) INTERNAL CLAIMS APPEALS.—

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

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

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

"(C) allow an enrollee to review their file, to present evidence and testimony as part of the

appeals process, and to receive continued coverage pending the outcome of the appeals process.

"(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

"(A) a group health plan and a health insurance issuer offering group health coverage 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. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

"(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

"(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

"(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

"(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

"(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

"(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

"(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable

process established under subsection (b), as determined appropriate by the Secretary.".

(h) Subpart II of part A of title XVIII of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by inserting after section 2719 the following:

"SEC. 2719A. PATIENT PROTECTIONS.

"(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

"(b) COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

"(A) without the need for any prior authorization determination;

"(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

"(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

"(i) by a nonparticipating health care provider with or without prior authorization; or

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

"(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that

would apply if such services were provided in-network;

"(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

"(2) DEFINITIONS.—In this subsection:

"(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means, with respect to an emergency medical condition—

"(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

"(C) STABILIZE.—The term 'to stabilize', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

"(c) ACCESS TO PEDIATRIC CARE.—

"(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a partici-

pating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

"(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

"(1) GENERAL RIGHTS.—

"(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gyne-

cology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

"(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

"(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

"(A) provides coverage for obstetric or gynecologic care; and

"(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

"(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

"(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

"(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.".

(i) Section 2794 of the Public Health Service Act, as added by section 1003 of this Act, is amended—

(1) in subsection (c)(1)—

(A) in subparagraph (A), by striking "and" at the end;

(B) in subparagraph (B), by striking the period and inserting "; and"; and

(C) by adding at the end the following:

"(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement in-

formation from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public."; and

(2) by adding at the end the following:

"(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

"(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

"(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

"(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

"(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

"(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

"(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

"(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.".

SEC. 10102. AMENDMENTS TO SUBTITLE B.

(a) Section 1102(a)(2)(B) of this Act is amended—

(1) in the matter preceding clause (i), by striking "group health benefits plan" and inserting "group benefits plan providing health benefits"; and

(2) in clause (i)(I), by inserting "or any agency or instrumentality of any of the foregoing" before the closed parenthetical.

(b) Section 1103(a) of this Act is amended—

(1) in paragraph (1), by inserting ", or small business in," after "residents of any"; and

(2) by striking paragraph (2) and inserting the following:

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

"(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

"(i) a single disease or condition; or

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

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

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

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

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

"(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.".

SEC. 10103. AMENDMENTS TO SUBTITLE C.

(a) Section 2701(a)(5) of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting "(other than self-insured group health plans offered in such market)" after "such market".

(b) Section 2708 of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by striking "or individual".

(c) Subpart I of part A of title XXVII of the Public Health Service Act, as added by section 1201(4) of this Act, is amended by inserting after section 2708, the following:

"SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

"(a) COVERAGE.—

"(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

"(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

"(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

"(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

"(2) ROUTINE PATIENT COSTS.—

"(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

"(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

"(i) the investigational item, device, or service, itself;

"(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

"(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

"(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved

clinical trial that is conducted outside the State in which the qualified individual resides.

"(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

"(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

"(2) Either—

"(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

"(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

"(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

"(d) APPROVED CLINICAL TRIAL DEFINED.—

"(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

"(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

"(i) The National Institutes of Health.

"(ii) The Centers for Disease Control and Prevention.

"(iii) The Agency for Health Care Research and Quality.

"(iv) The Centers for Medicare & Medicaid Services.

"(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

"(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

"(vii) Any of the following if the conditions described in paragraph (2) are met:

"(I) The Department of Veterans Affairs.

"(II) The Department of Defense.

"(III) The Department of Energy.

"(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

"(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

"(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or in-

vestigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

"(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

"(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

"(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term 'life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

"(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

"(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated

health insurance plans that is in addition to the policy required under this section.".

(d) Section 1251(a) of this Act is amended—

(1) in paragraph (2), by striking "With" and inserting "Except as provided in paragraph (3), with"; and

(2) by adding at the end the following:

"(3) APPLICATION OF CERTAIN PROVISIONS.—The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.".

(e) Section 1253 of this Act is amended insert before the period the following: ", except that—

"(1) section 1251 shall take effect on the date of enactment of this Act; and

"(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1201), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.".

(f) Subtitle C of title I of this Act is amended—

(1) by redesignating section 1253 as section 1255; and

(2) by inserting after section 1252, the following:

"SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.

"Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses). The Secretary shall submit such reports to the appropriate committees of Congress.

"SEC. 1254. STUDY OF LARGE GROUP MARKET.

"(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the fully-insured and self-insured group health plan markets to—

"(1) compare the characteristics of employers (including industry, size, and other characteristics as determined appropriate by the Secretary), health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and

"(2) determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.

"(b) COLLECTION OF INFORMATION.—In conducting the study under subsection (a), the Secretary, in coordination with the Secretary of Labor, shall collect information and analyze—

"(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

"(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

"(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

"(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the

appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).''.

SEC. 10104. AMENDMENTS TO SUBTITLE D.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

''(2) INCLUSION OF CO–OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO–OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

''(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

''(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums

by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).".

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking "may issue" and inserting "shall issue"; and

(2) by adding at the end the following:

"(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.".

(c) Section 1303 of this Act is amended to read as follows:

"SEC. 1303. SPECIAL RULES.

"(a) STATE OPT-OUT OF ABORTION COVERAGE.—

"(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

"(2) TERMINATION OF OPT OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

"(b) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

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

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

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

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

"(B) ABORTION SERVICES.—

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

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

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

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

following for purposes of paying for such services:

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

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

"(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

"(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

"(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services de-

scribed in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

"(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

"(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

"(C) SEGREGATION OF FUNDS.—

"(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

"(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

"(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

"(D) ACTUARIAL VALUE.—

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

"(ii) CONSIDERATIONS.—In making such estimate, the issuer—

"(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into

account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

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

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

"(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

"(ii) CLARIFICATION.—Nothing in clause (i) shall prohibit the right of an indi-

vidual or health plan to appeal such action in courts of competent jurisdiction.

"(3) RULES RELATING TO NOTICE.—

"(A) NOTICE.—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

"(B) RULES RELATING TO PAYMENTS.—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

"(4) NO DISCRIMINATION ON BASIS OF PROVISION OF ABORTION.—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

"(c) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

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

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

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

"(i) conscience protection;

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

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

"(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights

and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

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

(d) Section 1304 of this Act is amended by adding at the end the following:

"(e) EDUCATED HEALTH CARE CONSUMERS.—The term 'educated health care consumer' means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.".

(e) Section 1311(d) of this Act is amended—

(1) in paragraph (3)(B), by striking clause (ii) and inserting the following:

"(ii) STATE MUST ASSUME COST.—A State shall make payments—

"(I) to an individual enrolled in a qualified health plan offered in such State; or

"(II) on behalf of an individual described in subclause (I) directly to

the qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).''; and

(2) in paragraph (6)(A), by inserting ''educated'' before ''health care''.

(f) Section 1311(e) of this Act is amended—

(1) in paragraph (2), by striking ''may'' in the second sentence and inserting ''shall''; and

(2) by adding at the end the following:

''(3) TRANSPARENCY IN COVERAGE.—

''(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

''(i) Claims payment policies and practices.

''(ii) Periodic financial disclosures.

''(iii) Data on enrollment.

''(iv) Data on disenrollment.

''(v) Data on the number of claims that are denied.

''(vi) Data on rating practices.

"(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

"(viii) Information on enrollee and participant rights under this title.

"(ix) Other information as determined appropriate by the Secretary.

"(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. 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 concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

"(C) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage

that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

"(D) GROUP HEALTH PLANS.—The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).".

(g) Section 1311(g)(1) of this Act is amended—

(1) in subparagraph (C), by striking "; and" and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, commu-

nity outreach, and cultural competency trainings.".

(h) Section 1311(i)(2)((B) of this Act is amended by striking "small business development centers" and inserting "resource partners of the Small Business Administration".

(i) Section 1312 of this Act is amended—

(1) in subsection (a)(1), by inserting "and for which such individual is eligible" before the period;

(2) in subsection (e)—

(A) in paragraph (1), by inserting "and employers" after "enroll individuals"; and

(B) by striking the flush sentence at the end; and

(3) in subsection (f)(1)(A)(ii), by striking the parenthetical.

(j)(1) Subparagraph (B) of section 1313(a)(6) of this Act is hereby deemed null, void, and of no effect.

(2) Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

"(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

"(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

"(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

"(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

"(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.".

(k) Section 1313(b) of this Act is amended—

(1) in paragraph (3), by striking "and" at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following:

"(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and".

(l) Section 1322(b) of this Act is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2), the following:

"(3) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO–OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve re-

quirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.".

(m) Part III of subtitle D of title I of this Act is amended by striking section 1323.

(n) Section 1324(a) of this Act is amended by striking ", a community health" and all that follows through "1333(b)" and inserting ", or a multi-State qualified health plan under section 1334".

(o) Section 1331 of this Act is amended—

(1) in subsection (d)(3)(A)(i), by striking "85" and inserting "95"; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: ", or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status".

(p) Section 1333 of this Act is amended by striking subsection (b).

(q) Part IV of subtitle D of title I of this Act is amended by adding at the end the following:

"SEC. 1334. MULTI-STATE PLANS.

"(a) OVERSIGHT BY THE OFFICE OF PERSONNEL MANAGEMENT.—

"(1) IN GENERAL.—The Director of the Office of Personnel Management (referred to in this section as the 'Director') shall enter into contracts with health insurance issuers (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

"(2) TERMS.—Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act.

"(3) NON-PROFIT ENTITIES.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

"(4) ADMINISTRATION.—The Director shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program under chapter 89 of title 5, United States Code, including (through negotiating with each multi-state plan)—

"(A) a medical loss ratio;

"(B) a profit margin;

"(C) the premiums to be charged; and

"(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

"(5) AUTHORITY TO PROTECT CONSUMERS.—The Director may prohibit the offering of any multi-State health plan that does not meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

"(6) ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this sub-

section, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).

"(7) WITHDRAWAL.—Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

"(b) ELIGIBILITY.—A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

"(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

"(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

"(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

"(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

"(c) REQUIREMENTS FOR MULTI-STATE QUALIFIED HEALTH PLAN.—

"(1) IN GENERAL.—A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

"(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1302;

"(B) the plan meets all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

"(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis

of the rating requirements of part A of title XXVII of the Public Health Service Act; and

"(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

"(2) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

"(3) CREDITS.—

"(A) IN GENERAL.—An individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 and cost sharing assistance under section 1402 in the same manner as an individual who is enrolled in a qualified health plan.

"(B) NO ADDITIONAL FEDERAL COST.—A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified

health plan shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

"(4) STATE MUST ASSUME COST.—A State shall make payments—

"(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

"(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in paragraph (2).

"(5) APPLICATION OF CERTAIN STATE RATING REQUIREMENTS.—With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State's more protective age rating requirements.

"(d) PLANS DEEMED TO BE CERTIFIED.—A multi-State qualified health plan that is offered under a contract

under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A).

"(e) PHASE-IN.—Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if—

"(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

"(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

"(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

"(4) with respect to each subsequent year, such issuer offers the plan in all States.

"(f) APPLICABILITY.—The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.

"(g) CONTINUED SUPPORT FOR FEHBP.—

"(1) MAINTENANCE OF EFFORT.—Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(2) SEPARATE RISK POOL.—Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(3) AUTHORITY TO ESTABLISH SEPARATE ENTITIES.—The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(4) EFFECTIVE OVERSIGHT.—The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

"(5) ASSURANCE OF SEPARATE PROGRAM.—In carrying out this section, the Director shall ensure that the program under this section is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

"(6) FEHBP PLANS NOT REQUIRED TO PARTICIPATE.—Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, also offer a multi-State qualified health plan under this section.

"(h) ADVISORY BOARD.—The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

"(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.".

(r) Section 1341 of this Act is amended—

*(1) in the section heading, by striking "**AND SMALL GROUP MARKETS**" and inserting "**MARKET**";*

(2) in subsection (b)(2)(B), by striking "paragraph (1)(A)" and inserting "paragraph (1)(B)"; and

(3) in subsection (c)(1)(A), by striking "and small group markets" and inserting "market".

SEC. 10105. AMENDMENTS TO SUBTITLE E.

(a) Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking "is in excess of" and inserting "equals or exceeds".

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting "equals or" before "exceeds".

(c) Section 36B(c)(2)(C)(iv) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking "subsection (b)(3)(A)(ii)" and inserting "subsection (b)(3)(A)(iii)".

(d) Section 1401(d) of this Act is amended by adding at the end the following:

"(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting '36B,' after '36A,'.".

(e)(1) Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended to read as follows:

"(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2)—

"(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is $25,000.

"(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.".

(2) Subsection (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by striking "2011" both places it appears and inserting "2010, 2011".

(3) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1) of this Act, is amended by striking "2011" and inserting "2010, 2011".

(4) Section 1421(f) of this Act is amended by striking "2010" both places it appears and inserting "2009".

(5) The amendments made by this subsection shall take effect as if included in the enactment of section 1421 of this Act.

(f) Part I of subtitle E of title I of this Act is amended by adding at the end of subpart B, the following:

"SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICATION OF FPL.

"(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by 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 Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

"(b) INCLUSION OF TERRITORIES.—

"(1) IN GENERAL.—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention

is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care.

"(2) TERRITORIES DEFINED.—In this subsection, the term 'territories of the United States' includes the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and any other territory or possession of the United States.".

SEC. 10106. AMENDMENTS TO SUBTITLE F.

(a) Section 1501(a)(2) of this Act is amended to read as follows:

"(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

"(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which in-

creases financial risks to households and medical providers.

"(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

"(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

"(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Ameri-

cans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

"(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

"(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

"(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage,

the requirement, together with the other provisions of this Act, will improve financial security for families.

"(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

"(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in

which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

"(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.".

(b)(1) Section 5000A(b)(1) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

"(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer

a penalty with respect to such failures in the amount determined under subsection (c).".

(2) Paragraphs (1) and (2) of section 5000A(c) of the Internal Revenue Code of 1986, as so added, are amended to read as follows:

"(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

"(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

"(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

"(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection

(b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

"(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

"(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

"(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the taxpayer's household income for the taxable year:

"(i) 0.5 percent for taxable years beginning in 2014.

"(ii) 1.0 percent for taxable years beginning in 2015.

"(iii) 2.0 percent for taxable years beginning after 2015.".

(3) Section 5000A(c)(3) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended by striking "$350" and inserting "$495".

(c) Section 5000A(d)(2)(A) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

"(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

"(ii) an adherent of established tenets or teachings of such sect or division as described in such section.".

(d) Section 5000A(e)(1)(C) of the Internal Revenue Code of 1986, as added by section 1501(b) of this Act, is amended to read as follows:

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph

(A) shall be made by reference to required contribution of the employee.".

(e) Section 4980H(b) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended to read as follows:

"(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 60 DAYS.—

"(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment of $600 for each full-time employee of the employer to whom the extended waiting period applies.

"(2) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 60 days.".

(f)(1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting ", with respect to any month," after "means".

(2) Section 4980H(d)(2) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by adding at the end the following:

"(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

"(i) subparagraph (A) shall be applied by substituting 'who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceed $250,000 for such preceding calendar year' for 'who employed an average of at least 50 full-time employees on business days during the preceding calendar year', and

"(ii) subparagraph (B) shall be applied by substituting '5' for '50'.".

(3) The amendment made by paragraph (2) shall apply to months beginning after December 31, 2013.

(g) Section 6056(b) of the Internal Revenue Code of 1986, as added by section 1514(a) of the Act, is amended by adding at the end the following new flush sentence:

"The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer's share under paragraph (2)(C)(iv).".

SEC. 10107. AMENDMENTS TO SUBTITLE G.

(a) Section 1562 of this Act is amended, in the amendment made by subsection (a)(2)(B)(iii), by striking "subpart 1" and inserting "subparts I and II"; and

(b) Subtitle G of title I of this Act is amended—

(1) by redesignating section 1562 (as amended) as section 1563; and

(2) by inserting after section 1561 the following:

"SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL OF COVERAGE AND ENROLLMENT BY HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

"(a) IN GENERAL.—The Comptroller General of the United States (referred to in this section as the 'Comptroller General') shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

"(b) DATA.—

"(1) IN GENERAL.—In conducting the study described in subsection (a), the Comptroller General shall consider samples of data concerning the following:

"(A)(i) denials of coverage for medical services to a plan enrollees, by the types of services for which such coverage was denied; and

"(ii) the reasons such coverage was denied; and

"(B)(i) incidents in which group health plans and health insurance issuers deny the application of an individual to enroll in a health insurance plan offered by such group health plan or issuer; and

"(ii) the reasons such applications are denied.

"(2) SCOPE OF DATA.—

"(A) FAVORABLY RESOLVED DISPUTES.—The data that the Comptroller General considers under paragraph (1) shall include data concerning denials of coverage for medical services and denials of applications for enrollment in a plan by a group health plan or health insurance issuer, where such group health plan or health

insurance issuer later approves such coverage or application.

"(B) ALL HEALTH PLANS.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

"(c) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General shall submit to the Secretaries of Health and Human Services and Labor a report describing the results of the study conducted under this section.

"(d) PUBLICATION OF REPORT.—The Secretaries of Health and Human Services and Labor shall make the report described in subsection (c) available to the public on an Internet website.

"SEC. 1563. SMALL BUSINESS PROCUREMENT.

"Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract

awarded under any program or other authority under this Act or an amendment made by this Act.''.

SEC. 10108. FREE CHOICE VOUCHERS.

(a) IN GENERAL.—An offering employer shall provide free choice vouchers to each qualified employee of such employer.

(b) OFFERING EMPLOYER.—For purposes of this section, the term ''offering employer'' means any employer who—

(1) offers minimum essential coverage to its employees consisting of coverage through an eligible employer-sponsored plan; and

(2) pays any portion of the costs of such plan.

(c) QUALIFIED EMPLOYEE.—For purposes of this section—

(1) IN GENERAL.—The term ''qualified employee'' means, with respect to any plan year of an offering employer, any employee—

(A) whose required contribution (as determined under section 5000A(e)(1)(B)) for minimum essential coverage through an eligible employer-sponsored plan—

(i) exceeds 8 percent of such employee's household income for the taxable year de-

scribed in section 1412(b)(1)(B) which ends with or within in the plan year; and

(ii) does not exceed 9.8 percent of such employee's household income for such taxable year;

(B) whose household income for such taxable year is not greater than 400 percent of the poverty line for a family of the size involved; and

(C) who does not participate in a health plan offered by the offering employer.

(2) INDEXING.—In the case of any calendar year beginning after 2014, the Secretary shall adjust the 8 percent under paragraph (1)(A)(i) and 9.8 percent under paragraph (1)(A)(ii) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(d) FREE CHOICE VOUCHER.—

(1) AMOUNT.—

(A) IN GENERAL.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect

to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

(B) DETERMINATION OF COST.—The cost of any health plan shall be determined under the rules similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

(2) USE OF VOUCHERS.—An Exchange shall credit the amount of any free choice voucher provided under subsection (a) to the monthly premium of any qualified health plan in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

(3) PAYMENT OF EXCESS AMOUNTS.—If the amount of the free choice voucher exceeds the amount of the premium of the qualified health plan in which

the qualified employee is enrolled for such month, such excess shall be paid to the employee.

(e) OTHER DEFINITIONS.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

"SEC. 139D. FREE CHOICE VOUCHERS.

"Gross income shall not include the amount of any free choice voucher provided by an employer under section 10108 of the Patient Protection and Affordable Care Act to the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.".

(2) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139C the following new item:

"Sec. 139D. Free choice vouchers.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(g) DEDUCTION ALLOWED TO EMPLOYER.—

(1) IN GENERAL.—Section 162(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: "For purposes of paragraph (1), the amount of a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act shall be treated as an amount for compensation for personal services actually rendered.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to vouchers provided after December 31, 2013.

(h) VOUCHER TAKEN INTO ACCOUNT IN DETERMINING PREMIUM CREDIT.—

(1) IN GENERAL.—Subsection (c)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following new subparagraph:

"(D) EXCEPTION FOR INDIVIDUAL RECEIVING FREE CHOICE VOUCHERS.—The term 'coverage month' shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2013.

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.".

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

(2) NOTIFICATION REQUIREMENT.—Section 18B(a)(3) of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting "and the employer does not offer a free choice voucher" after "Exchange"; and

(B) by striking "will lose" and inserting "may lose".

(j) EMPLOYER REPORTING.—

(1) IN GENERAL.—Subsection (a) of section 6056 of the Internal Revenue Code of 1986, as added by section 1514, is amended by inserting "and every offering employer" before "shall".

(2) OFFERING EMPLOYERS.—Subsection (f) of section 6056 of such Code, as added by section 1514, is amended to read as follows:

"(f) DEFINITIONS.—For purposes of this section—

"(1) OFFERING EMPLOYER.—

"(A) IN GENERAL.—The term 'offering employer' means any offering employer (as defined in section 10108(b) of the Patient Protection and Affordable Care Act) if the required contribution (within the meaning of section 5000A(e)(1)(B)(i)) of any employee exceeds 8 percent of the wages (as defined in section 3121(a)) paid to such employee by such employer.

"(B) INDEXING.—In the case of any calendar year beginning after 2014, the 8 percent under subparagraph (A) shall be adjusted for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) OTHER DEFINITIONS.—Any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.".

(3) CONFORMING AMENDMENTS.—

*(A) The heading of section 6056 of such Code, as added by section 1514, is amended by striking "**LARGE**" and inserting "**CERTAIN**".*

(B) Section 6056(b)(2)(C) of such Code is amended—

(i) by inserting "in the case of an applicable large employer," before "the length" in clause (i);

(ii) by striking "and" at the end of clause (iii);

(iii) by striking "applicable large employer" in clause (iv) and inserting "employer";

(iv) by inserting "and" at the end of clause (iv); and

(v) by inserting at the end the following new clause:

"(v) in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under such option,".

(C) Section 6056(d)(2) of such Code is amended by inserting "or offering employer" after "applicable large employer".

(D) Section 6056(e) of such Code is amended by inserting "or offering employer" after "applicable large employer".

(E) Section 6724(d)(1)(B)(xxv) of such Code, as added by section 1514, is amended by striking "large" and inserting "certain".

(F) Section 6724(d)(2)(HH) of such Code, as added by section 1514, is amended by striking "large" and inserting "certain".

(G) The table of sections for subpart D of part III of subchapter A of chapter 1 of such Code, as amended by section 1514, is amended

by striking "Large employers" in the item relating to section 6056 and inserting "Certain employers".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to periods beginning after December 31, 2013.

SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

(1) DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—Section 1173(a) of the Social Security Act (42 U.S.C. 1320d–2(a)), as amended by section 1104(b)(2), is amended—

(A) in paragraph (1)(B), by inserting before the period the following: ", and subject to the requirements under paragraph (5)"; and

(B) by adding at the end the following new paragraph:

"(5) CONSIDERATION OF STANDARDIZATION OF ACTIVITIES AND ITEMS.—

"(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall solicit, not later than January 1, 2012, and not

less than every 3 years thereafter, input from entities described in subparagraph (B) on—

"(i) whether there could be greater uniformity in financial and administrative activities and items, as determined appropriate by the Secretary; and

"(ii) whether such activities should be considered financial and administrative transactions (as described in paragraph (1)(B)) for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative costs.

"(B) SOLICITATION OF INPUT.—For purposes of subparagraph (A), the Secretary shall seek input from—

"(i) the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee; and

"(ii) standard setting organizations and stakeholders, as determined appropriate by the Secretary.".

(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDERATION.—For purposes of section 1173(a)(5) of the Social Security Act, as added by subsection (a), the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall, not later than January 1, 2012, seek input on activities and items relating to the following areas:

(1) Whether the application process, including the use of a uniform application form, for enrollment of health care providers by health plans could be made electronic and standardized.

(2) Whether standards and operating rules described in section 1173 of the Social Security Act should apply to the health care transactions of automobile insurance, worker's compensation, and other programs or persons not described in section 1172(a) of such Act (42 U.S.C. 1320d–1(a)).

(3) Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies (including State auditors, the Office of the Inspector General of the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services), and other relevant entities as determined appropriate by the Secretary.

(4) Whether there could be greater transparency and consistency of methodologies and processes used to establish claim edits used by health plans (as described in section 1171(5) of the Social Security Act (42 U.S.C. 1320d(5))).

(5) Whether health plans should be required to publish their timeliness of payment rules.

(c) ICD CODING CROSSWALKS.—

(1) ICD–9 TO ICD–10 CROSSWALK.—The Secretary shall task the ICD–9–CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care providers, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD–9 and ICD–10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

(2) REVISION OF CROSSWALK.—For purposes of the crosswalk described in paragraph (1), the Secretary shall make appropriate revisions and post any such revised crosswalk on the website of the Centers for Medicare & Medicaid Services.

(3) USE OF REVISED CROSSWALK.—For purposes of paragraph (2), any revised crosswalk shall be treated as a code set for which a standard has been adopted by the Secretary for purposes of section 1173(c)(1)(B) of the Social Security Act (42 U.S.C. 1320d–2(c)(1)(B)).

(4) SUBSEQUENT CROSSWALKS.—For subsequent revisions of the International Classification of Diseases that are adopted by the Secretary as a standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)), the Secretary shall, after consultation with the appropriate stakeholders, post on the website of the Centers for Medicare & Medicaid Services a crosswalk between the previous and subsequent version of the International Classification of Diseases not later than the date of implementation of such subsequent revision.

Subtitle B—Provisions Relating to Title II

PART I—MEDICAID AND CHIP

SEC. 10201. AMENDMENTS TO THE SOCIAL SECURITY ACT AND TITLE II OF THIS ACT.

(a)(1) Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as added by section 2004(a), is amended to read as follows: