

1 **TITLE IX—REVENUE**
2 **PROVISIONS**
3 **Subtitle A—Revenue Offset**
4 **Provisions**

5 **SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPON-**
6 **SORED HEALTH COVERAGE.**

7 (a) *IN GENERAL.*—Chapter 43 of the Internal Revenue
8 Code of 1986, as amended by section 1513, is amended by
9 adding at the end the following:

10 **“SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPON-**
11 **SORED HEALTH COVERAGE.**

12 “(a) *IMPOSITION OF TAX.*—If—

13 “(1) *an employee is covered under any applica-*
14 *ble employer-sponsored coverage of an employer at*
15 *any time during a taxable period, and*

16 “(2) *there is any excess benefit with respect to*
17 *the coverage,*

18 *there is hereby imposed a tax equal to 40 percent of the*
19 *excess benefit.*

20 “(b) *EXCESS BENEFIT.*—*For purposes of this sec-*
21 *tion—*

22 “(1) *IN GENERAL.*—*The term ‘excess benefit’*
23 *means, with respect to any applicable employer-spon-*
24 *sored coverage made available by an employer to an*
25 *employee during any taxable period, the sum of the*

1 *excess amounts determined under paragraph (2) for*
2 *months during the taxable period.*

3 “(2) *MONTHLY EXCESS AMOUNT.*—*The excess*
4 *amount determined under this paragraph for any*
5 *month is the excess (if any) of—*

6 “(A) *the aggregate cost of the applicable em-*
7 *ployer-sponsored coverage of the employee for the*
8 *month, over*

9 “(B) *an amount equal to $\frac{1}{12}$ of the annual*
10 *limitation under paragraph (3) for the calendar*
11 *year in which the month occurs.*

12 “(3) *ANNUAL LIMITATION.*—*For purposes of this*
13 *subsection—*

14 “(A) *IN GENERAL.*—*The annual limitation*
15 *under this paragraph for any calendar year is*
16 *the dollar limit determined under subparagraph*
17 *(C) for the calendar year.*

18 “(B) *APPLICABLE ANNUAL LIMITATION.*—
19 *The annual limitation which applies for any*
20 *month shall be determined on the basis of the*
21 *type of coverage (as determined under subsection*
22 *(f)(1)) provided to the employee by the employer*
23 *as of the beginning of the month.*

24 “(C) *APPLICABLE DOLLAR LIMIT.*—*Except*
25 *as provided in subparagraph (D)—*

1 “(i) 2013.—*In the case of 2013, the*
2 *dollar limit under this subparagraph is—*

3 “(I) *in the case of an employee*
4 *with self-only coverage, \$8,500, and*

5 “(II) *in the case of an employee*
6 *with coverage other than self-only cov-*
7 *erage, \$23,000.*

8 “(ii) *EXCEPTION FOR CERTAIN INDI-*
9 *VIDUALS.—In the case of an individual who*
10 *is a qualified retiree or who participates in*
11 *a plan sponsored by an employer the major-*
12 *ity of whose employees are engaged in a*
13 *high-risk profession or employed to repair*
14 *or install electrical or telecommunications*
15 *lines—*

16 “(I) *the dollar amount in clause*
17 *(i)(I) (determined after the application*
18 *of subparagraph (D)) shall be in-*
19 *creased by \$1,350, and*

20 “(II) *the dollar amount in clause*
21 *(i)(II) (determined after the applica-*
22 *tion of subparagraph (D)) shall be in-*
23 *creased by \$3,000.*

24 “(iii) *SUBSEQUENT YEARS.—In the*
25 *case of any calendar year after 2013, each*

1 *of the dollar amounts under clauses (i) and*
2 *(ii) shall be increased to the amount equal*
3 *to such amount as in effect for the calendar*
4 *year preceding such year, increased by an*
5 *amount equal to the product of—*

6 *“(I) such amount as so in effect,*
7 *multiplied by*

8 *“(II) the cost-of-living adjustment*
9 *determined under section 1(f)(3) for*
10 *such year (determined by substituting*
11 *the calendar year that is 2 years before*
12 *such year for ‘1992’ in subparagraph*
13 *(B) thereof), increased by 1 percentage*
14 *point.*

15 *If any amount determined under this clause*
16 *is not a multiple of \$50, such amount shall*
17 *be rounded to the nearest multiple of \$50.*

18 *“(D) TRANSITION RULE FOR STATES WITH*
19 *HIGHEST COVERAGE COSTS.—*

20 *“(i) IN GENERAL.—If an employee is a*
21 *resident of a high cost State on the first day*
22 *of any month beginning in 2013, 2014, or*
23 *2015, the annual limitation under this*
24 *paragraph for such month with respect to*
25 *such employee shall be an amount equal to*

1 *the applicable percentage of the annual lim-*
2 *itation (determined without regard to this*
3 *subparagraph or subparagraph (C)(ii)).*

4 “(ii) *APPLICABLE PERCENTAGE.*—*The*
5 *applicable percentage is 120 percent for*
6 *2013, 110 percent for 2014, and 105 percent*
7 *for 2015.*

8 “(iii) *HIGH COST STATE.*—*The term*
9 *‘high cost State’ means each of the 17 States*
10 *which the Secretary of Health and Human*
11 *Services, in consultation with the Secretary,*
12 *estimates had the highest average cost dur-*
13 *ing 2012 for employer-sponsored coverage*
14 *under health plans. The Secretary’s estimate*
15 *shall be made on the basis of aggregate pre-*
16 *miums paid in the State for such health*
17 *plans, determined using the most recent*
18 *data available as of August 31, 2012.*

19 “(c) *LIABILITY TO PAY TAX.*—

20 “(1) *IN GENERAL.*—*Each coverage provider shall*
21 *pay the tax imposed by subsection (a) on its applica-*
22 *ble share of the excess benefit with respect to an em-*
23 *ployee for any taxable period.*

1 “(2) *COVERAGE PROVIDER.*—For purposes of this
2 subsection, the term ‘coverage provider’ means each of
3 the following:

4 “(A) *HEALTH INSURANCE COVERAGE.*—If
5 the applicable employer-sponsored coverage con-
6 sists of coverage under a group health plan
7 which provides health insurance coverage, the
8 health insurance issuer.

9 “(B) *HSA AND MSA CONTRIBUTIONS.*—If
10 the applicable employer-sponsored coverage con-
11 sists of coverage under an arrangement under
12 which the employer makes contributions de-
13 scribed in subsection (b) or (d) of section 106, the
14 employer.

15 “(C) *OTHER COVERAGE.*—In the case of any
16 other applicable employer-sponsored coverage, the
17 person that administers the plan benefits.

18 “(3) *APPLICABLE SHARE.*—For purposes of this
19 subsection, a coverage provider’s applicable share of
20 an excess benefit for any taxable period is the amount
21 which bears the same ratio to the amount of such ex-
22 cess benefit as—

23 “(A) the cost of the applicable employer-
24 sponsored coverage provided by the provider to
25 the employee during such period, bears to

1 “(B) *the aggregate cost of all applicable em-*
2 *ployer-sponsored coverage provided to the em-*
3 *ployee by all coverage providers during such pe-*
4 *riod.*

5 “(4) *RESPONSIBILITY TO CALCULATE TAX AND*
6 *APPLICABLE SHARES.—*

7 “(A) *IN GENERAL.—Each employer shall—*

8 “(i) *calculate for each taxable period*
9 *the amount of the excess benefit subject to*
10 *the tax imposed by subsection (a) and the*
11 *applicable share of such excess benefit for*
12 *each coverage provider, and*

13 “(ii) *notify, at such time and in such*
14 *manner as the Secretary may prescribe, the*
15 *Secretary and each coverage provider of the*
16 *amount so determined for the provider.*

17 “(B) *SPECIAL RULE FOR MULTIEMPLOYER*
18 *PLANS.—In the case of applicable employer-spon-*
19 *sored coverage made available to employees*
20 *through a multiemployer plan (as defined in sec-*
21 *tion 414(f)), the plan sponsor shall make the cal-*
22 *culations, and provide the notice, required under*
23 *subparagraph (A).*

24 “(d) *APPLICABLE EMPLOYER-SPONSORED COVERAGE;*
25 *COST.—For purposes of this section—*

1 “(1) *APPLICABLE EMPLOYER-SPONSORED COV-*
2 *ERAGE.*—

3 “(A) *IN GENERAL.*—*The term ‘applicable*
4 *employer-sponsored coverage’ means, with respect*
5 *to any employee, coverage under any group*
6 *health plan made available to the employee by*
7 *an employer which is excludable from the em-*
8 *ployee’s gross income under section 106, or*
9 *would be so excludable if it were employer-pro-*
10 *vided coverage (within the meaning of such sec-*
11 *tion 106).*

12 “(B) *EXCEPTIONS.*—*The term ‘applicable*
13 *employer-sponsored coverage’ shall not include—*

14 “(i) *any coverage (whether through in-*
15 *surance or otherwise) described in section*
16 *9832(c)(1)(A) or for long-term care, or*

17 “(ii) *any coverage described in section*
18 *9832(c)(3) the payment for which is not ex-*
19 *cludable from gross income and for which a*
20 *deduction under section 162(l) is not allow-*
21 *able.*

22 “(C) *COVERAGE INCLUDES EMPLOYEE PAID*
23 *PORTION.*—*Coverage shall be treated as applica-*
24 *ble employer-sponsored coverage without regard*

1 to whether the employer or employee pays for the
2 coverage.

3 “(D) *SELF-EMPLOYED INDIVIDUAL.*—In the
4 case of an individual who is an employee within
5 the meaning of section 401(c)(1), coverage under
6 any group health plan providing health insur-
7 ance coverage shall be treated as applicable em-
8 ployer-sponsored coverage if a deduction is al-
9 lowable under section 162(l) with respect to all
10 or any portion of the cost of the coverage.

11 “(E) *GOVERNMENTAL PLANS INCLUDED.*—
12 Applicable employer-sponsored coverage shall in-
13 clude coverage under any group health plan es-
14 tablished and maintained primarily for its civil-
15 ian employees by the Government of the United
16 States, by the government of any State or polit-
17 ical subdivision thereof, or by any agency or in-
18 strumentality of any such government.

19 “(2) *DETERMINATION OF COST.*—

20 “(A) *IN GENERAL.*—The cost of applicable
21 employer-sponsored coverage shall be determined
22 under rules similar to the rules of section
23 4980B(f)(4), except that in determining such
24 cost, any portion of the cost of such coverage
25 which is attributable to the tax imposed under

1 *this section shall not be taken into account and*
2 *the amount of such cost shall be calculated sepa-*
3 *rately for self-only coverage and other coverage.*
4 *In the case of applicable employer-sponsored cov-*
5 *erage which provides coverage to retired employ-*
6 *ees, the plan may elect to treat a retired em-*
7 *ployee who has not attained the age of 65 and*
8 *a retired employee who has attained the age of*
9 *65 as similarly situated beneficiaries.*

10 *“(B) HEALTH FSAS.—In the case of appli-*
11 *cable employer-sponsored coverage consisting of*
12 *coverage under a flexible spending arrangement*
13 *(as defined in section 106(c)(2)), the cost of the*
14 *coverage shall be equal to the sum of—*

15 *“(i) the amount of employer contribu-*
16 *tions under any salary reduction election*
17 *under the arrangement, plus*

18 *“(ii) the amount determined under*
19 *subparagraph (A) with respect to any reim-*
20 *bursement under the arrangement in excess*
21 *of the contributions described in clause (i).*

22 *“(C) ARCHER MSAS AND HSAS.—In the case*
23 *of applicable employer-sponsored coverage con-*
24 *sisting of coverage under an arrangement under*
25 *which the employer makes contributions de-*

1 *scribed in subsection (b) or (d) of section 106, the*
2 *cost of the coverage shall be equal to the amount*
3 *of employer contributions under the arrange-*
4 *ment.*

5 “(D) *ALLOCATION ON A MONTHLY BASIS.—*
6 *If cost is determined on other than a monthly*
7 *basis, the cost shall be allocated to months in a*
8 *taxable period on such basis as the Secretary*
9 *may prescribe.*

10 “(e) *PENALTY FOR FAILURE TO PROPERLY CAL-*
11 *CULATE EXCESS BENEFIT.—*

12 “(1) *IN GENERAL.—If, for any taxable period,*
13 *the tax imposed by subsection (a) exceeds the tax de-*
14 *termined under such subsection with respect to the*
15 *total excess benefit calculated by the employer or plan*
16 *sponsor under subsection (c)(4)—*

17 “(A) *each coverage provider shall pay the*
18 *tax on its applicable share (determined in the*
19 *same manner as under subsection (c)(4)) of the*
20 *excess, but no penalty shall be imposed on the*
21 *provider with respect to such amount, and*

22 “(B) *the employer or plan sponsor shall, in*
23 *addition to any tax imposed by subsection (a),*
24 *pay a penalty in an amount equal to such ex-*
25 *cess, plus interest at the underpayment rate de-*

1 *terminated under section 6621 for the period be-*
2 *ginning on the due date for the payment of tax*
3 *imposed by subsection (a) to which the excess re-*
4 *lates and ending on the date of payment of the*
5 *penalty.*

6 “(2) *LIMITATIONS ON PENALTY.—*

7 “(A) *PENALTY NOT TO APPLY WHERE FAIL-*
8 *URE NOT DISCOVERED EXERCISING REASONABLE*
9 *DILIGENCE.—No penalty shall be imposed by*
10 *paragraph (1)(B) on any failure to properly cal-*
11 *culate the excess benefit during any period for*
12 *which it is established to the satisfaction of the*
13 *Secretary that the employer or plan sponsor nei-*
14 *ther knew, nor exercising reasonable diligence*
15 *would have known, that such failure existed.*

16 “(B) *PENALTY NOT TO APPLY TO FAILURES*
17 *CORRECTED WITHIN 30 DAYS.—No penalty shall*
18 *be imposed by paragraph (1)(B) on any such*
19 *failure if—*

20 “(i) *such failure was due to reasonable*
21 *cause and not to willful neglect, and*

22 “(ii) *such failure is corrected during*
23 *the 30-day period beginning on the 1st date*
24 *that the employer knew, or exercising rea-*

1 *sonable diligence would have known, that*
2 *such failure existed.*

3 “(C) *WAIVER BY SECRETARY.*—*In the case*
4 *of any such failure which is due to reasonable*
5 *cause and not to willful neglect, the Secretary*
6 *may waive part or all of the penalty imposed by*
7 *paragraph (1), to the extent that the payment of*
8 *such penalty would be excessive or otherwise in-*
9 *equitable relative to the failure involved.*

10 “(f) *OTHER DEFINITIONS AND SPECIAL RULES.*—*For*
11 *purposes of this section—*

12 “(1) *COVERAGE DETERMINATIONS.*—

13 “(A) *IN GENERAL.*—*Except as provided in*
14 *subparagraph (B), an employee shall be treated*
15 *as having self-only coverage with respect to any*
16 *applicable employer-sponsored coverage of an*
17 *employer.*

18 “(B) *MINIMUM ESSENTIAL COVERAGE.*—*An*
19 *employee shall be treated as having coverage*
20 *other than self-only coverage only if the employee*
21 *is enrolled in coverage other than self-only cov-*
22 *erage in a group health plan which provides*
23 *minimum essential coverage (as defined in sec-*
24 *tion 5000A(f)) to the employee and at least one*
25 *other beneficiary, and the benefits provided*

1 *under such minimum essential coverage do not*
2 *vary based on whether any individual covered*
3 *under such coverage is the employee or another*
4 *beneficiary.*

5 “(2) *QUALIFIED RETIREE.*—*The term ‘qualified*
6 *retiree’ means any individual who—*

7 “(A) *is receiving coverage by reason of*
8 *being a retiree,*

9 “(B) *has attained age 55, and*

10 “(C) *is not entitled to benefits or eligible for*
11 *enrollment under the Medicare program under*
12 *title XVIII of the Social Security Act.*

13 “(3) *EMPLOYEES ENGAGED IN HIGH-RISK PRO-*
14 *FESSION.*—*The term ‘employees engaged in a high-*
15 *risk profession’ means law enforcement officers (as*
16 *such term is defined in section 1204 of the Omnibus*
17 *Crime Control and Safe Streets Act of 1968), employ-*
18 *ees in fire protection activities (as such term is de-*
19 *fined in section 3(y) of the Fair Labor Standards Act*
20 *of 1938), individuals who provide out-of-hospital*
21 *emergency medical care (including emergency medical*
22 *technicians, paramedics, and first-responders), and*
23 *individuals engaged in the construction, mining, ag-*
24 *riculture (not including food processing), forestry,*
25 *and fishing industries. Such term includes an em-*

1 *ployee who is retired from a high-risk profession de-*
2 *scribed in the preceding sentence, if such employee*
3 *satisfied the requirements of such sentence for a pe-*
4 *riod of not less than 20 years during the employee's*
5 *employment.*

6 “(4) *GROUP HEALTH PLAN.*—*The term ‘group*
7 *health plan’ has the meaning given such term by sec-*
8 *tion 5000(b)(1).*

9 “(5) *HEALTH INSURANCE COVERAGE; HEALTH*
10 *INSURANCE ISSUER.*—

11 “(A) *HEALTH INSURANCE COVERAGE.*—*The*
12 *term ‘health insurance coverage’ has the meaning*
13 *given such term by section 9832(b)(1) (applied*
14 *without regard to subparagraph (B) thereof, ex-*
15 *cept as provided by the Secretary in regula-*
16 *tions).*

17 “(B) *HEALTH INSURANCE ISSUER.*—*The*
18 *term ‘health insurance issuer’ has the meaning*
19 *given such term by section 9832(b)(2).*

20 “(6) *PERSON THAT ADMINISTERS THE PLAN*
21 *BENEFITS.*—*The term ‘person that administers the*
22 *plan benefits’ shall include the plan sponsor if the*
23 *plan sponsor administers benefits under the plan.*

24 “(7) *PLAN SPONSOR.*—*The term ‘plan sponsor’*
25 *has the meaning given such term in section 3(16)(B)*

1 *of the Employee Retirement Income Security Act of*
2 *1974.*

3 “(8) *TAXABLE PERIOD.*—*The term ‘taxable pe-*
4 *riod’ means the calendar year or such shorter period*
5 *as the Secretary may prescribe. The Secretary may*
6 *have different taxable periods for employers of vary-*
7 *ing sizes.*

8 “(9) *AGGREGATION RULES.*—*All employers treat-*
9 *ed as a single employer under subsection (b), (c), (m),*
10 *or (o) of section 414 shall be treated as a single em-*
11 *ployer.*

12 “(10) *DENIAL OF DEDUCTION.*—*For denial of a*
13 *deduction for the tax imposed by this section, see sec-*
14 *tion 275(a)(6).*

15 “(g) *REGULATIONS.*—*The Secretary shall prescribe*
16 *such regulations as may be necessary to carry out this sec-*
17 *tion.”.*

18 “(b) *CLERICAL AMENDMENT.*—*The table of sections for*
19 *chapter 43 of such Code, as amended by section 1513, is*
20 *amended by adding at the end the following new item:*

“Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.”.

21 “(c) *EFFECTIVE DATE.*—*The amendments made by this*
22 *section shall apply to taxable years beginning after Decem-*
23 *ber 31, 2012.*

1 **SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED**
2 **HEALTH COVERAGE ON W-2.**

3 (a) *IN GENERAL.*—Section 6051(a) of the Internal
4 Revenue Code of 1986 (relating to receipts for employees)
5 is amended by striking “and” at the end of paragraph (12),
6 by striking the period at the end of paragraph (13) and
7 inserting “, and”, and by adding after paragraph (13) the
8 following new paragraph:

9 “(14) the aggregate cost (determined under rules
10 similar to the rules of section 4980B(f)(4)) of applica-
11 ble employer-sponsored coverage (as defined in section
12 4980I(d)(1)), except that this paragraph shall not
13 apply to—

14 “(A) coverage to which paragraphs (11) and
15 (12) apply, or

16 “(B) the amount of any salary reduction
17 contributions to a flexible spending arrangement
18 (within the meaning of section 125).”.

19 (b) *EFFECTIVE DATE.*—The amendments made by this
20 section shall apply to taxable years beginning after Decem-
21 ber 31, 2010.

22 **SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY**
23 **IF FOR PRESCRIBED DRUG OR INSULIN.**

24 (a) *HSAs.*—Subparagraph (A) of section 223(d)(2) of
25 the Internal Revenue Code of 1986 is amended by adding
26 at the end the following: “Such term shall include an

1 *amount paid for medicine or a drug only if such medicine*
2 *or drug is a prescribed drug (determined without regard*
3 *to whether such drug is available without a prescription)*
4 *or is insulin.”.*

5 (b) *ARCHER MSAS.—Subparagraph (A) of section*
6 *220(d)(2) of the Internal Revenue Code of 1986 is amended*
7 *by adding at the end the following: “Such term shall include*
8 *an amount paid for medicine or a drug only if such medi-*
9 *cine or drug is a prescribed drug (determined without re-*
10 *gard to whether such drug is available without a prescrip-*
11 *tion) or is insulin.”.*

12 (c) *HEALTH FLEXIBLE SPENDING ARRANGEMENTS*
13 *AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section*
14 *106 of the Internal Revenue Code of 1986 is amended by*
15 *adding at the end the following new subsection:*

16 “(f) *REIMBURSEMENTS FOR MEDICINE RESTRICTED*
17 *TO PRESCRIBED DRUGS AND INSULIN.—For purposes of*
18 *this section and section 105, reimbursement for expenses in-*
19 *curring for a medicine or a drug shall be treated as a reim-*
20 *bursement for medical expenses only if such medicine or*
21 *drug is a prescribed drug (determined without regard to*
22 *whether such drug is available without a prescription) or*
23 *is insulin.”.*

24 (d) *EFFECTIVE DATES.—*

1 (1) *DISTRIBUTIONS FROM SAVINGS ACCOUNTS.*—
2 *The amendments made by subsections (a) and (b)*
3 *shall apply to amounts paid with respect to taxable*
4 *years beginning after December 31, 2010.*

5 (2) *REIMBURSEMENTS.*—*The amendment made*
6 *by subsection (c) shall apply to expenses incurred*
7 *with respect to taxable years beginning after Decem-*
8 *ber 31, 2010.*

9 **SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.**

12 (a) *HSAS.*—*Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.*

15 (b) *ARCHER MSAS.*—*Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.*

18 (c) *EFFECTIVE DATE.*—*The amendments made by this section shall apply to distributions made after December 31, 2010.*

21 **SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.**

23 (a) *IN GENERAL.*—*Section 125 of the Internal Revenue Code of 1986 is amended—*

1 (1) by redesignating subsections (i) and (j) as
2 subsections (j) and (k), respectively, and

3 (2) by inserting after subsection (h) the following
4 new subsection:

5 “(i) *LIMITATION ON HEALTH FLEXIBLE SPENDING*
6 *ARRANGEMENTS.*—For purposes of this section, if a benefit
7 is provided under a cafeteria plan through employer con-
8 tributions to a health flexible spending arrangement, such
9 benefit shall not be treated as a qualified benefit unless the
10 cafeteria plan provides that an employee may not elect for
11 any taxable year to have salary reduction contributions in
12 excess of \$2,500 made to such arrangement.”.

13 (b) *EFFECTIVE DATE.*—The amendments made by this
14 section shall apply to taxable years beginning after Decem-
15 ber 31, 2010.

16 **SEC. 9006. EXPANSION OF INFORMATION REPORTING RE-**
17 **QUIREMENTS.**

18 (a) *IN GENERAL.*—Section 6041 of the Internal Rev-
19 enue Code of 1986 is amended by adding at the end the
20 following new subsections:

21 “(h) *APPLICATION TO CORPORATIONS.*—Notwith-
22 standing any regulation prescribed by the Secretary before
23 the date of the enactment of this subsection, for purposes
24 of this section the term ‘person’ includes any corporation

1 *that is not an organization exempt from tax under section*
2 *501(a).*

3 “(i) *REGULATIONS.*—*The Secretary may prescribe*
4 *such regulations and other guidance as may be appropriate*
5 *or necessary to carry out the purposes of this section, in-*
6 *cluding rules to prevent duplicative reporting of trans-*
7 *actions.”.*

8 (b) *PAYMENTS FOR PROPERTY AND OTHER GROSS*
9 *PROCEEDS.*—*Subsection (a) of section 6041 of the Internal*
10 *Revenue Code of 1986 is amended—*

11 (1) *by inserting “amounts in consideration for*
12 *property,” after “wages,”*

13 (2) *by inserting “gross proceeds,” after “emolu-*
14 *ments, or other”, and*

15 (3) *by inserting “gross proceeds,” after “setting*
16 *forth the amount of such”.*

17 (c) *EFFECTIVE DATE.*—*The amendments made by this*
18 *section shall apply to payments made after December 31,*
19 *2011.*

20 **SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE**
21 **HOSPITALS.**

22 (a) *REQUIREMENTS TO QUALIFY AS SECTION*
23 *501(c)(3) CHARITABLE HOSPITAL ORGANIZATION.*—*Sec-*
24 *tion 501 of the Internal Revenue Code of 1986 (relating to*
25 *exemption from tax on corporations, certain trusts, etc.) is*

1 *amended by redesignating subsection (r) as subsection (s)*
2 *and by inserting after subsection (q) the following new sub-*
3 *section:*

4 “(r) *ADDITIONAL REQUIREMENTS FOR CERTAIN HOS-*
5 *PITALS.—*

6 “(1) *IN GENERAL.—A hospital organization to*
7 *which this subsection applies shall not be treated as*
8 *described in subsection (c)(3) unless the organiza-*
9 *tion—*

10 “(A) *meets the community health needs as-*
11 *essment requirements described in paragraph*
12 *(3),*

13 “(B) *meets the financial assistance policy*
14 *requirements described in paragraph (4),*

15 “(C) *meets the requirements on charges de-*
16 *scribed in paragraph (5), and*

17 “(D) *meets the billing and collection re-*
18 *quirement described in paragraph (6).*

19 “(2) *HOSPITAL ORGANIZATIONS TO WHICH SUB-*
20 *SECTION APPLIES.—*

21 “(A) *IN GENERAL.—This subsection shall*
22 *apply to—*

23 “(i) *an organization which operates a*
24 *facility which is required by a State to be*

1 *licensed, registered, or similarly recognized*
2 *as a hospital, and*

3 “(ii) *any other organization which the*
4 *Secretary determines has the provision of*
5 *hospital care as its principal function or*
6 *purpose constituting the basis for its exemp-*
7 *tion under subsection (c)(3) (determined*
8 *without regard to this subsection).*

9 “(B) *ORGANIZATIONS WITH MORE THAN 1*
10 *HOSPITAL FACILITY.—If a hospital organization*
11 *operates more than 1 hospital facility—*

12 “(i) *the organization shall meet the re-*
13 *quirements of this subsection separately*
14 *with respect to each such facility, and*

15 “(ii) *the organization shall not be*
16 *treated as described in subsection (c)(3)*
17 *with respect to any such facility for which*
18 *such requirements are not separately met.*

19 “(3) *COMMUNITY HEALTH NEEDS ASSESS-*
20 *MENTS.—*

21 “(A) *IN GENERAL.—An organization meets*
22 *the requirements of this paragraph with respect*
23 *to any taxable year only if the organization—*

24 “(i) *has conducted a community health*
25 *needs assessment which meets the require-*

1 *ments of subparagraph (B) in such taxable*
2 *year or in either of the 2 taxable years im-*
3 *mediately preceding such taxable year, and*

4 *“(ii) has adopted an implementation*
5 *strategy to meet the community health needs*
6 *identified through such assessment.*

7 *“(B) COMMUNITY HEALTH NEEDS ASSESS-*
8 *MENT.—A community health needs assessment*
9 *meets the requirements of this paragraph if such*
10 *community health needs assessment—*

11 *“(i) takes into account input from per-*
12 *sons who represent the broad interests of the*
13 *community served by the hospital facility,*
14 *including those with special knowledge of or*
15 *expertise in public health, and*

16 *“(ii) is made widely available to the*
17 *public.*

18 *“(4) FINANCIAL ASSISTANCE POLICY.—An orga-*
19 *nization meets the requirements of this paragraph if*
20 *the organization establishes the following policies:*

21 *“(A) FINANCIAL ASSISTANCE POLICY.—A*
22 *written financial assistance policy which in-*
23 *cludes—*

1 “(i) *eligibility criteria for financial as-*
2 *istance, and whether such assistance in-*
3 *cludes free or discounted care,*

4 “(ii) *the basis for calculating amounts*
5 *charged to patients,*

6 “(iii) *the method for applying for fi-*
7 *nancial assistance,*

8 “(iv) *in the case of an organization*
9 *which does not have a separate billing and*
10 *collections policy, the actions the organiza-*
11 *tion may take in the event of non-payment,*
12 *including collections action and reporting*
13 *to credit agencies, and*

14 “(v) *measures to widely publicize the*
15 *policy within the community to be served*
16 *by the organization.*

17 “(B) *POLICY RELATING TO EMERGENCY*
18 *MEDICAL CARE.—A written policy requiring the*
19 *organization to provide, without discrimination,*
20 *care for emergency medical conditions (within*
21 *the meaning of section 1867 of the Social Secu-*
22 *rity Act (42 U.S.C. 1395dd)) to individuals re-*
23 *gardless of their eligibility under the financial*
24 *assistance policy described in subparagraph (A).*

1 “(5) *LIMITATION ON CHARGES.*—*An organiza-*
2 *tion meets the requirements of this paragraph if the*
3 *organization—*

4 “(A) *limits amounts charged for emergency*
5 *or other medically necessary care provided to in-*
6 *dividuals eligible for assistance under the finan-*
7 *cial assistance policy described in paragraph*
8 *(4)(A) to not more than the lowest amounts*
9 *charged to individuals who have insurance cov-*
10 *ering such care, and*

11 “(B) *prohibits the use of gross charges.*

12 “(6) *BILLING AND COLLECTION REQUIRE-*
13 *MENTS.*—*An organization meets the requirement of*
14 *this paragraph only if the organization does not en-*
15 *gage in extraordinary collection actions before the or-*
16 *ganization has made reasonable efforts to determine*
17 *whether the individual is eligible for assistance under*
18 *the financial assistance policy described in paragraph*
19 *(4)(A).*

20 “(7) *REGULATORY AUTHORITY.*—*The Secretary*
21 *shall issue such regulations and guidance as may be*
22 *necessary to carry out the provisions of this sub-*
23 *section, including guidance relating to what con-*
24 *stitutes reasonable efforts to determine the eligibility*

1 of a patient under a financial assistance policy for
2 purposes of paragraph (6).”.

3 (b) *EXCISE TAX FOR FAILURES TO MEET HOSPITAL*
4 *EXEMPTION REQUIREMENTS.*—

5 (1) *IN GENERAL.*—Subchapter D of chapter 42 of
6 the Internal Revenue Code of 1986 (relating to failure
7 by certain charitable organizations to meet certain
8 qualification requirements) is amended by adding at
9 the end the following new section:

10 **“SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZA-**
11 **TIONS.**

12 *“If a hospital organization to which section 501(r) ap-*
13 *plies fails to meet the requirement of section 501(r)(3) for*
14 *any taxable year, there is imposed on the organization a*
15 *tax equal to \$50,000.”.*

16 (2) *CONFORMING AMENDMENT.*—The table of sec-
17 tions for subchapter D of chapter 42 of such Code is
18 amended by adding at the end the following new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

19 (c) *MANDATORY REVIEW OF TAX EXEMPTION FOR*
20 *HOSPITALS.*—The Secretary of the Treasury or the Sec-
21 *retary’s delegate shall review at least once every 3 years*
22 *the community benefit activities of each hospital organiza-*
23 *tion to which section 501(r) of the Internal Revenue Code*
24 *of 1986 (as added by this section) applies.*

25 (d) *ADDITIONAL REPORTING REQUIREMENTS.*—

1 (1) *COMMUNITY HEALTH NEEDS ASSESSMENTS*
2 *AND AUDITED FINANCIAL STATEMENTS.*—Section
3 *6033(b) of the Internal Revenue Code of 1986 (relat-*
4 *ing to certain organizations described in section*
5 *501(c)(3)) is amended by striking “and” at the end*
6 *of paragraph (14), by redesignating paragraph (15)*
7 *as paragraph (16), and by inserting after paragraph*
8 *(14) the following new paragraph:*

9 *“(15) in the case of an organization to which the*
10 *requirements of section 501(r) apply for the taxable*
11 *year—*

12 *“(A) a description of how the organization*
13 *is addressing the needs identified in each com-*
14 *munity health needs assessment conducted under*
15 *section 501(r)(3) and a description of any such*
16 *needs that are not being addressed together with*
17 *the reasons why such needs are not being ad-*
18 *dressed, and*

19 *“(B) the audited financial statements of*
20 *such organization (or, in the case of an organi-*
21 *zation the financial statements of which are in-*
22 *cluded in a consolidated financial statement*
23 *with other organizations, such consolidated fi-*
24 *nancial statement).”.*

1 (2) *TAXES.*—Section 6033(b)(10) of such Code is
2 amended by striking “and” at the end of subpara-
3 graph (B), by inserting “and” at the end of subpara-
4 graph (C), and by adding at the end the following
5 new subparagraph:

6 “(D) section 4959 (relating to taxes on fail-
7 ures by hospital organizations),”.

8 (e) *REPORTS.*—

9 (1) *REPORT ON LEVELS OF CHARITY CARE.*—The
10 Secretary of the Treasury, in consultation with the
11 Secretary of Health and Human Services, shall sub-
12 mit to the Committees on Ways and Means, Edu-
13 cation and Labor, and Energy and Commerce of the
14 House of Representatives and to the Committees on
15 Finance and Health, Education, Labor, and Pensions
16 of the Senate an annual report on the following:

17 (A) Information with respect to private tax-
18 exempt, taxable, and government-owned hospitals
19 regarding—

20 (i) levels of charity care provided,

21 (ii) bad debt expenses,

22 (iii) unreimbursed costs for services
23 provided with respect to means-tested gov-
24 ernment programs, and

1 (iv) *unreimbursed costs for services*
2 *provided with respect to non-means tested*
3 *government programs.*

4 (B) *Information with respect to private tax-*
5 *exempt hospitals regarding costs incurred for*
6 *community benefit activities.*

7 (2) *REPORT ON TRENDS.—*

8 (A) *STUDY.—The Secretary of the Treasury,*
9 *in consultation with the Secretary of Health and*
10 *Human Services, shall conduct a study on trends*
11 *in the information required to be reported under*
12 *paragraph (1).*

13 (B) *REPORT.—Not later than 5 years after*
14 *the date of the enactment of this Act, the Sec-*
15 *retary of the Treasury, in consultation with the*
16 *Secretary of Health and Human Services, shall*
17 *submit a report on the study conducted under*
18 *subparagraph (A) to the Committees on Ways*
19 *and Means, Education and Labor, and Energy*
20 *and Commerce of the House of Representatives*
21 *and to the Committees on Finance and Health,*
22 *Education, Labor, and Pensions of the Senate.*

23 (f) *EFFECTIVE DATES.—*

24 (1) *IN GENERAL.—Except as provided in para-*
25 *graphs (2) and (3), the amendments made by this sec-*

1 *tion shall apply to taxable years beginning after the*
2 *date of the enactment of this Act.*

3 (2) *COMMUNITY HEALTH NEEDS ASSESSMENT.—*

4 *The requirements of section 501(r)(3) of the Internal*
5 *Revenue Code of 1986, as added by subsection (a),*
6 *shall apply to taxable years beginning after the date*
7 *which is 2 years after the date of the enactment of*
8 *this Act.*

9 (3) *EXCISE TAX.—The amendments made by*
10 *subsection (b) shall apply to failures occurring after*
11 *the date of the enactment of this Act.*

12 **SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRE-**
13 **SCRIPTION PHARMACEUTICAL MANUFACTUR-**
14 **ERS AND IMPORTERS.**

15 (a) *IMPOSITION OF FEE.—*

16 (1) *IN GENERAL.—Each covered entity engaged*
17 *in the business of manufacturing or importing brand-*
18 *ed prescription drugs shall pay to the Secretary of the*
19 *Treasury not later than the annual payment date of*
20 *each calendar year beginning after 2009 a fee in an*
21 *amount determined under subsection (b).*

22 (2) *ANNUAL PAYMENT DATE.—For purposes of*
23 *this section, the term “annual payment date” means*
24 *with respect to any calendar year the date determined*

1 *by the Secretary, but in no event later than Sep-*
 2 *tember 30 of such calendar year.*

3 *(b) DETERMINATION OF FEE AMOUNT.—*

4 *(1) IN GENERAL.—With respect to each covered*
 5 *entity, the fee under this section for any calendar*
 6 *year shall be equal to an amount that bears the same*
 7 *ratio to \$2,300,000,000 as—*

8 *(A) the covered entity’s branded prescrip-*
 9 *tion drug sales taken into account during the*
 10 *preceding calendar year, bear to*

11 *(B) the aggregate branded prescription drug*
 12 *sales of all covered entities taken into account*
 13 *during such preceding calendar year.*

14 *(2) SALES TAKEN INTO ACCOUNT.—For purposes*
 15 *of paragraph (1), the branded prescription drug sales*
 16 *taken into account during any calendar year with re-*
 17 *spect to any covered entity shall be determined in ac-*
 18 *cordance with the following table:*

<i>With respect to a covered entity’s aggregate branded pre-</i> <i>scription drug sales during the calendar year that are:</i>	<i>The percentage of such</i> <i>sales taken into ac-</i> <i>count is:</i>
<i>Not more than \$5,000,000</i>	<i>0 percent</i>
<i>More than \$5,000,000 but not more than</i> <i>\$125,000,000.</i>	<i>10 percent</i>
<i>More than \$125,000,000 but not more than</i> <i>\$225,000,000.</i>	<i>40 percent</i>
<i>More than \$225,000,000 but not more than</i> <i>\$400,000,000.</i>	<i>75 percent</i>
<i>More than \$400,000,000</i>	<i>100 percent.</i>

1 (3) *SECRETARIAL DETERMINATION.*—*The Sec-*
2 *retary of the Treasury shall calculate the amount of*
3 *each covered entity’s fee for any calendar year under*
4 *paragraph (1). In calculating such amount, the Sec-*
5 *retary of the Treasury shall determine such covered*
6 *entity’s branded prescription drug sales on the basis*
7 *of reports submitted under subsection (g) and through*
8 *the use of any other source of information available*
9 *to the Secretary of the Treasury.*

10 (c) *TRANSFER OF FEES TO MEDICARE PART B TRUST*
11 *FUND.*—*There is hereby appropriated to the Federal Sup-*
12 *plementary Medical Insurance Trust Fund established*
13 *under section 1841 of the Social Security Act an amount*
14 *equal to the fees received by the Secretary of the Treasury*
15 *under subsection (a).*

16 (d) *COVERED ENTITY.*—

17 (1) *IN GENERAL.*—*For purposes of this section,*
18 *the term “covered entity” means any manufacturer or*
19 *importer with gross receipts from branded prescrip-*
20 *tion drug sales.*

21 (2) *CONTROLLED GROUPS.*—

22 (A) *IN GENERAL.*—*For purposes of this sub-*
23 *section, all persons treated as a single employer*
24 *under subsection (a) or (b) of section 52 of the*
25 *Internal Revenue Code of 1986 or subsection (m)*

1 or (o) of section 414 of such Code shall be treated
2 as a single covered entity.

3 (B) *INCLUSION OF FOREIGN CORPORATIONS.*—For purposes of subparagraph (A), in
4 applying subsections (a) and (b) of section 52 of
5 such Code to this section, section 1563 of such
6 Code shall be applied without regard to sub-
7 section (b)(2)(C) thereof.

8
9 (e) *BRANDED PRESCRIPTION DRUG SALES.*—For pur-
10 poses of this section—

11 (1) *IN GENERAL.*—The term “branded prescrip-
12 tion drug sales” means sales of branded prescription
13 drugs to any specified government program or pursu-
14 ant to coverage under any such program.

15 (2) *BRANDED PRESCRIPTION DRUGS.*—

16 (A) *IN GENERAL.*—The term “branded pre-
17 scription drug” means—

18 (i) any prescription drug the applica-
19 tion for which was submitted under section
20 505(b) of the Federal Food, Drug, and Cos-
21 metic Act (21 U.S.C. 355(b)), or

22 (ii) any biological product the license
23 for which was submitted under section
24 351(a) of the Public Health Service Act (42
25 U.S.C. 262(a)).

1 (B) *PRESCRIPTION DRUG.*—For purposes of
2 subparagraph (A)(i), the term “prescription
3 drug” means any drug which is subject to section
4 503(b) of the *Federal Food, Drug, and Cosmetic*
5 *Act* (21 U.S.C. 353(b)).

6 (3) *EXCLUSION OF ORPHAN DRUG SALES.*—The
7 term “branded prescription drug sales” shall not in-
8 clude sales of any drug or biological product with re-
9 spect to which a credit was allowed for any taxable
10 year under section 45C of the *Internal Revenue Code*
11 of 1986. The preceding sentence shall not apply with
12 respect to any such drug or biological product after
13 the date on which such drug or biological product is
14 approved by the *Food and Drug Administration* for
15 marketing for any indication other than the treat-
16 ment of the rare disease or condition with respect to
17 which such credit was allowed.

18 (4) *SPECIFIED GOVERNMENT PROGRAM.*—The
19 term “specified government program” means—

20 (A) the *Medicare Part D* program under
21 part D of title XVIII of the *Social Security Act*,

22 (B) the *Medicare Part B* program under
23 part B of title XVIII of the *Social Security Act*,

24 (C) the *Medicaid* program under title XIX
25 of the *Social Security Act*,

1 (D) any program under which branded pre-
2 scription drugs are procured by the Department
3 of Veterans Affairs,

4 (E) any program under which branded pre-
5 scription drugs are procured by the Department
6 of Defense, or

7 (F) the TRICARE retail pharmacy pro-
8 gram under section 1074g of title 10, United
9 States Code.

10 (f) *TAX TREATMENT OF FEES.*—The fees imposed by
11 *this section—*

12 (1) for purposes of subtitle F of the Internal Rev-
13 enue Code of 1986, shall be treated as excise taxes
14 with respect to which only civil actions for refund
15 under procedures of such subtitle shall apply, and

16 (2) for purposes of section 275 of such Code, shall
17 be considered to be a tax described in section
18 275(a)(6).

19 (g) *REPORTING REQUIREMENT.*—Not later than the
20 *date determined by the Secretary of the Treasury following*
21 *the end of any calendar year, the Secretary of Health and*
22 *Human Services, the Secretary of Veterans Affairs, and the*
23 *Secretary of Defense shall report to the Secretary of the*
24 *Treasury, in such manner as the Secretary of the Treasury*
25 *prescribes, the total branded prescription drug sales for each*

1 *covered entity with respect to each specified government*
2 *program under such Secretary's jurisdiction using the fol-*
3 *lowing methodology:*

4 (1) *MEDICARE PART D PROGRAM.*—*The Sec-*
5 *retary of Health and Human Services shall report,*
6 *for each covered entity and for each branded prescrip-*
7 *tion drug of the covered entity covered by the Medi-*
8 *care Part D program, the product of—*

9 (A) *the per-unit ingredient cost, as reported*
10 *to the Secretary of Health and Human Services*
11 *by prescription drug plans and Medicare Advan-*
12 *tage prescription drug plans, minus any per-*
13 *unit rebate, discount, or other price concession*
14 *provided by the covered entity, as reported to the*
15 *Secretary of Health and Human Services by the*
16 *prescription drug plans and Medicare Advantage*
17 *prescription drug plans, and*

18 (B) *the number of units of the branded pre-*
19 *scription drug paid for under the Medicare Part*
20 *D program.*

21 (2) *MEDICARE PART B PROGRAM.*—*The Sec-*
22 *retary of Health and Human Services shall report,*
23 *for each covered entity and for each branded prescrip-*
24 *tion drug of the covered entity covered by the Medi-*

1 *care Part B program under section 1862(a) of the So-*
2 *cial Security Act, the product of—*

3 *(A) the per-unit average sales price (as de-*
4 *finied in section 1847A(c) of the Social Security*
5 *Act) or the per-unit Part B payment rate for a*
6 *separately paid branded prescription drug with-*
7 *out a reported average sales price, and*

8 *(B) the number of units of the branded pre-*
9 *scription drug paid for under the Medicare Part*
10 *B program.*

11 *The Centers for Medicare and Medicaid Services shall*
12 *establish a process for determining the units and the*
13 *allocated price for purposes of this section for those*
14 *branded prescription drugs that are not separately*
15 *payable or for which National Drug Codes are not re-*
16 *ported.*

17 *(3) MEDICAID PROGRAM.—The Secretary of*
18 *Health and Human Services shall report, for each*
19 *covered entity and for each branded prescription drug*
20 *of the covered entity covered under the Medicaid pro-*
21 *gram, the product of—*

22 *(A) the per-unit ingredient cost paid to*
23 *pharmacies by States for the branded prescrip-*
24 *tion drug dispensed to Medicaid beneficiaries,*
25 *minus any per-unit rebate paid by the covered*

1 *entity under section 1927 of the Social Security*
2 *Act and any State supplemental rebate, and*

3 *(B) the number of units of the branded pre-*
4 *scription drug paid for under the Medicaid pro-*
5 *gram.*

6 *(4) DEPARTMENT OF VETERANS AFFAIRS PRO-*
7 *GRAMS.—The Secretary of Veterans Affairs shall re-*
8 *port, for each covered entity and for each branded*
9 *prescription drug of the covered entity the total*
10 *amount paid for each such branded prescription drug*
11 *procured by the Department of Veterans Affairs for*
12 *its beneficiaries.*

13 *(5) DEPARTMENT OF DEFENSE PROGRAMS AND*
14 *TRICARE.—The Secretary of Defense shall report, for*
15 *each covered entity and for each branded prescription*
16 *drug of the covered entity, the sum of—*

17 *(A) the total amount paid for each such*
18 *branded prescription drug procured by the De-*
19 *partment of Defense for its beneficiaries, and*

20 *(B) for each such branded prescription drug*
21 *dispensed under the TRICARE retail pharmacy*
22 *program, the product of—*

23 *(i) the per-unit ingredient cost, minus*
24 *any per-unit rebate paid by the covered en-*
25 *tity, and*

1 (ii) *the number of units of the branded*
2 *prescription drug dispensed under such pro-*
3 *gram.*

4 (h) *SECRETARY.*—*For purposes of this section, the*
5 *term “Secretary” includes the Secretary’s delegate.*

6 (i) *GUIDANCE.*—*The Secretary of the Treasury shall*
7 *publish guidance necessary to carry out the purposes of this*
8 *section.*

9 (j) *APPLICATION OF SECTION.*—*This section shall*
10 *apply to any branded prescription drug sales after Decem-*
11 *ber 31, 2008.*

12 (k) *CONFORMING AMENDMENT.*—*Section 1841(a) of*
13 *the Social Security Act is amended by inserting “or section*
14 *9008(c) of the Patient Protection and Affordable Care Act*
15 *of 2009” after “this part”.*

16 **SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DE-**
17 **VICE MANUFACTURERS AND IMPORTERS.**

18 (a) *IMPOSITION OF FEE.*—

19 (1) *IN GENERAL.*—*Each covered entity engaged*
20 *in the business of manufacturing or importing med-*
21 *ical devices shall pay to the Secretary not later than*
22 *the annual payment date of each calendar year begin-*
23 *ning after 2009 a fee in an amount determined under*
24 *subsection (b).*

1 (2) *ANNUAL PAYMENT DATE.*—For purposes of
 2 this section, the term “annual payment date” means
 3 with respect to any calendar year the date determined
 4 by the Secretary, but in no event later than Sep-
 5 tember 30 of such calendar year.

6 (b) *DETERMINATION OF FEE AMOUNT.*—

7 (1) *IN GENERAL.*—With respect to each covered
 8 entity, the fee under this section for any calendar
 9 year shall be equal to an amount that bears the same
 10 ratio to \$2,000,000,000 as—

11 (A) the covered entity’s gross receipts from
 12 medical device sales taken into account during
 13 the preceding calendar year, bear to

14 (B) the aggregate gross receipts of all cov-
 15 ered entities from medical device sales taken into
 16 account during such preceding calendar year.

17 (2) *GROSS RECEIPTS FROM SALES TAKEN INTO*
 18 *ACCOUNT.*—For purposes of paragraph (1), the gross
 19 receipts from medical device sales taken into account
 20 during any calendar year with respect to any covered
 21 entity shall be determined in accordance with the fol-
 22 lowing table:

<i>With respect to a covered entity’s aggregate gross re- ceipts from medical device sales during the calendar year that are:</i>	<i>The percentage of gross receipts taken into ac- count is:</i>
<i>Not more than \$5,000,000</i>	<i>0 percent</i>
<i>More than \$5,000,000 but not more than \$25,000,000.</i>	<i>50 percent</i>

<i>With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:</i>	<i>The percentage of gross receipts taken into account is:</i>
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<i>More than \$25,000,000</i>	<i>100 percent.</i>
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1 (3) *SECRETARIAL DETERMINATION.*—*The Sec-*
 2 *retary shall calculate the amount of each covered enti-*
 3 *ty's fee for any calendar year under paragraph (1).*
 4 *In calculating such amount, the Secretary shall deter-*
 5 *mine such covered entity's gross receipts from medical*
 6 *device sales on the basis of reports submitted by the*
 7 *covered entity under subsection (f) and through the*
 8 *use of any other source of information available to the*
 9 *Secretary.*

10 (c) *COVERED ENTITY.*—

11 (1) *IN GENERAL.*—*For purposes of this section,*
 12 *the term "covered entity" means any manufacturer or*
 13 *importer with gross receipts from medical device*
 14 *sales.*

15 (2) *CONTROLLED GROUPS.*—

16 (A) *IN GENERAL.*—*For purposes of this sub-*
 17 *section, all persons treated as a single employer*
 18 *under subsection (a) or (b) of section 52 of the*
 19 *Internal Revenue Code of 1986 or subsection (m)*
 20 *or (o) of section 414 of such Code shall be treated*
 21 *as a single covered entity.*

22 (B) *INCLUSION OF FOREIGN CORPORA-*
 23 *TIONS.*—*For purposes of subparagraph (A), in*

1 *applying subsections (a) and (b) of section 52 of*
2 *such Code to this section, section 1563 of such*
3 *Code shall be applied without regard to sub-*
4 *section (b)(2)(C) thereof.*

5 *(d) MEDICAL DEVICE SALES.—For purposes of this*
6 *section—*

7 *(1) IN GENERAL.—The term “medical device*
8 *sales” means sales for use in the United States of any*
9 *medical device, other than the sales of a medical de-*
10 *vice that—*

11 *(A) has been classified in class II under sec-*
12 *tion 513 of the Federal Food, Drug, and Cos-*
13 *metic Act (21 U.S.C. 360c) and is primarily sold*
14 *to consumers at retail for not more than \$100*
15 *per unit, or*

16 *(B) has been classified in class I under such*
17 *section.*

18 *(2) UNITED STATES.—For purposes of para-*
19 *graph (1), the term “United States” means the several*
20 *States, the District of Columbia, the Commonwealth*
21 *of Puerto Rico, and the possessions of the United*
22 *States.*

23 *(3) MEDICAL DEVICE.—For purposes of para-*
24 *graph (1), the term “medical device” means any de-*
25 *vice (as defined in section 201(h) of the Federal Food,*

1 *Drug, and Cosmetic Act (21 U.S.C. 321(h)) intended*
2 *for humans.*

3 *(e) TAX TREATMENT OF FEES.—The fees imposed by*
4 *this section—*

5 *(1) for purposes of subtitle F of the Internal Rev-*
6 *enue Code of 1986, shall be treated as excise taxes*
7 *with respect to which only civil actions for refund*
8 *under procedures of such subtitle shall apply, and*

9 *(2) for purposes of section 275 of such Code, shall*
10 *be considered to be a tax described in section*
11 *275(a)(6).*

12 *(f) REPORTING REQUIREMENT.—*

13 *(1) IN GENERAL.—Not later than the date deter-*
14 *mined by the Secretary following the end of any cal-*
15 *endar year, each covered entity shall report to the*
16 *Secretary, in such manner as the Secretary pre-*
17 *scribes, the gross receipts from medical device sales of*
18 *such covered entity during such calendar year.*

19 *(2) PENALTY FOR FAILURE TO REPORT.—*

20 *(A) IN GENERAL.—In the case of any fail-*
21 *ure to make a report containing the information*
22 *required by paragraph (1) on the date prescribed*
23 *therefor (determined with regard to any exten-*
24 *sion of time for filing), unless it is shown that*
25 *such failure is due to reasonable cause, there*

1 shall be paid by the covered entity failing to file
2 such report, an amount equal to—

3 (i) \$10,000, plus

4 (ii) the lesser of—

5 (I) an amount equal to \$1,000,
6 multiplied by the number of days dur-
7 ing which such failure continues, or

8 (II) the amount of the fee imposed
9 by this section for which such report
10 was required.

11 (B) *TREATMENT OF PENALTY.*—The penalty
12 imposed under subparagraph (A)—

13 (i) shall be treated as a penalty for
14 purposes of subtitle F of the Internal Rev-
15 enue Code of 1986,

16 (ii) shall be paid on notice and de-
17 mand by the Secretary and in the same
18 manner as tax under such Code, and

19 (iii) with respect to which only civil
20 actions for refund under procedures of such
21 subtitle F shall apply.

22 (g) *SECRETARY.*—For purposes of this section, the
23 term “Secretary” means the Secretary of the Treasury or
24 the Secretary’s delegate.

1 (h) *GUIDANCE.*—*The Secretary shall publish guidance*
2 *necessary to carry out the purposes of this section, including*
3 *identification of medical devices described in subsection*
4 *(d)(1)(A) and with respect to the treatment of gross receipts*
5 *from sales of medical devices to another covered entity or*
6 *to another entity by reason of the application of subsection*
7 *(c)(2).*

8 (i) *APPLICATION OF SECTION.*—*This section shall*
9 *apply to any medical device sales after December 31, 2008.*

10 **SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSUR-**
11 **ANCE PROVIDERS.**

12 (a) *IMPOSITION OF FEE.*—

13 (1) *IN GENERAL.*—*Each covered entity engaged*
14 *in the business of providing health insurance shall*
15 *pay to the Secretary not later than the annual pay-*
16 *ment date of each calendar year beginning after 2009*
17 *a fee in an amount determined under subsection (b).*

18 (2) *ANNUAL PAYMENT DATE.*—*For purposes of*
19 *this section, the term “annual payment date” means*
20 *with respect to any calendar year the date determined*
21 *by the Secretary, but in no event later than Sep-*
22 *tember 30 of such calendar year.*

23 (b) *DETERMINATION OF FEE AMOUNT.*—

24 (1) *IN GENERAL.*—*With respect to each covered*
25 *entity, the fee under this section for any calendar*

1 *year shall be equal to an amount that bears the same*
2 *ratio to \$6,700,000,000 as—*

3 *(A) the sum of—*

4 *(i) the covered entity's net premiums*
5 *written with respect to health insurance for*
6 *any United States health risk that are*
7 *taken into account during the preceding cal-*
8 *endar year, plus*

9 *(ii) 200 percent of the covered entity's*
10 *third party administration agreement fees*
11 *that are taken into account during the pre-*
12 *ceding calendar year, bears to*

13 *(B) the sum of—*

14 *(i) the aggregate net premiums written*
15 *with respect to such health insurance of all*
16 *covered entities that are taken into account*
17 *during such preceding calendar year, plus*

18 *(ii) 200 percent of the aggregate third*
19 *party administration agreement fees of all*
20 *covered entities that are taken into account*
21 *during such preceding calendar year.*

22 *(2) AMOUNTS TAKEN INTO ACCOUNT.—For pur-*
23 *poses of paragraph (1)—*

24 *(A) NET PREMIUMS WRITTEN.—The net*
25 *premiums written with respect to health insur-*

1 *ance for any United States health risk that are*
 2 *taken into account during any calendar year*
 3 *with respect to any covered entity shall be deter-*
 4 *mined in accordance with the following table:*

<i>With respect to a covered entity's net premiums written during the calendar year that are:</i>	<i>The percentage of net premiums written that are taken into account is:</i>
<i>Not more than \$25,000,000</i>	<i>0 percent</i>
<i>More than \$25,000,000 but not more than \$50,000,000.</i>	<i>50 percent</i>
<i>More than \$50,000,000</i>	<i>100 percent.</i>

5 *(B) THIRD PARTY ADMINISTRATION AGREE-*
 6 *MENT FEES.—The third party administration*
 7 *agreement fees that are taken into account dur-*
 8 *ing any calendar year with respect to any cov-*
 9 *ered entity shall be determined in accordance*
 10 *with the following table:*

<i>With respect to a covered entity's third party administration agreement fees during the calendar year that are:</i>	<i>The percentage of third party administration agreement fees that are taken into account is:</i>
<i>Not more than \$5,000,000</i>	<i>0 percent</i>
<i>More than \$5,000,000 but not more than \$10,000,000.</i>	<i>50 percent</i>
<i>More than \$10,000,000</i>	<i>100 percent.</i>

11 *(3) SECRETARIAL DETERMINATION.—The Sec-*
 12 *retary shall calculate the amount of each covered enti-*
 13 *ty's fee for any calendar year under paragraph (1).*
 14 *In calculating such amount, the Secretary shall deter-*
 15 *mine such covered entity's net premiums written with*
 16 *respect to any United States health risk and third*

1 *party administration agreement fees on the basis of*
2 *reports submitted by the covered entity under sub-*
3 *section (g) and through the use of any other source of*
4 *information available to the Secretary.*

5 *(c) COVERED ENTITY.—*

6 *(1) IN GENERAL.—For purposes of this section,*
7 *the term “covered entity” means any entity which*
8 *provides health insurance for any United States*
9 *health risk.*

10 *(2) EXCLUSION.—Such term does not include—*

11 *(A) any employer to the extent that such*
12 *employer self-insures its employees’ health risks,*
13 *or*

14 *(B) any governmental entity (except to the*
15 *extent such an entity provides health insurance*
16 *coverage through the community health insur-*
17 *ance option under section 1323).*

18 *(3) CONTROLLED GROUPS.—*

19 *(A) IN GENERAL.—For purposes of this sub-*
20 *section, all persons treated as a single employer*
21 *under subsection (a) or (b) of section 52 of the*
22 *Internal Revenue Code of 1986 or subsection (m)*
23 *or (o) of section 414 of such Code shall be treated*
24 *as a single covered entity (or employer for pur-*
25 *poses of paragraph (2)).*

1 (B) *INCLUSION OF FOREIGN CORPORA-*
2 *TIONS.—For purposes of subparagraph (A), in*
3 *applying subsections (a) and (b) of section 52 of*
4 *such Code to this section, section 1563 of such*
5 *Code shall be applied without regard to sub-*
6 *section (b)(2)(C) thereof.*

7 (d) *UNITED STATES HEALTH RISK.—For purposes of*
8 *this section, the term “United States health risk” means*
9 *the health risk of any individual who is—*

10 (1) *a United States citizen,*

11 (2) *a resident of the United States (within the*
12 *meaning of section 7701(b)(1)(A) of the Internal Rev-*
13 *enue Code of 1986), or*

14 (3) *located in the United States, with respect to*
15 *the period such individual is so located.*

16 (e) *THIRD PARTY ADMINISTRATION AGREEMENT*
17 *FEES.—For purposes of this section, the term “third party*
18 *administration agreement fees” means, with respect to any*
19 *covered entity, amounts received from an employer which*
20 *are in excess of payments made by such covered entity for*
21 *health benefits under an arrangement under which such em-*
22 *ployer self-insures the United States health risk of its em-*
23 *ployees.*

24 (f) *TAX TREATMENT OF FEES.—The fees imposed by*
25 *this section—*

1 (1) *for purposes of subtitle F of the Internal Rev-*
2 *enue Code of 1986, shall be treated as excise taxes*
3 *with respect to which only civil actions for refund*
4 *under procedures of such subtitle shall apply, and*

5 (2) *for purposes of section 275 of such Code shall*
6 *be considered to be a tax described in section*
7 *275(a)(6).*

8 (g) *REPORTING REQUIREMENT.—*

9 (1) *IN GENERAL.—Not later than the date deter-*
10 *mined by the Secretary following the end of any cal-*
11 *endar year, each covered entity shall report to the*
12 *Secretary, in such manner as the Secretary pre-*
13 *scribes, the covered entity's net premiums written*
14 *with respect to health insurance for any United*
15 *States health risk and third party administration*
16 *agreement fees for such calendar year.*

17 (2) *PENALTY FOR FAILURE TO REPORT.—*

18 (A) *IN GENERAL.—In the case of any fail-*
19 *ure to make a report containing the information*
20 *required by paragraph (1) on the date prescribed*
21 *therefor (determined with regard to any exten-*
22 *sion of time for filing), unless it is shown that*
23 *such failure is due to reasonable cause, there*
24 *shall be paid by the covered entity failing to file*
25 *such report, an amount equal to—*

1992

1 (i) \$10,000, plus

2 (ii) the lesser of—

3 (I) an amount equal to \$1,000,
4 multiplied by the number of days dur-
5 ing which such failure continues, or

6 (II) the amount of the fee imposed
7 by this section for which such report
8 was required.

9 (B) TREATMENT OF PENALTY.—The penalty
10 imposed under subparagraph (A)—

11 (i) shall be treated as a penalty for
12 purposes of subtitle F of the Internal Rev-
13 enue Code of 1986,

14 (ii) shall be paid on notice and de-
15 mand by the Secretary and in the same
16 manner as tax under such Code, and

17 (iii) with respect to which only civil
18 actions for refund under procedures of such
19 subtitle F shall apply.

20 (h) ADDITIONAL DEFINITIONS.—For purposes of this
21 section—

22 (1) SECRETARY.—The term “Secretary” means
23 the Secretary of the Treasury or the Secretary’s dele-
24 gate.

1 (2) *UNITED STATES.*—*The term “United States”*
2 *means the several States, the District of Columbia, the*
3 *Commonwealth of Puerto Rico, and the possessions of*
4 *the United States.*

5 (3) *HEALTH INSURANCE.*—*The term “health in-*
6 *surance” shall not include insurance for long-term*
7 *care or disability.*

8 (i) *GUIDANCE.*—*The Secretary shall publish guidance*
9 *necessary to carry out the purposes of this section.*

10 (j) *APPLICATION OF SECTION.*—*This section shall*
11 *apply to any net premiums written after December 31,*
12 *2008, with respect to health insurance for any United*
13 *States health risk, and any third party administration*
14 *agreement fees received after such date.*

15 **SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS**

16 **HEALTH CARE.**

17 (a) *IN GENERAL.*—*The Secretary of Veterans Affairs*
18 *shall conduct a study on the effect (if any) of the provisions*
19 *of sections 9008, 9009, and 9010 on—*

20 (1) *the cost of medical care provided to veterans,*
21 *and*

22 (2) *veterans’ access to medical devices and*
23 *branded prescription drugs.*

24 (b) *REPORT.*—*The Secretary of Veterans Affairs shall*
25 *report the results of the study under subsection (a) to the*

1 *Committee on Ways and Means of the House of Representa-*
2 *tives and to the Committee on Finance of the Senate not*
3 *later than December 31, 2012.*

4 **SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES AL-**
5 **LOCABLE TO MEDICARE PART D SUBSIDY.**

6 (a) *IN GENERAL.*—Section 139A of the Internal Rev-
7 *enue Code of 1986 is amended by striking the second sen-*
8 *tence.*

9 (b) *EFFECTIVE DATE.*—The amendment made by this
10 *section shall apply to taxable years beginning after Decem-*
11 *ber 31, 2010.*

12 **SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR**
13 **MEDICAL EXPENSES.**

14 (a) *IN GENERAL.*—Subsection (a) of section 213 of the
15 *Internal Revenue Code of 1986 is amended by striking “7.5*
16 *percent” and inserting “10 percent”.*

17 (b) *TEMPORARY WAIVER OF INCREASE FOR CERTAIN*
18 *SENIORS.*—Section 213 of the Internal Revenue Code of
19 *1986 is amended by adding at the end the following new*
20 *subsection:*

21 “(f) *SPECIAL RULE FOR 2013, 2014, 2015, AND*
22 *2016.*—In the case of any taxable year beginning after De-
23 *cember 31, 2012, and ending before January 1, 2017, sub-*
24 *section (a) shall be applied with respect to a taxpayer by*
25 *substituting ‘7.5 percent’ for ‘10 percent’ if such taxpayer*

1 *or such taxpayer's spouse has attained age 65 before the*
 2 *close of such taxable year.”.*

3 (c) *CONFORMING AMENDMENT.—Section 56(b)(1)(B)*
 4 *of the Internal Revenue Code of 1986 is amended by strik-*
 5 *ing “by substituting ‘10 percent’ for ‘7.5 percent’” and in-*
 6 *serting “without regard to subsection (f) of such section”.*

7 (d) *EFFECTIVE DATE.—The amendments made by this*
 8 *section shall apply to taxable years beginning after Decem-*
 9 *ber 31, 2012.*

10 **SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION**

11 **PAID BY CERTAIN HEALTH INSURANCE PRO-**
 12 **VIDERS.**

13 (a) *IN GENERAL.—Section 162(m) of the Internal Rev-*
 14 *enue Code of 1986 is amended by adding at the end the*
 15 *following new subparagraph:*

16 “(6) *SPECIAL RULE FOR APPLICATION TO CER-*
 17 *TAIN HEALTH INSURANCE PROVIDERS.—*

18 “(A) *IN GENERAL.—No deduction shall be*
 19 *allowed under this chapter—*

20 “(i) *in the case of applicable indi-*
 21 *vidual remuneration which is for any dis-*
 22 *qualified taxable year beginning after De-*
 23 *cember 31, 2012, and which is attributable*
 24 *to services performed by an applicable indi-*
 25 *vidual during such taxable year, to the ex-*

1 *tent that the amount of such remuneration*
2 *exceeds \$500,000, or*

3 *“(ii) in the case of deferred deduction*
4 *remuneration for any taxable year begin-*
5 *ning after December 31, 2012, which is at-*
6 *tributable to services performed by an ap-*
7 *plicable individual during any disqualified*
8 *taxable year beginning after December 31,*
9 *2009, to the extent that the amount of such*
10 *remuneration exceeds \$500,000 reduced (but*
11 *not below zero) by the sum of—*

12 *“(I) the applicable individual re-*
13 *muneration for such disqualified tax-*
14 *able year, plus*

15 *“(II) the portion of the deferred*
16 *deduction remuneration for such serv-*
17 *ices which was taken into account*
18 *under this clause in a preceding tax-*
19 *able year (or which would have been*
20 *taken into account under this clause in*
21 *a preceding taxable year if this clause*
22 *were applied by substituting ‘December*
23 *31, 2009’ for ‘December 31, 2012’ in*
24 *the matter preceding subclause (I)).*

1 “(B) *DISQUALIFIED TAXABLE YEAR.*—For
2 purposes of this paragraph, the term ‘disquali-
3 fied taxable year’ means, with respect to any em-
4 ployer, any taxable year for which such employer
5 is a covered health insurance provider.

6 “(C) *COVERED HEALTH INSURANCE PRO-*
7 *VIDER.*—For purposes of this paragraph—

8 “(i) *IN GENERAL.*—The term ‘covered
9 health insurance provider’ means—

10 “(I) with respect to taxable years
11 beginning after December 31, 2009,
12 and before January 1, 2013, any em-
13 ployer which is a health insurance
14 issuer (as defined in section
15 9832(b)(2)) and which receives pre-
16 miums from providing health insur-
17 ance coverage (as defined in section
18 9832(b)(1)), and

19 “(II) with respect to taxable years
20 beginning after December 31, 2012,
21 any employer which is a health insur-
22 ance issuer (as defined in section
23 9832(b)(2)) and with respect to which
24 not less than 25 percent of the gross
25 premiums received from providing

1 *health insurance coverage (as defined*
2 *in section 9832(b)(1)) is from min-*
3 *imum essential coverage (as defined in*
4 *section 5000A(f)).*

5 “(ii) *AGGREGATION RULES.—Two or*
6 *more persons who are treated as a single*
7 *employer under subsection (b), (c), (m), or*
8 *(o) of section 414 shall be treated as a single*
9 *employer, except that in applying section*
10 *1563(a) for purposes of any such subsection,*
11 *paragraphs (2) and (3) thereof shall be dis-*
12 *regarded.*

13 “(D) *APPLICABLE INDIVIDUAL REMUNERA-*
14 *TION.—For purposes of this paragraph, the term*
15 *‘applicable individual remuneration’ means,*
16 *with respect to any applicable individual for*
17 *any disqualified taxable year, the aggregate*
18 *amount allowable as a deduction under this*
19 *chapter for such taxable year (determined with-*
20 *out regard to this subsection) for remuneration*
21 *(as defined in paragraph (4) without regard to*
22 *subparagraphs (B), (C), and (D) thereof) for*
23 *services performed by such individual (whether*
24 *or not during the taxable year). Such term shall*
25 *not include any deferred deduction remuneration*

1 *with respect to services performed during the dis-*
2 *qualified taxable year.*

3 “(E) *DEFERRED DEDUCTION REMUNERA-*
4 *TION.—For purposes of this paragraph, the term*
5 *‘deferred deduction remuneration’ means remu-*
6 *neration which would be applicable individual*
7 *remuneration for services performed in a dis-*
8 *qualified taxable year but for the fact that the*
9 *deduction under this chapter (determined with-*
10 *out regard to this paragraph) for such remunera-*
11 *tion is allowable in a subsequent taxable year.*

12 “(F) *APPLICABLE INDIVIDUAL.—For pur-*
13 *poses of this paragraph, the term ‘applicable in-*
14 *dividual’ means, with respect to any covered*
15 *health insurance provider for any disqualified*
16 *taxable year, any individual—*

17 “(i) *who is an officer, director, or em-*
18 *ployee in such taxable year, or*

19 “(ii) *who provides services for or on*
20 *behalf of such covered health insurance pro-*
21 *vider during such taxable year.*

22 “(G) *COORDINATION.—Rules similar to the*
23 *rules of subparagraphs (F) and (G) of paragraph*
24 *(4) shall apply for purposes of this paragraph.*

1 “(H) *REGULATORY AUTHORITY.*—*The Sec-*
2 *retary may prescribe such guidance, rules, or*
3 *regulations as are necessary to carry out the*
4 *purposes of this paragraph.*”.

5 (b) *EFFECTIVE DATE.*—*The amendment made by this*
6 *section shall apply to taxable years beginning after Decem-*
7 *ber 31, 2009, with respect to services performed after such*
8 *date.*

9 **SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON**
10 **HIGH-INCOME TAXPAYERS.**

11 (a) *FICA.*—

12 (1) *IN GENERAL.*—*Section 3101(b) of the Inter-*
13 *nal Revenue Code of 1986 is amended—*

14 (A) *by striking “In addition” and inserting*
15 *the following:*

16 “(1) *IN GENERAL.*—*In addition*”,

17 (B) *by striking “the following percentages of*
18 *the” and inserting “1.45 percent of the”,*

19 (C) *by striking “(as defined in section*
20 *3121(b))—” and all that follows and inserting*
21 *“(as defined in section 3121(b)).”, and*

22 (D) *by adding at the end the following new*
23 *paragraph:*

24 “(2) *ADDITIONAL TAX.*—*In addition to the tax*
25 *imposed by paragraph (1) and the preceding sub-*

1 *section, there is hereby imposed on every taxpayer*
2 *(other than a corporation, estate, or trust) a tax equal*
3 *to 0.5 percent of wages which are received with re-*
4 *spect to employment (as defined in section 3121(b))*
5 *during any taxable year beginning after December 31,*
6 *2012, and which are in excess of—*

7 *“(A) in the case of a joint return, \$250,000,*

8 *and*

9 *“(B) in any other case, \$200,000.”.*

10 *(2) COLLECTION OF TAX.—Section 3102 of the*
11 *Internal Revenue Code of 1986 is amended by adding*
12 *at the end the following new subsection:*

13 *“(f) SPECIAL RULES FOR ADDITIONAL TAX.—*

14 *“(1) IN GENERAL.—In the case of any tax im-*
15 *posed by section 3101(b)(2), subsection (a) shall only*
16 *apply to the extent to which the taxpayer receives*
17 *wages from the employer in excess of \$200,000, and*
18 *the employer may disregard the amount of wages re-*
19 *ceived by such taxpayer’s spouse.*

20 *“(2) COLLECTION OF AMOUNTS NOT WITH-*
21 *HELD.—To the extent that the amount of any tax im-*
22 *posed by section 3101(b)(2) is not collected by the em-*
23 *ployer, such tax shall be paid by the employee.*

24 *“(3) TAX PAID BY RECIPIENT.—If an employer,*
25 *in violation of this chapter, fails to deduct and with-*

1 *hold the tax imposed by section 3101(b)(2) and there-*
2 *after the tax is paid by the employee, the tax so re-*
3 *quired to be deducted and withheld shall not be col-*
4 *lected from the employer, but this paragraph shall in*
5 *no case relieve the employer from liability for any*
6 *penalties or additions to tax otherwise applicable in*
7 *respect of such failure to deduct and withhold.”.*

8 *(b) SECA.—*

9 *(1) IN GENERAL.—Section 1401(b) of the Inter-*
10 *nal Revenue Code of 1986 is amended—*

11 *(A) by striking “In addition” and inserting*
12 *the following:*

13 *“(1) IN GENERAL.—In addition”, and*

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

16 *“(2) ADDITIONAL TAX.—*

17 *“(A) IN GENERAL.—In addition to the tax*
18 *imposed by paragraph (1) and the preceding*
19 *subsection, there is hereby imposed on every tax-*
20 *payer (other than a corporation, estate, or trust)*
21 *for each taxable year beginning after December*
22 *31, 2012, a tax equal to 0.5 percent of the self-*
23 *employment income for such taxable year which*
24 *is in excess of—*

1 “(i) in the case of a joint return,
2 \$250,000, and

3 “(ii) in any other case, \$200,000.

4 “(B) COORDINATION WITH FICA.—The
5 amounts under clauses (i) and (ii) of subpara-
6 graph (A) shall be reduced (but not below zero)
7 by the amount of wages taken into account in
8 determining the tax imposed under section
9 3121(b)(2) with respect to the taxpayer.”.

10 (2) NO DEDUCTION FOR ADDITIONAL TAX.—

11 (A) IN GENERAL.—Section 164(f) of such
12 Code is amended by inserting “(other than the
13 taxes imposed by section 1401(b)(2))” after “sec-
14 tion 1401)”.

15 (B) DEDUCTION FOR NET EARNINGS FROM
16 SELF-EMPLOYMENT.—Subparagraph (B) of sec-
17 tion 1402(a)(12) is amended by inserting “(de-
18 termined without regard to the rate imposed
19 under paragraph (2) of section 1401(b))” after
20 “for such year”.

21 (c) EFFECTIVE DATE.—The amendments made by this
22 section shall apply with respect to remuneration received,
23 and taxable years beginning, after December 31, 2012.

1 **SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF**
 2 **CERTAIN HEALTH ORGANIZATIONS.**

3 (a) *IN GENERAL.*—Subsection (c) of section 833 of the
 4 *Internal Revenue Code of 1986 is amended by adding at*
 5 *the end the following new paragraph:*

6 “(5) *NONAPPLICATION OF SECTION IN CASE OF*
 7 *LOW MEDICAL LOSS RATIO.*—Notwithstanding the pre-
 8 *ceding paragraphs, this section shall not apply to any*
 9 *organization unless such organization’s percentage of*
 10 *total premium revenue expended on reimbursement*
 11 *for clinical services provided to enrollees under its*
 12 *policies during such taxable year (as reported under*
 13 *section 2718 of the Public Health Service Act) is not*
 14 *less than 85 percent.”.*

15 (b) *EFFECTIVE DATE.*—The amendment made by this
 16 section shall apply to taxable years beginning after Decem-
 17 ber 31, 2009.

18 **SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL**
 19 **PROCEDURES.**

20 (a) *IN GENERAL.*—Subtitle D of the *Internal Revenue*
 21 *Code of 1986, as amended by this Act, is amended by add-*
 22 *ing at the end the following new chapter:*

23 **“CHAPTER 49—ELECTIVE COSMETIC**
 24 **MEDICAL PROCEDURES**

“Sec. 5000B. *Imposition of tax on elective cosmetic medical procedures.*

1 **“SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC**
2 **MEDICAL PROCEDURES.**

3 “(a) *IN GENERAL.*—*There is hereby imposed on any*
4 *cosmetic surgery and medical procedure a tax equal to 5*
5 *percent of the amount paid for such procedure (determined*
6 *without regard to this section), whether paid by insurance*
7 *or otherwise.*

8 “(b) *COSMETIC SURGERY AND MEDICAL PROCE-*
9 *DURE.*—*For purposes of this section, the term ‘cosmetic sur-*
10 *gery and medical procedure’ means any cosmetic surgery*
11 *(as defined in section 213(d)(9)(B)) or other similar proce-*
12 *dure which—*

13 “(1) *is performed by a licensed medical profes-*
14 *sional, and*

15 “(2) *is not necessary to ameliorate a deformity*
16 *arising from, or directly related to, a congenital ab-*
17 *normality, a personal injury resulting from an acci-*
18 *dent or trauma, or disfiguring disease.*

19 “(c) *PAYMENT OF TAX.*—

20 “(1) *IN GENERAL.*—*The tax imposed by this sec-*
21 *tion shall be paid by the individual on whom the pro-*
22 *cedure is performed.*

23 “(2) *COLLECTION.*—*Every person receiving a*
24 *payment for procedures on which a tax is imposed*
25 *under subsection (a) shall collect the amount of the*
26 *tax from the individual on whom the procedure is*

1 *performed and remit such tax quarterly to the Sec-*
2 *retary at such time and in such manner as provided*
3 *by the Secretary.*

4 “(3) *SECONDARY LIABILITY.*—Where any tax im-
5 *posed by subsection (a) is not paid at the time pay-*
6 *ments for cosmetic surgery and medical procedures*
7 *are made, then to the extent that such tax is not col-*
8 *lected, such tax shall be paid by the person who per-*
9 *forms the procedure.”.*

10 “(b) *CLERICAL AMENDMENT.*—The table of chapters for
11 *subtitle D of the Internal Revenue Code of 1986, as amended*
12 *by this Act, is amended by inserting after the item relating*
13 *to chapter 48 the following new item:*

 “CHAPTER 49—*ELECTIVE COSMETIC MEDICAL PROCEDURES*”.

14 “(c) *EFFECTIVE DATE.*—The amendments made by this
15 *section shall apply to procedures performed on or after Jan-*
16 *uary 1, 2010.*

17 ***Subtitle B—Other Provisions***

18 ***SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY*** 19 ***INDIAN TRIBAL GOVERNMENTS.***

20 “(a) *IN GENERAL.*—Part III of subchapter B of chapter
21 *1 of the Internal Revenue Code of 1986 is amended by in-*
22 *serting after section 139C the following new section:*

1 **“SEC. 139D. INDIAN HEALTH CARE BENEFITS.**

2 “(a) *GENERAL RULE.—Except as otherwise provided*
3 *in this section, gross income does not include the value of*
4 *any qualified Indian health care benefit.*

5 “(b) *QUALIFIED INDIAN HEALTH CARE BENEFIT.—*
6 *For purposes of this section, the term ‘qualified Indian*
7 *health care benefit’ means—*

8 “(1) *any health service or benefit provided or*
9 *purchased, directly or indirectly, by the Indian*
10 *Health Service through a grant to or a contract or*
11 *compact with an Indian tribe or tribal organization,*
12 *or through a third-party program funded by the In-*
13 *Indian Health Service,*

14 “(2) *medical care provided or purchased by, or*
15 *amounts to reimburse for such medical care provided*
16 *by, an Indian tribe or tribal organization for, or to,*
17 *a member of an Indian tribe, including a spouse or*
18 *dependent of such a member,*

19 “(3) *coverage under accident or health insurance*
20 *(or an arrangement having the effect of accident or*
21 *health insurance), or an accident or health plan, pro-*
22 *vided by an Indian tribe or tribal organization for*
23 *medical care to a member of an Indian tribe, include*
24 *a spouse or dependent of such a member, and*

25 “(4) *any other medical care provided by an In-*
26 *Indian tribe or tribal organization that supplements, re-*

1 *places, or substitutes for a program or service relating*
2 *to medical care provided by the Federal government*
3 *to Indian tribes or members of such a tribe.*

4 “(c) *DEFINITIONS.—For purposes of this section—*

5 “(1) *INDIAN TRIBE.—The term ‘Indian tribe’ has*
6 *the meaning given such term by section 45A(c)(6).*

7 “(2) *TRIBAL ORGANIZATION.—The term ‘tribal*
8 *organization’ has the meaning given such term by sec-*
9 *tion 4(l) of the Indian Self-Determination and Edu-*
10 *cation Assistance Act.*

11 “(3) *MEDICAL CARE.—The term ‘medical care’*
12 *has the same meaning as when used in section 213.*

13 “(4) *ACCIDENT OR HEALTH INSURANCE; ACCI-*
14 *DENT OR HEALTH PLAN.—The terms ‘accident or*
15 *health insurance’ and ‘accident or health plan’ have*
16 *the same meaning as when used in section 105.*

17 “(5) *DEPENDENT.—The term ‘dependent’ has the*
18 *meaning given such term by section 152, determined*
19 *without regard to subsections (b)(1), (b)(2), and*
20 *(d)(1)(B) thereof.*

21 “(d) *DENIAL OF DOUBLE BENEFIT.—Subsection (a)*
22 *shall not apply to the amount of any qualified Indian*
23 *health care benefit which is not includible in gross income*
24 *of the beneficiary of such benefit under any other provision*
25 *of this chapter, or to the amount of any such benefit for*

1 *which a deduction is allowed to such beneficiary under any*
 2 *other provision of this chapter.”.*

3 (b) *CLERICAL AMENDMENT.*—*The table of sections for*
 4 *part III of subchapter B of chapter 1 of the Internal Rev-*
 5 *enue Code of 1986 is amended by inserting after the item*
 6 *relating to section 139C the following new item:*

“Sec. 139D. Indian health care benefits.”.

7 (c) *EFFECTIVE DATE.*—*The amendments made by this*
 8 *section shall apply to benefits and coverage provided after*
 9 *the date of the enactment of this Act.*

10 (d) *NO INFERENCE.*—*Nothing in the amendments*
 11 *made by this section shall be construed to create an infer-*
 12 *ence with respect to the exclusion from gross income of—*

13 (1) *benefits provided by an Indian tribe or tribal*
 14 *organization that are not within the scope of this sec-*
 15 *tion, and*

16 (2) *benefits provided prior to the date of the en-*
 17 *actment of this Act.*

18 **SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS**
 19 **FOR SMALL BUSINESSES.**

20 (a) *IN GENERAL.*—*Section 125 of the Internal Revenue*
 21 *Code of 1986 (relating to cafeteria plans), as amended by*
 22 *this Act, is amended by redesignating subsections (j) and*
 23 *(k) as subsections (k) and (l), respectively, and by inserting*
 24 *after subsection (i) the following new subsection:*

1 “(j) *SIMPLE CAFETERIA PLANS FOR SMALL BUSI-*
2 *NESSES.*—

3 “(1) *IN GENERAL.*—*An eligible employer main-*
4 *taining a simple cafeteria plan with respect to which*
5 *the requirements of this subsection are met for any*
6 *year shall be treated as meeting any applicable non-*
7 *discrimination requirement during such year.*

8 “(2) *SIMPLE CAFETERIA PLAN.*—*For purposes of*
9 *this subsection, the term ‘simple cafeteria plan’ means*
10 *a cafeteria plan—*

11 “(A) *which is established and maintained*
12 *by an eligible employer, and*

13 “(B) *with respect to which the contribution*
14 *requirements of paragraph (3), and the eligi-*
15 *bility and participation requirements of para-*
16 *graph (4), are met.*

17 “(3) *CONTRIBUTION REQUIREMENTS.*—

18 “(A) *IN GENERAL.*—*The requirements of*
19 *this paragraph are met if, under the plan the*
20 *employer is required, without regard to whether*
21 *a qualified employee makes any salary reduction*
22 *contribution, to make a contribution to provide*
23 *qualified benefits under the plan on behalf of*
24 *each qualified employee in an amount equal to—*

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1 “(i) a uniform percentage (not less
2 than 2 percent) of the employee’s compensa-
3 tion for the plan year, or

4 “(ii) an amount which is not less than
5 the lesser of—

6 “(I) 6 percent of the employee’s
7 compensation for the plan year, or

8 “(II) twice the amount of the sal-
9 ary reduction contributions of each
10 qualified employee.

11 “(B) *MATCHING CONTRIBUTIONS ON BE-*
12 *HALF OF HIGHLY COMPENSATED AND KEY EM-*
13 *PLOYEES.—The requirements of subparagraph*
14 *(A)(ii) shall not be treated as met if, under the*
15 *plan, the rate of contributions with respect to*
16 *any salary reduction contribution of a highly*
17 *compensated or key employee at any rate of con-*
18 *tribution is greater than that with respect to an*
19 *employee who is not a highly compensated or key*
20 *employee.*

21 “(C) *ADDITIONAL CONTRIBUTIONS.—Subject*
22 *to subparagraph (B), nothing in this paragraph*
23 *shall be treated as prohibiting an employer from*
24 *making contributions to provide qualified bene-*

1 *fits under the plan in addition to contributions*
2 *required under subparagraph (A).*

3 “(D) *DEFINITIONS.*—*For purposes of this*
4 *paragraph—*

5 “(i) *SALARY REDUCTION CONTRIBU-*
6 *TION.*—*The term ‘salary reduction contribu-*
7 *tion’ means, with respect to a cafeteria*
8 *plan, any amount which is contributed to*
9 *the plan at the election of the employee and*
10 *which is not includible in gross income by*
11 *reason of this section.*

12 “(ii) *QUALIFIED EMPLOYEE.*—*The*
13 *term ‘qualified employee’ means, with re-*
14 *spect to a cafeteria plan, any employee who*
15 *is not a highly compensated or key em-*
16 *ployee and who is eligible to participate in*
17 *the plan.*

18 “(iii) *HIGHLY COMPENSATED EM-*
19 *PLOYEE.*—*The term ‘highly compensated*
20 *employee’ has the meaning given such term*
21 *by section 414(q).*

22 “(iv) *KEY EMPLOYEE.*—*The term ‘key*
23 *employee’ has the meaning given such term*
24 *by section 416(i).*

1 “(4) *MINIMUM ELIGIBILITY AND PARTICIPATION*
2 *REQUIREMENTS.*—

3 “(A) *IN GENERAL.*—*The requirements of*
4 *this paragraph shall be treated as met with re-*
5 *spect to any year if, under the plan—*

6 “(i) *all employees who had at least*
7 *1,000 hours of service for the preceding plan*
8 *year are eligible to participate, and*

9 “(ii) *each employee eligible to partici-*
10 *pate in the plan may, subject to terms and*
11 *conditions applicable to all participants,*
12 *elect any benefit available under the plan.*

13 “(B) *CERTAIN EMPLOYEES MAY BE EX-*
14 *CLUDED.*—*For purposes of subparagraph (A)(i),*
15 *an employer may elect to exclude under the plan*
16 *employees—*

17 “(i) *who have not attained the age of*
18 *21 before the close of a plan year,*

19 “(ii) *who have less than 1 year of serv-*
20 *ice with the employer as of any day during*
21 *the plan year,*

22 “(iii) *who are covered under an agree-*
23 *ment which the Secretary of Labor finds to*
24 *be a collective bargaining agreement if there*
25 *is evidence that the benefits covered under*

1 *the cafeteria plan were the subject of good*
2 *faith bargaining between employee rep-*
3 *resentatives and the employer, or*

4 “(iv) *who are described in section*
5 *410(b)(3)(C) (relating to nonresident aliens*
6 *working outside the United States).*

7 *A plan may provide a shorter period of service*
8 *or younger age for purposes of clause (i) or (ii).*

9 “(5) *ELIGIBLE EMPLOYER.—For purposes of this*
10 *subsection—*

11 “(A) *IN GENERAL.—The term ‘eligible em-*
12 *ployer’ means, with respect to any year, any em-*
13 *ployer if such employer employed an average of*
14 *100 or fewer employees on business days during*
15 *either of the 2 preceding years. For purposes of*
16 *this subparagraph, a year may only be taken*
17 *into account if the employer was in existence*
18 *throughout the year.*

19 “(B) *EMPLOYERS NOT IN EXISTENCE DUR-*
20 *ING PRECEDING YEAR.—If an employer was not*
21 *in existence throughout the preceding year, the*
22 *determination under subparagraph (A) shall be*
23 *based on the average number of employees that*
24 *it is reasonably expected such employer will em-*
25 *ploy on business days in the current year.*

1 “(C) *GROWING EMPLOYERS RETAIN TREAT-*
2 *MENT AS SMALL EMPLOYER.—*

3 “(i) *IN GENERAL.—If—*

4 “(I) *an employer was an eligible*
5 *employer for any year (a ‘qualified*
6 *year’), and*

7 “(II) *such employer establishes a*
8 *simple cafeteria plan for its employees*
9 *for such year,*

10 *then, notwithstanding the fact the employer*
11 *fails to meet the requirements of subpara-*
12 *graph (A) for any subsequent year, such*
13 *employer shall be treated as an eligible em-*
14 *ployer for such subsequent year with respect*
15 *to employees (whether or not employees dur-*
16 *ing a qualified year) of any trade or busi-*
17 *ness which was covered by the plan during*
18 *any qualified year.*

19 “(ii) *EXCEPTION.—This subparagraph*
20 *shall cease to apply if the employer employs*
21 *an average of 200 or more employees on*
22 *business days during any year preceding*
23 *any such subsequent year.*

24 “(D) *SPECIAL RULES.—*

1 “(i) *PREDECESSORS.*—Any reference
2 in this paragraph to an employer shall in-
3 clude a reference to any predecessor of such
4 employer.

5 “(ii) *AGGREGATION RULES.*—All per-
6 sons treated as a single employer under sub-
7 section (a) or (b) of section 52, or subsection
8 (n) or (o) of section 414, shall be treated as
9 one person.

10 “(6) *APPLICABLE NONDISCRIMINATION REQUIRE-*
11 *MENT.*—For purposes of this subsection, the term ‘ap-
12 plicable nondiscrimination requirement’ means any
13 requirement under subsection (b) of this section, sec-
14 tion 79(d), section 105(h), or paragraph (2), (3), (4),
15 or (8) of section 129(d).

16 “(7) *COMPENSATION.*—The term ‘compensation’
17 has the meaning given such term by section 414(s).”.

18 “(b) *EFFECTIVE DATE.*—The amendments made by this
19 section shall apply to years beginning after December 31,
20 2010.

21 **SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY**
22 **PROJECT CREDIT.**

23 “(a) *IN GENERAL.*—Subpart E of part IV of subchapter
24 A of chapter 1 of the Internal Revenue Code of 1986 is

1 amended by inserting after section 48C the following new
2 section:

3 **“SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY**
4 **PROJECT CREDIT.**

5 “(a) *IN GENERAL.*—For purposes of section 46, the
6 qualifying therapeutic discovery project credit for any tax-
7 able year is an amount equal to 50 percent of the qualified
8 investment for such taxable year with respect to any quali-
9 fying therapeutic discovery project of an eligible taxpayer.

10 “(b) *QUALIFIED INVESTMENT.*—

11 “(1) *IN GENERAL.*—For purposes of subsection
12 (a), the qualified investment for any taxable year is
13 the aggregate amount of the costs paid or incurred in
14 such taxable year for expenses necessary for and di-
15 rectly related to the conduct of a qualifying thera-
16 peutic discovery project.

17 “(2) *LIMITATION.*—The amount which is treated
18 as qualified investment for all taxable years with re-
19 spect to any qualifying therapeutic discovery project
20 shall not exceed the amount certified by the Secretary
21 as eligible for the credit under this section.

22 “(3) *EXCLUSIONS.*—The qualified investment for
23 any taxable year with respect to any qualifying
24 therapeutic discovery project shall not take into ac-
25 count any cost—

1 “(A) for remuneration for an employee de-
2 scribed in section 162(m)(3),

3 “(B) for interest expenses,

4 “(C) for facility maintenance expenses,

5 “(D) which is identified as a service cost
6 under section 1.263A-1(e)(4) of title 26, Code of
7 Federal Regulations, or

8 “(E) for any other expense as determined by
9 the Secretary as appropriate to carry out the
10 purposes of this section.

11 “(4) CERTAIN PROGRESS EXPENDITURE RULES
12 MADE APPLICABLE.—In the case of costs described in
13 paragraph (1) that are paid for property of a char-
14 acter subject to an allowance for depreciation, rules
15 similar to the rules of subsections (c)(4) and (d) of
16 section 46 (as in effect on the day before the date of
17 the enactment of the Revenue Reconciliation Act of
18 1990) shall apply for purposes of this section.

19 “(5) APPLICATION OF SUBSECTION.—An invest-
20 ment shall be considered a qualified investment under
21 this subsection only if such investment is made in a
22 taxable year beginning in 2009 or 2010.

23 “(c) DEFINITIONS.—

1 “(1) *QUALIFYING THERAPEUTIC DISCOVERY*
2 *PROJECT.*—*The term ‘qualifying therapeutic discovery*
3 *project’ means a project which is designed—*

4 “(A) *to treat or prevent diseases or condi-*
5 *tions by conducting pre-clinical activities, clin-*
6 *ical trials, and clinical studies, or carrying out*
7 *research protocols, for the purpose of securing*
8 *approval of a product under section 505(b) of the*
9 *Federal Food, Drug, and Cosmetic Act or section*
10 *351(a) of the Public Health Service Act,*

11 “(B) *to diagnose diseases or conditions or to*
12 *determine molecular factors related to diseases or*
13 *conditions by developing molecular diagnostics to*
14 *guide therapeutic decisions, or*

15 “(C) *to develop a product, process, or tech-*
16 *nology to further the delivery or administration*
17 *of therapeutics.*

18 “(2) *ELIGIBLE TAXPAYER.*—

19 “(A) *IN GENERAL.*—*The term ‘eligible tax-*
20 *payer’ means a taxpayer which employs not*
21 *more than 250 employees in all businesses of the*
22 *taxpayer at the time of the submission of the ap-*
23 *plication under subsection (d)(2).*

24 “(B) *AGGREGATION RULES.*—*All persons*
25 *treated as a single employer under subsection (a)*

1 or (b) of section 52, or subsection (m) or (o) of
2 section 414, shall be so treated for purposes of
3 this paragraph.

4 “(3) *FACILITY MAINTENANCE EXPENSES.*—The
5 term ‘facility maintenance expenses’ means costs paid
6 or incurred to maintain a facility, including—

7 “(A) mortgage or rent payments,

8 “(B) insurance payments,

9 “(C) utility and maintenance costs, and

10 “(D) costs of employment of maintenance
11 personnel.

12 “(d) *QUALIFYING THERAPEUTIC DISCOVERY PROJECT*
13 *PROGRAM.*—

14 “(1) *ESTABLISHMENT.*—

15 “(A) *IN GENERAL.*—Not later than 60 days
16 after the date of the enactment of this section, the
17 Secretary, in consultation with the Secretary of
18 Health and Human Services, shall establish a
19 qualifying therapeutic discovery project program
20 to consider and award certifications for qualified
21 investments eligible for credits under this section
22 to qualifying therapeutic discovery project spon-
23 sors.

24 “(B) *LIMITATION.*—The total amount of
25 credits that may be allocated under the program

1 *shall not exceed \$1,000,000,000 for the 2-year pe-*
2 *riod beginning with 2009.*

3 “(2) *CERTIFICATION.—*

4 “(A) *APPLICATION PERIOD.—Each appli-*
5 *cant for certification under this paragraph shall*
6 *submit an application containing such informa-*
7 *tion as the Secretary may require during the pe-*
8 *riod beginning on the date the Secretary estab-*
9 *lishes the program under paragraph (1).*

10 “(B) *TIME FOR REVIEW OF APPLICA-*
11 *TIONS.—The Secretary shall take action to ap-*
12 *prove or deny any application under subpara-*
13 *graph (A) within 30 days of the submission of*
14 *such application.*

15 “(C) *MULTI-YEAR APPLICATIONS.—An ap-*
16 *plication for certification under subparagraph*
17 *(A) may include a request for an allocation of*
18 *credits for more than 1 of the years described in*
19 *paragraph (1)(B).*

20 “(3) *SELECTION CRITERIA.—In determining the*
21 *qualifying therapeutic discovery projects with respect*
22 *to which qualified investments may be certified under*
23 *this section, the Secretary—*

24 “(A) *shall take into consideration only those*
25 *projects that show reasonable potential—*

1 “(i) to result in new therapies—
2 “(I) to treat areas of unmet med-
3 ical need, or
4 “(II) to prevent, detect, or treat
5 chronic or acute diseases and condi-
6 tions,
7 “(ii) to reduce long-term health care
8 costs in the United States, or
9 “(iii) to significantly advance the goal
10 of curing cancer within the 30-year period
11 beginning on the date the Secretary estab-
12 lishes the program under paragraph (1),
13 and
14 “(B) shall take into consideration which
15 projects have the greatest potential—
16 “(i) to create and sustain (directly or
17 indirectly) high quality, high-paying jobs in
18 the United States, and
19 “(ii) to advance United States com-
20 petitiveness in the fields of life, biological,
21 and medical sciences.
22 “(4) DISCLOSURE OF ALLOCATIONS.—The Sec-
23 retary shall, upon making a certification under this
24 subsection, publicly disclose the identity of the appli-

1 *cant and the amount of the credit with respect to such*
2 *applicant.*

3 “(e) *SPECIAL RULES.*—

4 “(1) *BASIS ADJUSTMENT.*—*For purposes of this*
5 *subtitle, if a credit is allowed under this section for*
6 *an expenditure related to property of a character sub-*
7 *ject to an allowance for depreciation, the basis of such*
8 *property shall be reduced by the amount of such cred-*
9 *it.*

10 “(2) *DENIAL OF DOUBLE BENEFIT.*—

11 “(A) *BONUS DEPRECIATION.*—*A credit shall*
12 *not be allowed under this section for any invest-*
13 *ment for which bonus depreciation is allowed*
14 *under section 168(k), 1400L(b)(1), or*
15 *1400N(d)(1).*

16 “(B) *DEDUCTIONS.*—*No deduction under*
17 *this subtitle shall be allowed for the portion of*
18 *the expenses otherwise allowable as a deduction*
19 *taken into account in determining the credit*
20 *under this section for the taxable year which is*
21 *equal to the amount of the credit determined for*
22 *such taxable year under subsection (a) attrib-*
23 *utable to such portion. This subparagraph shall*
24 *not apply to expenses related to property of a*
25 *character subject to an allowance for deprecia-*

1 *tion the basis of which is reduced under para-*
2 *graph (1), or which are described in section*
3 *280C(g).*

4 “(C) *CREDIT FOR RESEARCH ACTIVITIES.—*

5 *“(i) IN GENERAL.—Except as provided*
6 *in clause (ii), any expenses taken into ac-*
7 *count under this section for a taxable year*
8 *shall not be taken into account for purposes*
9 *of determining the credit allowable under*
10 *section 41 or 45C for such taxable year.*

11 *“(ii) EXPENSES INCLUDED IN DETER-*
12 *MINING BASE PERIOD RESEARCH EX-*
13 *PENSES.—Any expenses for any taxable*
14 *year which are qualified research expenses*
15 *(within the meaning of section 41(b)) shall*
16 *be taken into account in determining base*
17 *period research expenses for purposes of ap-*
18 *plying section 41 to subsequent taxable*
19 *years.*

20 “(f) *COORDINATION WITH DEPARTMENT OF TREASURY*
21 *GRANTS.—In the case of any investment with respect to*
22 *which the Secretary makes a grant under section 9023(e)*
23 *of the Patient Protection and Affordable Care Act of 2009—*

24 *“(1) DENIAL OF CREDIT.—No credit shall be de-*
25 *termined under this section with respect to such in-*

1 *vestment for the taxable year in which such grant is*
2 *made or any subsequent taxable year.*

3 *“(2) RECAPTURE OF CREDITS FOR PROGRESS*
4 *EXPENDITURES MADE BEFORE GRANT.—If a credit*
5 *was determined under this section with respect to*
6 *such investment for any taxable year ending before*
7 *such grant is made—*

8 *“(A) the tax imposed under subtitle A on*
9 *the taxpayer for the taxable year in which such*
10 *grant is made shall be increased by so much of*
11 *such credit as was allowed under section 38,*

12 *“(B) the general business carryforwards*
13 *under section 39 shall be adjusted so as to recap-*
14 *ture the portion of such credit which was not so*
15 *allowed, and*

16 *“(C) the amount of such grant shall be de-*
17 *termined without regard to any reduction in the*
18 *basis of any property of a character subject to an*
19 *allowance for depreciation by reason of such*
20 *credit.*

21 *“(3) TREATMENT OF GRANTS.—Any such grant*
22 *shall not be includible in the gross income of the tax-*
23 *payer.”.*

1 **(b) INCLUSION AS PART OF INVESTMENT CREDIT.**—
2 *Section 46 of the Internal Revenue Code of 1986 is amend-*
3 *ed—*

4 (1) *by adding a comma at the end of paragraph*
5 *(2),*

6 (2) *by striking the period at the end of para-*
7 *graph (5) and inserting “, and”, and*

8 (3) *by adding at the end the following new para-*
9 *graph:*

10 “*(6) the qualifying therapeutic discovery project*
11 *credit.*”.

12 **(c) CONFORMING AMENDMENTS.**—

13 (1) *Section 49(a)(1)(C) of the Internal Revenue*
14 *Code of 1986 is amended—*

15 (A) *by striking “and” at the end of clause*
16 *(iv),*

17 (B) *by striking the period at the end of*
18 *clause (v) and inserting “, and”, and*

19 (C) *by adding at the end the following new*
20 *clause:*

21 “*(vi) the basis of any property to*
22 *which paragraph (1) of section 48D(e) ap-*
23 *plies which is part of a qualifying thera-*
24 *peutic discovery project under such section*
25 *48D.*”.

1 (2) *Section 280C of such Code is amended by*
2 *adding at the end the following new subsection:*

3 “*(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT*
4 *CREDIT.—*

5 “*(1) IN GENERAL.—No deduction shall be al-*
6 *lowed for that portion of the qualified investment (as*
7 *defined in section 48D(b)) otherwise allowable as a*
8 *deduction for the taxable year which—*

9 “*(A) would be qualified research expenses*
10 *(as defined in section 41(b)), basic research ex-*
11 *periences (as defined in section 41(e)(2)), or quali-*
12 *fied clinical testing expenses (as defined in sec-*
13 *tion 45C(b)) if the credit under section 41 or sec-*
14 *tion 45C were allowed with respect to such ex-*
15 *periences for such taxable year, and*

16 “*(B) is equal to the amount of the credit de-*
17 *termined for such taxable year under section*
18 *48D(a), reduced by—*

19 “*(i) the amount disallowed as a deduc-*
20 *tion by reason of section 48D(e)(2)(B), and*

21 “*(ii) the amount of any basis reduction*
22 *under section 48D(e)(1).*

23 “*(2) SIMILAR RULE WHERE TAXPAYER CAPITAL-*
24 *IZES RATHER THAN DEDUCTS EXPENSES.—In the*
25 *case of expenses described in paragraph (1)(A) taken*

1 into account in determining the credit under section
2 48D for the taxable year, if—

3 “(A) the amount of the portion of the credit
4 determined under such section with respect to
5 such expenses, exceeds

6 “(B) the amount allowable as a deduction
7 for such taxable year for such expenses (deter-
8 mined without regard to paragraph (1)),
9 the amount chargeable to capital account for the tax-
10 able year for such expenses shall be reduced by the
11 amount of such excess.

12 “(3) CONTROLLED GROUPS.—Paragraph (3) of
13 subsection (b) shall apply for purposes of this sub-
14 section.”.

15 (d) CLERICAL AMENDMENT.—The table of sections for
16 subpart E of part IV of subchapter A of chapter 1 of the
17 Internal Revenue Code of 1986 is amended by inserting
18 after the item relating to section 48C the following new
19 item:

 “Sec. 48D. Qualifying therapeutic discovery project credit.”.

20 (e) GRANTS FOR QUALIFIED INVESTMENTS IN THERA-
21 PEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

22 (1) IN GENERAL.—Upon application, the Sec-
23 retary of the Treasury shall, subject to the require-
24 ments of this subsection, provide a grant to each per-
25 son who makes a qualified investment in a qualifying

1 *therapeutic discovery project in the amount of 50 per-*
2 *cent of such investment. No grant shall be made under*
3 *this subsection with respect to any investment unless*
4 *such investment is made during a taxable year begin-*
5 *ning in 2009 or 2010.*

6 (2) *APPLICATION.—*

7 (A) *IN GENERAL.—At the stated election of*
8 *the applicant, an application for certification*
9 *under section 48D(d)(2) of the Internal Revenue*
10 *Code of 1986 for a credit under such section for*
11 *the taxable year of the applicant which begins in*
12 *2009 shall be considered to be an application for*
13 *a grant under paragraph (1) for such taxable*
14 *year.*

15 (B) *TAXABLE YEARS BEGINNING IN 2010.—*
16 *An application for a grant under paragraph (1)*
17 *for a taxable year beginning in 2010 shall be*
18 *submitted—*

19 (i) *not earlier than the day after the*
20 *last day of such taxable year, and*

21 (ii) *not later than the due date (in-*
22 *cluding extensions) for filing the return of*
23 *tax for such taxable year.*

24 (C) *INFORMATION TO BE SUBMITTED.—An*
25 *application for a grant under paragraph (1)*

1 *shall include such information and be in such*
2 *form as the Secretary may require to state the*
3 *amount of the credit allowable (but for the re-*
4 *ceipt of a grant under this subsection) under sec-*
5 *tion 48D for the taxable year for the qualified*
6 *investment with respect to which such applica-*
7 *tion is made.*

8 (3) *TIME FOR PAYMENT OF GRANT.*—

9 (A) *IN GENERAL.*—*The Secretary of the*
10 *Treasury shall make payment of the amount of*
11 *any grant under paragraph (1) during the 30-*
12 *day period beginning on the later of—*

13 (i) *the date of the application for such*
14 *grant, or*

15 (ii) *the date the qualified investment*
16 *for which the grant is being made is made.*

17 (B) *REGULATIONS.*—*In the case of invest-*
18 *ments of an ongoing nature, the Secretary shall*
19 *issue regulations to determine the date on which*
20 *a qualified investment shall be deemed to have*
21 *been made for purposes of this paragraph.*

22 (4) *QUALIFIED INVESTMENT.*—*For purposes of*
23 *this subsection, the term “qualified investment”*
24 *means a qualified investment that is certified under*

1 *section 48D(d) of the Internal Revenue Code of 1986*
2 *for purposes of the credit under such section 48D.*

3 (5) *APPLICATION OF CERTAIN RULES.—*

4 (A) *IN GENERAL.—In making grants under*
5 *this subsection, the Secretary of the Treasury*
6 *shall apply rules similar to the rules of section*
7 *50 of the Internal Revenue Code of 1986. In ap-*
8 *plying such rules, any increase in tax under*
9 *chapter 1 of such Code by reason of an invest-*
10 *ment ceasing to be a qualified investment shall*
11 *be imposed on the person to whom the grant was*
12 *made.*

13 (B) *SPECIAL RULES.—*

14 (i) *RECAPTURE OF EXCESSIVE GRANT*
15 *AMOUNTS.—If the amount of a grant made*
16 *under this subsection exceeds the amount al-*
17 *lowable as a grant under this subsection,*
18 *such excess shall be recaptured under sub-*
19 *paragraph (A) as if the investment to which*
20 *such excess portion of the grant relates had*
21 *ceased to be a qualified investment imme-*
22 *diately after such grant was made.*

23 (ii) *GRANT INFORMATION NOT TREAT-*
24 *ED AS RETURN INFORMATION.—In no event*
25 *shall the amount of a grant made under*

1 *paragraph (1), the identity of the person to*
2 *whom such grant was made, or a descrip-*
3 *tion of the investment with respect to which*
4 *such grant was made be treated as return*
5 *information for purposes of section 6103 of*
6 *the Internal Revenue Code of 1986.*

7 (6) *EXCEPTION FOR CERTAIN NON-TAXPAYERS.—*

8 *The Secretary of the Treasury shall not make any*
9 *grant under this subsection to—*

10 (A) *any Federal, State, or local government*
11 *(or any political subdivision, agency, or instru-*
12 *mentality thereof),*

13 (B) *any organization described in section*
14 *501(c) of the Internal Revenue Code of 1986 and*
15 *exempt from tax under section 501(a) of such*
16 *Code,*

17 (C) *any entity referred to in paragraph (4)*
18 *of section 54(j) of such Code, or*

19 (D) *any partnership or other pass-thru en-*
20 *tity any partner (or other holder of an equity or*
21 *profits interest) of which is described in subpara-*
22 *graph (A), (B) or (C).*

23 *In the case of a partnership or other pass-thru entity*
24 *described in subparagraph (D), partners and other*
25 *holders of any equity or profits interest shall provide*

1 *to such partnership or entity such information as the*
2 *Secretary of the Treasury may require to carry out*
3 *the purposes of this paragraph.*

4 (7) *SECRETARY.*—*Any reference in this sub-*
5 *section to the Secretary of the Treasury shall be treat-*
6 *ed as including the Secretary’s delegate.*

7 (8) *OTHER TERMS.*—*Any term used in this sub-*
8 *section which is also used in section 48D of the Inter-*
9 *nal Revenue Code of 1986 shall have the same mean-*
10 *ing for purposes of this subsection as when used in*
11 *such section.*

12 (9) *DENIAL OF DOUBLE BENEFIT.*—*No credit*
13 *shall be allowed under section 46(6) of the Internal*
14 *Revenue Code of 1986 by reason of section 48D of*
15 *such Code for any investment for which a grant is*
16 *awarded under this subsection.*

17 (10) *APPROPRIATIONS.*—*There is hereby appro-*
18 *priated to the Secretary of the Treasury such sums as*
19 *may be necessary to carry out this subsection.*

20 (11) *TERMINATION.*—*The Secretary of the Treas-*
21 *ury shall not make any grant to any person under*
22 *this subsection unless the application of such person*
23 *for such grant is received before January 1, 2013.*

24 (12) *PROTECTING MIDDLE CLASS FAMILIES FROM*
25 *TAX INCREASES.*—*It is the sense of the Senate that the*

1 *Senate should reject any procedural maneuver that*
 2 *would raise taxes on middle class families, such as a*
 3 *motion to commit the pending legislation to the Com-*
 4 *mittee on Finance, which is designed to kill legisla-*
 5 *tion that provides tax cuts for American workers and*
 6 *families, including the affordability tax credit and*
 7 *the small business tax credit.*

8 *(f) EFFECTIVE DATE.—The amendments made by sub-*
 9 *sections (a) through (d) of this section shall apply to*
 10 *amounts paid or incurred after December 31, 2008, in tax-*
 11 *able years beginning after such date.*

12 **TITLE X—STRENGTHENING**
 13 **QUALITY, AFFORDABLE**
 14 **HEALTH CARE FOR ALL AMER-**
 15 **ICANS**

16 **Subtitle A—Provisions Relating to**
 17 **Title I**

18 **SEC. 10101. AMENDMENTS TO SUBTITLE A.**

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

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

23 **“(a) PROHIBITION.—**

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

4 “(A) *lifetime limits on the dollar value of*
5 *benefits for any participant or beneficiary; or*

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

9 “(2) *ANNUAL LIMITS PRIOR TO 2014.*—With re-
10 *spect to plan years beginning prior to January 1,*
11 *2014, a group health plan and a health insurance*
12 *issuer offering group or individual health insurance*
13 *coverage may only establish a restricted annual limit*
14 *on the dollar value of benefits for any participant or*
15 *beneficiary with respect to the scope of benefits that*
16 *are essential health benefits under section 1302(b) of*
17 *the Patient Protection and Affordable Care Act, as de-*
18 *termined by the Secretary. In defining the term ‘re-*
19 *stricted annual limit’ for purposes of the preceding*
20 *sentence, the Secretary shall ensure that access to*
21 *needed services is made available with a minimal im-*
22 *pact on premiums.*

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

1 *eficiary limits on specific covered benefits that are not es-*
2 *sential health benefits under section 1302(b) of the Patient*
3 *Protection and Affordable Care Act, to the extent that such*
4 *limits are otherwise permitted under Federal or State*
5 *law.”.*

6 (b) *Section 2715(a) of the Public Health Service Act,*
7 *as added by section 1001(5) of this Act, is amended by strik-*
8 *ing “and providing to enrollees” and inserting “and pro-*
9 *viding to applicants, enrollees, and policyholders or certifi-*
10 *cate holders”.*

11 (c) *Subpart II of part A of title XXVII of the Public*
12 *Health Service Act, as added by section 1001(5), is amend-*
13 *ed by inserting after section 2715, the following:*

14 **“SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.**

15 “*A group health plan and a health insurance issuer*
16 *offering group or individual health insurance coverage shall*
17 *comply with the provisions of section 1311(e)(3) of the Pa-*
18 *tient Protection and Affordable Care Act, except that a plan*
19 *or coverage that is not offered through an Exchange shall*
20 *only be required to submit the information required to the*
21 *Secretary and the State insurance commissioner, and make*
22 *such information available to the public.”.*

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

1 **“SEC. 2716. PROHIBITION ON DISCRIMINATION IN FAVOR**
2 **OF HIGHLY COMPENSATED INDIVIDUALS.**

3 “(a) *IN GENERAL.*—A group health plan (other than
4 a self-insured plan) shall satisfy the requirements of section
5 105(h)(2) of the Internal Revenue Code of 1986 (relating
6 to prohibition on discrimination in favor of highly com-
7 pensated individuals).

8 “(b) *RULES AND DEFINITIONS.*—For purposes of this
9 section—

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

13 “(2) *HIGHLY COMPENSATED INDIVIDUAL.*—The
14 term ‘highly compensated individual’ has the mean-
15 ing given such term by section 105(h)(5) of such
16 Code.”.

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

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

21 (2) by inserting after subsection (b), the fol-
22 lowing:

23 “(c) *PROTECTION OF SECOND AMENDMENT GUN*
24 *RIGHTS.*—

25 “(1) *WELLNESS AND PREVENTION PROGRAMS.*—
26 A wellness and health promotion activity imple-

1 *mented under subsection (a)(1)(D) may not require*
2 *the disclosure or collection of any information relat-*
3 *ing to—*

4 *“(A) the presence or storage of a lawfully-*
5 *possessed firearm or ammunition in the resi-*
6 *dence or on the property of an individual; or*

7 *“(B) the lawful use, possession, or storage of*
8 *a firearm or ammunition by an individual.*

9 *“(2) LIMITATION ON DATA COLLECTION.—None*
10 *of the authorities provided to the Secretary under the*
11 *Patient Protection and Affordable Care Act or an*
12 *amendment made by that Act shall be construed to*
13 *authorize or may be used for the collection of any in-*
14 *formation relating to—*

15 *“(A) the lawful ownership or possession of*
16 *a firearm or ammunition;*

17 *“(B) the lawful use of a firearm or ammu-*
18 *nition; or*

19 *“(C) the lawful storage of a firearm or am-*
20 *munition.*

21 *“(3) LIMITATION ON DATABASES OR DATA*
22 *BANKS.—None of the authorities provided to the Sec-*
23 *retary under the Patient Protection and Affordable*
24 *Care Act or an amendment made by that Act shall*
25 *be construed to authorize or may be used to maintain*

1 *records of individual ownership or possession of a*
2 *firearm or ammunition.*

3 “(4) *LIMITATION ON DETERMINATION OF PRE-*
4 *MIUM RATES OR ELIGIBILITY FOR HEALTH INSUR-*
5 *ANCE.—A premium rate may not be increased, health*
6 *insurance coverage may not be denied, and a dis-*
7 *count, rebate, or reward offered for participation in*
8 *a wellness program may not be reduced or withheld*
9 *under any health benefit plan issued pursuant to or*
10 *in accordance with the Patient Protection and Afford-*
11 *able Care Act or an amendment made by that Act on*
12 *the basis of, or on reliance upon—*

13 “(A) *the lawful ownership or possession of*
14 *a firearm or ammunition; or*

15 “(B) *the lawful use or storage of a firearm*
16 *or ammunition.*

17 “(5) *LIMITATION ON DATA COLLECTION RE-*
18 *QUIREMENTS FOR INDIVIDUALS.—No individual shall*
19 *be required to disclose any information under any*
20 *data collection activity authorized under the Patient*
21 *Protection and Affordable Care Act or an amendment*
22 *made by that Act relating to—*

23 “(A) *the lawful ownership or possession of*
24 *a firearm or ammunition; or*

1 “(B) *the lawful use, possession, or storage of*
2 *a firearm or ammunition.*”.

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

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

7 “(a) *CLEAR ACCOUNTING FOR COSTS.—A health in-*
8 *surance issuer offering group or individual health insur-*
9 *ance coverage (including a grandfathered health plan) shall,*
10 *with respect to each plan year, submit to the Secretary a*
11 *report concerning the ratio of the incurred loss (or incurred*
12 *claims) plus the loss adjustment expense (or change in con-*
13 *tract reserves) to earned premiums. Such report shall in-*
14 *clude the percentage of total premium revenue, after ac-*
15 *counting for collections or receipts for risk adjustment and*
16 *risk corridors and payments of reinsurance, that such cov-*
17 *erage expends—*

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

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

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

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

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

6 “(1) *REQUIREMENT TO PROVIDE VALUE FOR*
7 *PREMIUM PAYMENTS.*—

8 “(A) *REQUIREMENT.*—*Beginning not later*
9 *than January 1, 2011, a health insurance issuer*
10 *offering group or individual health insurance*
11 *coverage (including a grandfathered health plan)*
12 *shall, with respect to each plan year, provide an*
13 *annual rebate to each enrollee under such cov-*
14 *erage, on a pro rata basis, if the ratio of the*
15 *amount of premium revenue expended by the*
16 *issuer on costs described in paragraphs (1) and*
17 *(2) of subsection (a) to the total amount of pre-*
18 *mium revenue (excluding Federal and State*
19 *taxes and licensing or regulatory fees and after*
20 *accounting for payments or receipts for risk ad-*
21 *justment, risk corridors, and reinsurance under*
22 *sections 1341, 1342, and 1343 of the Patient*
23 *Protection and Affordable Care Act) for the plan*
24 *year (except as provided in subparagraph*
25 *(B)(ii)), is less than—*

1 “(i) *with respect to a health insurance*
2 *issuer offering coverage in the large group*
3 *market, 85 percent, or such higher percent-*
4 *age as a State may by regulation deter-*
5 *mine; or*

6 “(ii) *with respect to a health insurance*
7 *issuer offering coverage in the small group*
8 *market or in the individual market, 80 per-*
9 *cent, or such higher percentage as a State*
10 *may by regulation determine, except that*
11 *the Secretary may adjust such percentage*
12 *with respect to a State if the Secretary de-*
13 *termines that the application of such 80*
14 *percent may destabilize the individual mar-*
15 *ket in such State.*

16 “(B) *REBATE AMOUNT.—*

17 “(i) *CALCULATION OF AMOUNT.—The*
18 *total amount of an annual rebate required*
19 *under this paragraph shall be in an amount*
20 *equal to the product of—*

21 “(I) *the amount by which the per-*
22 *centage described in clause (i) or (ii) of*
23 *subparagraph (A) exceeds the ratio de-*
24 *scribed in such subparagraph; and*

1 “(II) the total amount of pre-
2 mium revenue (excluding Federal and
3 State taxes and licensing or regulatory
4 fees and after accounting for payments
5 or receipts for risk adjustment, risk
6 corridors, and reinsurance under sec-
7 tions 1341, 1342, and 1343 of the Pa-
8 tient Protection and Affordable Care
9 Act) for such plan year.

10 “(ii) *CALCULATION BASED ON AVER-*
11 *AGE RATIO.*—Beginning on January 1,
12 2014, the determination made under sub-
13 paragraph (A) for the year involved shall be
14 based on the averages of the premiums ex-
15 pended on the costs described in such sub-
16 paragraph and total premium revenue for
17 each of the previous 3 years for the plan.

18 “(2) *CONSIDERATION IN SETTING PERCENT-*
19 *AGES.*—In determining the percentages under para-
20 graph (1), a State shall seek to ensure adequate par-
21 ticipation by health insurance issuers, competition in
22 the health insurance market in the State, and value
23 for consumers so that premiums are used for clinical
24 services and quality improvements.

1 “(3) *ENFORCEMENT.*—*The Secretary shall pro-*
2 *mulgate regulations for enforcing the provisions of*
3 *this section and may provide for appropriate pen-*
4 *alties.*

5 “(c) *DEFINITIONS.*—*Not later than December 31, 2010,*
6 *and subject to the certification of the Secretary, the Na-*
7 *tional Association of Insurance Commissioners shall estab-*
8 *lish uniform definitions of the activities reported under sub-*
9 *section (a) and standardized methodologies for calculating*
10 *measures of such activities, including definitions of which*
11 *activities, and in what regard such activities, constitute ac-*
12 *tivities described in subsection (a)(2). Such methodologies*
13 *shall be designed to take into account the special cir-*
14 *cumstances of smaller plans, different types of plans, and*
15 *newer plans.*

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

20 “(e) *STANDARD HOSPITAL CHARGES.*—*Each hospital*
21 *operating within the United States shall for each year es-*
22 *tablish (and update) and make public (in accordance with*
23 *guidelines developed by the Secretary) a list of the hospital’s*
24 *standard charges for items and services provided by the hos-*

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

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

6 **“SEC. 2719. APPEALS PROCESS.**

7 *“(a) INTERNAL CLAIMS APPEALS.—*

8 *“(1) IN GENERAL.—A group health plan and a*
9 *health insurance issuer offering group or individual*
10 *health insurance coverage shall implement an effective*
11 *appeals process for appeals of coverage determinations*
12 *and claims, under which the plan or issuer shall, at*
13 *a minimum—*

14 *“(A) have in effect an internal claims ap-*
15 *peal process;*

16 *“(B) provide notice to enrollees, in a cul-*
17 *turally and linguistically appropriate manner,*
18 *of available internal and external appeals proc-*
19 *esses, and the availability of any applicable of-*
20 *fice of health insurance consumer assistance or*
21 *ombudsman established under section 2793 to as-*
22 *sist such enrollees with the appeals processes;*
23 *and*

24 *“(C) allow an enrollee to review their file,*
25 *to present evidence and testimony as part of the*

1 *appeals process, and to receive continued cov-*
2 *erage pending the outcome of the appeals process.*

3 “(2) *ESTABLISHED PROCESSES.—To comply*
4 *with paragraph (1)—*

5 “(A) *a group health plan and a health in-*
6 *surance issuer offering group health coverage*
7 *shall provide an internal claims and appeals*
8 *process that initially incorporates the claims and*
9 *appeals procedures (including urgent claims) set*
10 *forth at section 2560.503–1 of title 29, Code of*
11 *Federal Regulations, as published on November*
12 *21, 2000 (65 Fed. Reg. 70256), and shall update*
13 *such process in accordance with any standards*
14 *established by the Secretary of Labor for such*
15 *plans and issuers; and*

16 “(B) *a health insurance issuer offering indi-*
17 *vidual health coverage, and any other issuer not*
18 *subject to subparagraph (A), shall provide an in-*
19 *ternal claims and appeals process that initially*
20 *incorporates the claims and appeals procedures*
21 *set forth under applicable law (as in existence on*
22 *the date of enactment of this section), and shall*
23 *update such process in accordance with any*
24 *standards established by the Secretary of Health*
25 *and Human Services for such issuers.*

1 “(b) *EXTERNAL REVIEW.*—A group health plan and
2 a health insurance issuer offering group or individual
3 health insurance coverage—

4 “(1) shall comply with the applicable State ex-
5 ternal review process for such plans and issuers that,
6 at a minimum, includes the consumer protections set
7 forth in the Uniform External Review Model Act pro-
8 mulgated by the National Association of Insurance
9 Commissioners and is binding on such plans; or

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

14 “(A) if the applicable State has not estab-
15 lished an external review process that meets the
16 requirements of paragraph (1); or

17 “(B) if the plan is a self-insured plan that
18 is not subject to State insurance regulation (in-
19 cluding a State law that establishes an external
20 review process described in paragraph (1)).

21 “(c) *SECRETARY AUTHORITY.*—The Secretary may
22 deem the external review process of a group health plan or
23 health insurance issuer, in operation as of the date of enact-
24 ment of this section, to be in compliance with the applicable

1 *process established under subsection (b), as determined ap-*
2 *propriate by the Secretary.”.*

3 *(h) Subpart II of part A of title XVIII of the Public*
4 *Health Service Act, as added by section 1001(5) of this Act,*
5 *is amended by inserting after section 2719 the following:*
6 **“SEC. 2719A. PATIENT PROTECTIONS.**

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

15 *“(b) COVERAGE OF EMERGENCY SERVICES.—*

16 *“(1) IN GENERAL.—If a group health plan, or a*
17 *health insurance issuer offering group or individual*
18 *health insurance issuer, provides or covers any bene-*
19 *fits with respect to services in an emergency depart-*
20 *ment of a hospital, the plan or issuer shall cover*
21 *emergency services (as defined in paragraph*
22 *(2)(B))—*

23 *“(A) without the need for any prior author-*
24 *ization determination;*

1 “(B) whether the health care provider fur-
2 nishing such services is a participating provider
3 with respect to such services;

4 “(C) in a manner so that, if such services
5 are provided to a participant, beneficiary, or en-
6 rollee—

7 “(i) by a nonparticipating health care
8 provider with or without prior authoriza-
9 tion; or

10 “(ii)(I) such services will be provided
11 without imposing any requirement under
12 the plan for prior authorization of services
13 or any limitation on coverage where the
14 provider of services does not have a contrac-
15 tual relationship with the plan for the pro-
16 viding of services that is more restrictive
17 than the requirements or limitations that
18 apply to emergency department services re-
19 ceived from providers who do have such a
20 contractual relationship with the plan; and

21 “(II) if such services are provided out-
22 of-network, the cost-sharing requirement
23 (expressed as a copayment amount or coin-
24 surance rate) is the same requirement that

1 *would apply if such services were provided*
2 *in-network;*

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

11 “(2) *DEFINITIONS.—In this subsection:*

12 “(A) *EMERGENCY MEDICAL CONDITION.—*
13 *The term ‘emergency medical condition’ means a*
14 *medical condition manifesting itself by acute*
15 *symptoms of sufficient severity (including severe*
16 *pain) such that a prudent layperson, who pos-*
17 *sesses an average knowledge of health and medi-*
18 *cine, could reasonably expect the absence of im-*
19 *mediate medical attention to result in a condi-*
20 *tion described in clause (i), (ii), or (iii) of sec-*
21 *tion 1867(e)(1)(A) of the Social Security Act.*

22 “(B) *EMERGENCY SERVICES.—The term*
23 *‘emergency services’ means, with respect to an*
24 *emergency medical condition—*

1 “(i) a medical screening examination
2 (as required under section 1867 of the So-
3 cial Security Act) that is within the capa-
4 bility of the emergency department of a hos-
5 pital, including ancillary services routinely
6 available to the emergency department to
7 evaluate such emergency medical condition,
8 and

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

14 “(C) *STABILIZE*.—The term ‘to stabilize’,
15 with respect to an emergency medical condition
16 (as defined in subparagraph (A)), has the mean-
17 ing give in section 1867(e)(3) of the Social Secu-
18 rity Act (42 U.S.C. 1395dd(e)(3)).

19 “(c) *ACCESS TO PEDIATRIC CARE*.—

20 “(1) *PEDIATRIC CARE*.—In the case of a person
21 who has a child who is a participant, beneficiary, or
22 enrollee under a group health plan, or health insur-
23 ance coverage offered by a health insurance issuer in
24 the group or individual market, if the plan or issuer
25 requires or provides for the designation of a partici-

1 *participating primary care provider for the child, the plan*
2 *or issuer shall permit such person to designate a phy-*
3 *sician (allopathic or osteopathic) who specializes in*
4 *pediatrics as the child's primary care provider if such*
5 *provider participates in the network of the plan or*
6 *issuer.*

7 “(2) *CONSTRUCTION.*—*Nothing in paragraph (1)*
8 *shall be construed to waive any exclusions of coverage*
9 *under the terms and conditions of the plan or health*
10 *insurance coverage with respect to coverage of pedi-*
11 *atric care.*

12 “(d) *PATIENT ACCESS TO OBSTETRICAL AND GYNECO-*
13 *LOGICAL CARE.*—

14 “(1) *GENERAL RIGHTS.*—

15 “(A) *DIRECT ACCESS.*—*A group health*
16 *plan, or health insurance issuer offering group*
17 *or individual health insurance coverage, de-*
18 *scribed in paragraph (2) may not require au-*
19 *thorization or referral by the plan, issuer, or any*
20 *person (including a primary care provider de-*
21 *scribed in paragraph (2)(B)) in the case of a fe-*
22 *male participant, beneficiary, or enrollee who*
23 *seeks coverage for obstetrical or gynecological*
24 *care provided by a participating health care pro-*
25 *fessional who specializes in obstetrics or gynec-*

1 *cology. Such professional shall agree to otherwise*
2 *adhere to such plan's or issuer's policies and*
3 *procedures, including procedures regarding refer-*
4 *als and obtaining prior authorization and pro-*
5 *viding services pursuant to a treatment plan (if*
6 *any) approved by the plan or issuer.*

7 “(B) *OBSTETRICAL AND GYNECOLOGICAL*
8 *CARE.—A group health plan or health insurance*
9 *issuer described in paragraph (2) shall treat the*
10 *provision of obstetrical and gynecological care,*
11 *and the ordering of related obstetrical and gynec-*
12 *ological items and services, pursuant to the di-*
13 *rect access described under subparagraph (A), by*
14 *a participating health care professional who spe-*
15 *cializes in obstetrics or gynecology as the author-*
16 *ization of the primary care provider.*

17 “(2) *APPLICATION OF PARAGRAPH.—A group*
18 *health plan, or health insurance issuer offering group*
19 *or individual health insurance coverage, described in*
20 *this paragraph is a group health plan or coverage*
21 *that—*

22 “(A) *provides coverage for obstetric or*
23 *gynecologic care; and*

1 “(B) requires the designation by a partici-
2 pant, beneficiary, or enrollee of a participating
3 primary care provider.

4 “(3) CONSTRUCTION.—Nothing in paragraph (1)
5 shall be construed to—

6 “(A) waive any exclusions of coverage under
7 the terms and conditions of the plan or health
8 insurance coverage with respect to coverage of ob-
9 stetrical or gynecological care; or

10 “(B) preclude the group health plan or
11 health insurance issuer involved from requiring
12 that the obstetrical or gynecological provider no-
13 tify the primary care health care professional or
14 the plan or issuer of treatment decisions.”.

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

17 (1) in subsection (c)(1)—

18 (A) in subparagraph (A), by striking “and”
19 at the end;

20 (B) in subparagraph (B), by striking the
21 period and inserting “; and”; and

22 (C) by adding at the end the following:

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

1 *formation from health insurance issuers, to ana-*
2 *lyze and organize such information, and to make*
3 *such information available to such issuers, health*
4 *care providers, health researchers, health care*
5 *policy makers, and the general public.”; and*
6 *(2) by adding at the end the following:*

7 “(d) *MEDICAL REIMBURSEMENT DATA CENTERS.—*

8 “(1) *FUNCTIONS.—A center established under*
9 *subsection (c)(1)(C) shall—*

10 “(A) *develop fee schedules and other data-*
11 *base tools that fairly and accurately reflect mar-*
12 *ket rates for medical services and the geographic*
13 *differences in those rates;*

14 “(B) *use the best available statistical meth-*
15 *ods and data processing technology to develop*
16 *such fee schedules and other database tools;*

17 “(C) *regularly update such fee schedules*
18 *and other database tools to reflect changes in*
19 *charges for medical services;*

20 “(D) *make health care cost information*
21 *readily available to the public through an Inter-*
22 *net website that allows consumers to understand*
23 *the amounts that health care providers in their*
24 *area charge for particular medical services; and*

1 “(E) regularly publish information con-
2 cerning the statistical methodologies used by the
3 center to analyze health charge data and make
4 such data available to researchers and policy
5 makers.

6 “(2) *CONFLICTS OF INTEREST.*—A center estab-
7 lished under subsection (c)(1)(C) shall adopt by-laws
8 that ensures that the center (and all members of the
9 governing board of the center) is independent and free
10 from all conflicts of interest. Such by-laws shall en-
11 sure that the center is not controlled or influenced by,
12 and does not have any corporate relation to, any in-
13 dividual or entity that may make or receive payments
14 for health care services based on the center’s analysis
15 of health care costs.

16 “(3) *RULE OF CONSTRUCTION.*—Nothing in this
17 subsection shall be construed to permit a center estab-
18 lished under subsection (c)(1)(C) to compel health in-
19 surance issuers to provide data to the center.”.

20 **SEC. 10102. AMENDMENTS TO SUBTITLE B.**

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

22 (1) in the matter preceding clause (i), by strik-
23 ing “group health benefits plan” and inserting
24 “group benefits plan providing health benefits”; and

1 (2) *in clause (i)(I), by inserting “or any agency*
2 *or instrumentality of any of the foregoing” before the*
3 *closed parenthetical.*

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

5 (1) *in paragraph (1), by inserting “, or small*
6 *business in,” after “residents of any”; and*

7 (2) *by striking paragraph (2) and inserting the*
8 *following:*

9 **“(2) CONNECTING TO AFFORDABLE COVERAGE.—**
10 *An Internet website established under paragraph (1)*
11 *shall, to the extent practicable, provide ways for resi-*
12 *dents of, and small businesses in, any State to receive*
13 *information on at least the following coverage options:*

14 **“(A) Health insurance coverage offered by**
15 *health insurance issuers, other than coverage that*
16 *provides reimbursement only for the treatment or*
17 *mitigation of—*

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

19 **“(ii) an unreasonably limited set of**
20 *diseases or conditions (as determined by the*
21 *Secretary).*

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

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

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

4 “(E) Coverage under a high risk pool under
5 section 1101.

6 “(F) Coverage within the small group mar-
7 ket for small businesses and their employees, in-
8 cluding reinsurance for early retirees under sec-
9 tion 1102, tax credits available under section
10 45R of the Internal Revenue Code of 1986 (as
11 added by section 1421), and other information
12 specifically for small businesses regarding afford-
13 able health care options.”.

14 **SEC. 10103. AMENDMENTS TO SUBTITLE C.**

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

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

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

1 **“SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING**
2 **IN APPROVED CLINICAL TRIALS.**

3 “(a) *COVERAGE.*—

4 “(1) *IN GENERAL.*—If a group health plan or a
5 health insurance issuer offering group or individual
6 health insurance coverage provides coverage to a
7 qualified individual, then such plan or issuer—

8 “(A) may not deny the individual partici-
9 pation in the clinical trial referred to in sub-
10 section (b)(2);

11 “(B) subject to subsection (c), may not deny
12 (or limit or impose additional conditions on) the
13 coverage of routine patient costs for items and
14 services furnished in connection with participa-
15 tion in the trial; and

16 “(C) may not discriminate against the in-
17 dividual on the basis of the individual’s partici-
18 pation in such trial.

19 “(2) *ROUTINE PATIENT COSTS.*—

20 “(A) *INCLUSION.*—For purposes of para-
21 graph (1)(B), subject to subparagraph (B), rou-
22 tine patient costs include all items and services
23 consistent with the coverage provided in the plan
24 (or coverage) that is typically covered for a
25 qualified individual who is not enrolled in a
26 clinical trial.

1 “(B) *EXCLUSION.*—*For purposes of para-*
2 *graph (1)(B), routine patient costs does not in-*
3 *clude—*

4 “(i) *the investigational item, device, or*
5 *service, itself;*

6 “(ii) *items and services that are pro-*
7 *vided solely to satisfy data collection and*
8 *analysis needs and that are not used in the*
9 *direct clinical management of the patient;*
10 *or*

11 “(iii) *a service that is clearly incon-*
12 *sistent with widely accepted and established*
13 *standards of care for a particular diagnosis.*

14 “(3) *USE OF IN-NETWORK PROVIDERS.*—*If one or*
15 *more participating providers is participating in a*
16 *clinical trial, nothing in paragraph (1) shall be con-*
17 *strued as preventing a plan or issuer from requiring*
18 *that a qualified individual participate in the trial*
19 *through such a participating provider if the provider*
20 *will accept the individual as a participant in the*
21 *trial.*

22 “(4) *USE OF OUT-OF-NETWORK.*—*Notwith-*
23 *standing paragraph (3), paragraph (1) shall apply to*
24 *a qualified individual participating in an approved*

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

3 “(b) *QUALIFIED INDIVIDUAL DEFINED.*—*For purposes*
4 *of subsection (a), the term ‘qualified individual’ means an*
5 *individual who is a participant or beneficiary in a health*
6 *plan or with coverage described in subsection (a)(1) and*
7 *who meets the following conditions:*

8 “(1) *The individual is eligible to participate in*
9 *an approved clinical trial according to the trial pro-*
10 *tol with respect to treatment of cancer or other life-*
11 *threatening disease or condition.*

12 “(2) *Either—*

13 “(A) *the referring health care professional is*
14 *a participating health care provider and has*
15 *concluded that the individual’s participation in*
16 *such trial would be appropriate based upon the*
17 *individual meeting the conditions described in*
18 *paragraph (1); or*

19 “(B) *the participant or beneficiary provides*
20 *medical and scientific information establishing*
21 *that the individual’s participation in such trial*
22 *would be appropriate based upon the individual*
23 *meeting the conditions described in paragraph*
24 *(1).*

1 “(c) *LIMITATIONS ON COVERAGE.*—*This section shall*
2 *not be construed to require a group health plan, or a health*
3 *insurance issuer offering group or individual health insur-*
4 *ance coverage, to provide benefits for routine patient care*
5 *services provided outside of the plan’s (or coverage’s) health*
6 *care provider network unless out-of-network benefits are*
7 *otherwise provided under the plan (or coverage).*

8 “(d) *APPROVED CLINICAL TRIAL DEFINED.*—

9 “(1) *IN GENERAL.*—*In this section, the term ‘ap-*
10 *proved clinical trial’ means a phase I, phase II, phase*
11 *III, or phase IV clinical trial that is conducted in re-*
12 *lation to the prevention, detection, or treatment of*
13 *cancer or other life-threatening disease or condition*
14 *and is described in any of the following subpara-*
15 *graphs:*

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

20 “(i) *The National Institutes of Health.*

21 “(ii) *The Centers for Disease Control*
22 *and Prevention.*

23 “(iii) *The Agency for Health Care Re-*
24 *search and Quality.*

1 “(iv) *The Centers for Medicare & Med-*
2 *icaid Services.*

3 “(v) *cooperative group or center of any*
4 *of the entities described in clauses (i)*
5 *through (iv) or the Department of Defense*
6 *or the Department of Veterans Affairs.*

7 “(vi) *A qualified non-governmental re-*
8 *search entity identified in the guidelines*
9 *issued by the National Institutes of Health*
10 *for center support grants.*

11 “(vii) *Any of the following if the condi-*
12 *tions described in paragraph (2) are met:*

13 “(I) *The Department of Veterans*
14 *Affairs.*

15 “(II) *The Department of Defense.*

16 “(III) *The Department of Energy.*

17 “(B) *The study or investigation is con-*
18 *ducted under an investigational new drug appli-*
19 *cation reviewed by the Food and Drug Adminis-*
20 *tration.*

21 “(C) *The study or investigation is a drug*
22 *trial that is exempt from having such an inves-*
23 *tigational new drug application.*

24 “(2) *CONDITIONS FOR DEPARTMENTS.—The con-*
25 *ditions described in this paragraph, for a study or in-*

1 *vestigation conducted by a Department, are that the*
2 *study or investigation has been reviewed and ap-*
3 *proved through a system of peer review that the Sec-*
4 *retary determines—*

5 *“(A) to be comparable to the system of peer*
6 *review of studies and investigations used by the*
7 *National Institutes of Health, and*

8 *“(B) assures unbiased review of the highest*
9 *scientific standards by qualified individuals who*
10 *have no interest in the outcome of the review.*

11 *“(e) LIFE-THREATENING CONDITION DEFINED.—In*
12 *this section, the term ‘life-threatening condition’ means any*
13 *disease or condition from which the likelihood of death is*
14 *probable unless the course of the disease or condition is in-*
15 *terrupted.*

16 *“(f) CONSTRUCTION.—Nothing in this section shall be*
17 *construed to limit a plan’s or issuer’s coverage with respect*
18 *to clinical trials.*

19 *“(g) APPLICATION TO FEHBP.—Notwithstanding any*
20 *provision of chapter 89 of title 5, United States Code, this*
21 *section shall apply to health plans offered under the pro-*
22 *gram under such chapter.*

23 *“(h) PREEMPTION.—Notwithstanding any other provi-*
24 *sion of this Act, nothing in this section shall preempt State*
25 *laws that require a clinical trials policy for State regulated*

1 *health insurance plans that is in addition to the policy re-*
2 *quired under this section.”.*

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

4 *(1) in paragraph (2), by striking “With” and*
5 *inserting “Except as provided in paragraph (3),*
6 *with”; and*

7 *(2) by adding at the end the following:*

8 *“(3) APPLICATION OF CERTAIN PROVISIONS.—*
9 *The provisions of sections 2715 and 2718 of the Pub-*
10 *lic Health Service Act (as added by subtitle A) shall*
11 *apply to grandfathered health plans for plan years*
12 *beginning on or after the date of enactment of this*
13 *Act.”.*

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

16 *“(1) section 1251 shall take effect on the date of*
17 *enactment of this Act; and*

18 *“(2) the provisions of section 2704 of the Public*
19 *Health Service Act (as amended by section 1201), as*
20 *they apply to enrollees who are under 19 years of age,*
21 *shall become effective for plan years beginning on or*
22 *after the date that is 6 months after the date of enact-*
23 *ment of this Act.”.*

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

1 (1) *by redesignating section 1253 as section*
2 *1255; and*

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

4 **“SEC. 1253. ANNUAL REPORT ON SELF-INSURED PLANS.**

5 *“Not later than 1 year after the date of enactment of*
6 *this Act, and annually thereafter, the Secretary of Labor*
7 *shall prepare an aggregate annual report, using data col-*
8 *lected from the Annual Return/Report of Employee Benefit*
9 *Plan (Department of Labor Form 5500), that shall include*
10 *general information on self-insured group health plans (in-*
11 *cluding plan type, number of participants, benefits offered,*
12 *funding arrangements, and benefit arrangements) as well*
13 *as data from the financial filings of self-insured employers*
14 *(including information on assets, liabilities, contributions,*
15 *investments, and expenses). The Secretary shall submit such*
16 *reports to the appropriate committees of Congress.*

17 **“SEC. 1254. STUDY OF LARGE GROUP MARKET.**

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

21 *“(1) compare the characteristics of employers*
22 *(including industry, size, and other characteristics as*
23 *determined appropriate by the Secretary), health plan*
24 *benefits, financial solvency, capital reserve levels, and*
25 *the risks of becoming insolvent; and*

1 “(2) *determine the extent to which new insur-*
2 *ance market reforms are likely to cause adverse selec-*
3 *tion in the large group market or to encourage small*
4 *and midsize employers to self-insure.*

5 “(b) *COLLECTION OF INFORMATION.—In conducting*
6 *the study under subsection (a), the Secretary, in coordina-*
7 *tion with the Secretary of Labor, shall collect information*
8 *and analyze—*

9 “(1) *the extent to which self-insured group health*
10 *plans can offer less costly coverage and, if so, whether*
11 *lower costs are due to more efficient plan administra-*
12 *tion and lower overhead or to the denial of claims*
13 *and the offering very limited benefit packages;*

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

18 “(3) *any potential conflict of interest as it re-*
19 *lates to the health care needs of self-insured enrollees*
20 *and self-insured employer’s financial contribution or*
21 *profit margin, and the impact of such conflict on ad-*
22 *ministration of the health plan.*

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

1 *appropriate committees of Congress a report concerning the*
2 *results of the study conducted under subsection (a).”.*

3 **SEC. 10104. AMENDMENTS TO SUBTITLE D.**

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

6 *“(2) INCLUSION OF CO-OP PLANS AND MULTI-*
7 *STATE QUALIFIED HEALTH PLANS.—Any reference in*
8 *this title to a qualified health plan shall be deemed*
9 *to include a qualified health plan offered through the*
10 *CO-OP program under section 1322, and a multi-*
11 *State plan under section 1334, unless specifically pro-*
12 *vided for otherwise.*

13 *“(3) TREATMENT OF QUALIFIED DIRECT PRI-*
14 *MARY CARE MEDICAL HOME PLANS.—The Secretary of*
15 *Health and Human Services shall permit a qualified*
16 *health plan to provide coverage through a qualified*
17 *direct primary care medical home plan that meets*
18 *criteria established by the Secretary, so long as the*
19 *qualified health plan meets all requirements that are*
20 *otherwise applicable and the services covered by the*
21 *medical home plan are coordinated with the entity of-*
22 *fering the qualified health plan.*

23 *“(4) VARIATION BASED ON RATING AREA.—A*
24 *qualified health plan, including a multi-State quali-*
25 *fied health plan, may as appropriate vary premiums*

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

3 *(b) Section 1302 of this Act is amended—*

4 *(1) in subsection (d)(2)(B), by striking “may*
5 *issue” and inserting “shall issue”; and*

6 *(2) by adding at the end the following:*

7 *“(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH*
8 *CENTERS.—If any item or service covered by a qualified*
9 *health plan is provided by a Federally-qualified health cen-*
10 *ter (as defined in section 1905(l)(2)(B) of the Social Secu-*
11 *rity Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the*
12 *plan, the offeror of the plan shall pay to the center for the*
13 *item or service an amount that is not less than the amount*
14 *of payment that would have been paid to the center under*
15 *section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such*
16 *item or service.”.*

17 *(c) Section 1303 of this Act is amended to read as fol-*
18 *lows:*

19 **“SEC. 1303. SPECIAL RULES.**

20 *“(a) STATE OPT-OUT OF ABORTION COVERAGE.—*

21 *“(1) IN GENERAL.—A State may elect to pro-*
22 *hibit abortion coverage in qualified health plans of-*
23 *fered through an Exchange in such State if such State*
24 *enacts a law to provide for such prohibition.*

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

4 “(b) *SPECIAL RULES RELATING TO COVERAGE OF*
5 *ABORTION SERVICES.*—

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

8 “(A) *IN GENERAL.*—*Notwithstanding any*
9 *other provision of this title (or any amendment*
10 *made by this title)—*

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

18 “(ii) *subject to subsection (a), the*
19 *issuer of a qualified health plan shall deter-*
20 *mine whether or not the plan provides cov-*
21 *erage of services described in subparagraph*
22 *(B)(i) or (B)(ii) as part of such benefits for*
23 *the plan year.*

24 “(B) *ABORTION SERVICES.*—

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

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

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

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

1 following for purposes of paying for such serv-
2 ices:

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

8 “(ii) Any cost-sharing reduction under
9 section 1402 of the Patient Protection and
10 Affordable Care Act (and the amount (if
11 any) of the advance payment of the reduc-
12 tion under section 1412 of the Patient Pro-
13 tection and Affordable Care Act).

14 “(B) ESTABLISHMENT OF ALLOCATION AC-
15 COUNTS.—In the case of a plan to which sub-
16 paragraph (A) applies, the issuer of the plan
17 shall—

18 “(i) collect from each enrollee in the
19 plan (without regard to the enrollee’s age,
20 sex, or family status) a separate payment
21 for each of the following:

22 “(I) an amount equal to the por-
23 tion of the premium to be paid directly
24 by the enrollee for coverage under the
25 plan of services other than services de-

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

5 “(II) an amount equal to the ac-
6 tuarial value of the coverage of services
7 described in paragraph (1)(B)(i), and

8 “(ii) shall deposit all such separate
9 payments into separate allocation accounts
10 as provided in subparagraph (C).

11 *In the case of an enrollee whose premium for*
12 *coverage under the plan is paid through em-*
13 *ployee payroll deposit, the separate payments re-*
14 *quired under this subparagraph shall each be*
15 *paid by a separate deposit.*

16 “(C) *SEGREGATION OF FUNDS.*—

17 “(i) *IN GENERAL.*—*The issuer of a*
18 *plan to which subparagraph (A) applies*
19 *shall establish allocation accounts described*
20 *in clause (ii) for enrollees receiving*
21 *amounts described in subparagraph (A).*

22 “(ii) *ALLOCATION ACCOUNTS.*—*The*
23 *issuer of a plan to which subparagraph (A)*
24 *applies shall deposit—*

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

7 “(II) all payments described in
8 subparagraph (B)(i)(II) into a separate
9 account that consists solely of such
10 payments and that is used exclusively
11 to pay for services described in para-
12 graph (1)(B)(i).

13 “(D) ACTUARIAL VALUE.—

14 “(i) IN GENERAL.—The issuer of a
15 qualified health plan shall estimate the
16 basic per enrollee, per month cost, deter-
17 mined on an average actuarial basis, for in-
18 cluding coverage under the qualified health
19 plan of the services described in paragraph
20 (1)(B)(i).

21 “(ii) CONSIDERATIONS.—In making
22 such estimate, the issuer—

23 “(I) may take into account the
24 impact on overall costs of the inclusion
25 of such coverage, but may not take into

1 *account any cost reduction estimated*
2 *to result from such services, including*
3 *prenatal care, delivery, or postnatal*
4 *care;*

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

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

11 *“(E) ENSURING COMPLIANCE WITH SEG-*
12 *REGATION REQUIREMENTS.—*

13 *“(i) IN GENERAL.—Subject to clause*
14 *(ii), State health insurance commissioners*
15 *shall ensure that health plans comply with*
16 *the segregation requirements in this sub-*
17 *section through the segregation of plan*
18 *funds in accordance with applicable provi-*
19 *sions of generally accepted accounting re-*
20 *quirements, circulars on funds management*
21 *of the Office of Management and Budget,*
22 *and guidance on accounting of the Govern-*
23 *ment Accountability Office.*

24 *“(ii) CLARIFICATION.—Nothing in*
25 *clause (i) shall prohibit the right of an indi-*

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

3 “(3) *RULES RELATING TO NOTICE.—*

4 “(A) *NOTICE.—A qualified health plan that*
5 *provides for coverage of the services described in*
6 *paragraph (1)(B)(i) shall provide a notice to en-*
7 *rollees, only as part of the summary of benefits*
8 *and coverage explanation, at the time of enroll-*
9 *ment, of such coverage.*

10 “(B) *RULES RELATING TO PAYMENTS.—The*
11 *notice described in subparagraph (A), any adver-*
12 *tising used by the issuer with respect to the plan,*
13 *any information provided by the Exchange, and*
14 *any other information specified by the Secretary*
15 *shall provide information only with respect to*
16 *the total amount of the combined payments for*
17 *services described in paragraph (1)(B)(i) and*
18 *other services covered by the plan.*

19 “(4) *NO DISCRIMINATION ON BASIS OF PROVI-*
20 *SION OF ABORTION.—No qualified health plan offered*
21 *through an Exchange may discriminate against any*
22 *individual health care provider or health care facility*
23 *because of its unwillingness to provide, pay for, pro-*
24 *vide coverage of, or refer for abortions*

1 “(c) *APPLICATION OF STATE AND FEDERAL LAWS RE-*
2 *GARDING ABORTION.—*

3 “(1) *NO PREEMPTION OF STATE LAWS REGARD-*
4 *ING ABORTION.—Nothing in this Act shall be con-*
5 *strued to preempt or otherwise have any effect on*
6 *State laws regarding the prohibition of (or require-*
7 *ment of) coverage, funding, or procedural require-*
8 *ments on abortions, including parental notification or*
9 *consent for the performance of an abortion on a*
10 *minor.*

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

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

16 “(i) *conscience protection;*

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

19 “(iii) *discrimination on the basis of*
20 *the willingness or refusal to provide, pay*
21 *for, cover, or refer for abortion or to provide*
22 *or participate in training to provide abor-*
23 *tion.*

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

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

3 “(d) *APPLICATION OF EMERGENCY SERVICES LAWS.—*
4 *Nothing in this Act shall be construed to relieve any health*
5 *care provider from providing emergency services as required*
6 *by State or Federal law, including section 1867 of the So-*
7 *cial Security Act (popularly known as ‘EMTALA’).”.*

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

10 “(e) *EDUCATED HEALTH CARE CONSUMERS.—The*
11 *term ‘educated health care consumer’ means an individual*
12 *who is knowledgeable about the health care system, and has*
13 *background or experience in making informed decisions re-*
14 *garding health, medical, and scientific matters.”.*

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

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

18 “(ii) *STATE MUST ASSUME COST.—A*
19 *State shall make payments—*

20 “(I) *to an individual enrolled in*
21 *a qualified health plan offered in such*
22 *State; or*

23 “(II) *on behalf of an individual*
24 *described in subclause (I) directly to*

1 *the qualified health plan in which such*
2 *individual is enrolled;*
3 *to defray the cost of any additional benefits*
4 *described in clause (i).”; and*
5 (2) *in paragraph (6)(A), by inserting “educated”*
6 *before “health care”.*

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

8 (1) *in paragraph (2), by striking “may” in the*
9 *second sentence and inserting “shall”; and*

10 (2) *by adding at the end the following:*

11 “(3) *TRANSPARENCY IN COVERAGE.—*

12 “(A) *IN GENERAL.—The Exchange shall re-*
13 *quire health plans seeking certification as quali-*
14 *fied health plans to submit to the Exchange, the*
15 *Secretary, the State insurance commissioner,*
16 *and make available to the public, accurate and*
17 *timely disclosure of the following information:*

18 “(i) *Claims payment policies and*
19 *practices.*

20 “(ii) *Periodic financial disclosures.*

21 “(iii) *Data on enrollment.*

22 “(iv) *Data on disenrollment.*

23 “(v) *Data on the number of claims*
24 *that are denied.*

25 “(vi) *Data on rating practices.*

1 “(vii) *Information on cost-sharing and*
2 *payments with respect to any out-of-net-*
3 *work coverage.*

4 “(viii) *Information on enrollee and*
5 *participant rights under this title.*

6 “(ix) *Other information as determined*
7 *appropriate by the Secretary.*

8 “(B) *USE OF PLAIN LANGUAGE.—The infor-*
9 *mation required to be submitted under subpara-*
10 *graph (A) shall be provided in plain language.*
11 *The term ‘plain language’ means language that*
12 *the intended audience, including individuals*
13 *with limited English proficiency, can readily*
14 *understand and use because that language is*
15 *concise, well-organized, and follows other best*
16 *practices of plain language writing. The Sec-*
17 *retary and the Secretary of Labor shall jointly*
18 *develop and issue guidance on best practices of*
19 *plain language writing.*

20 “(C) *COST SHARING TRANSPARENCY.—The*
21 *Exchange shall require health plans seeking cer-*
22 *tification as qualified health plans to permit in-*
23 *dividuals to learn the amount of cost-sharing*
24 *(including deductibles, copayments, and coinsur-*
25 *ance) under the individual’s plan or coverage*

1 *that the individual would be responsible for pay-*
2 *ing with respect to the furnishing of a specific*
3 *item or service by a participating provider in a*
4 *timely manner upon the request of the indi-*
5 *vidual. At a minimum, such information shall*
6 *be made available to such individual through an*
7 *Internet website and such other means for indi-*
8 *viduals without access to the Internet.*

9 “(D) *GROUP HEALTH PLANS.*—*The Sec-*
10 *retary of Labor shall update and harmonize the*
11 *Secretary’s rules concerning the accurate and*
12 *timely disclosure to participants by group health*
13 *plans of plan disclosure, plan terms and condi-*
14 *tions, and periodic financial disclosure with the*
15 *standards established by the Secretary under*
16 *subparagraph (A).”.*

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

18 *(1) in subparagraph (C), by striking “; and”*
19 *and inserting a semicolon;*

20 *(2) in subparagraph (D), by striking the period*
21 *and inserting “; and”; and*

22 *(3) by adding at the end the following:*

23 *“(E) the implementation of activities to re-*
24 *duce health and health care disparities, includ-*
25 *ing through the use of language services, commu-*

1 *nity outreach, and cultural competency*
2 *trainings.”.*

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

6 *(i) Section 1312 of this Act is amended—*

7 *(1) in subsection (a)(1), by inserting “and for*
8 *which such individual is eligible” before the period;*

9 *(2) in subsection (e)—*

10 *(A) in paragraph (1), by inserting “and*
11 *employers” after “enroll individuals”; and*

12 *(B) by striking the flush sentence at the end;*

13 *and*

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

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

18 *(2) Section 3730(e) of title 31, United States Code, is*
19 *amended by striking paragraph (4) and inserting the fol-*
20 *lowing:*

21 *“(4)(A) The court shall dismiss an action or*
22 *claim under this section, unless opposed by the Gov-*
23 *ernment, if substantially the same allegations or*
24 *transactions as alleged in the action or claim were*
25 *publicly disclosed—*

1 “(i) in a Federal criminal, civil, or admin-
2 istrative hearing in which the Government or its
3 agent is a party;

4 “(ii) in a congressional, Government Ac-
5 countability Office, or other Federal report, hear-
6 ing, audit, or investigation; or

7 “(iii) from the news media,
8 unless the action is brought by the Attorney General
9 or the person bringing the action is an original
10 source of the information.

11 “(B) For purposes of this paragraph, “original
12 source” means an individual who either (i) prior to
13 a public disclosure under subsection (e)(4)(a), has vol-
14 untarily disclosed to the Government the information
15 on which allegations or transactions in a claim are
16 based, or (2) who has knowledge that is independent
17 of and materially adds to the publicly disclosed alle-
18 gations or transactions, and who has voluntarily pro-
19 vided the information to the Government before filing
20 an action under this section.”.

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

22 (1) in paragraph (3), by striking “and” at the
23 end;

24 (2) by redesignating paragraph (4) as para-
25 graph (5); and

1 (3) *by inserting after paragraph (3) the fol-*
2 *lowing:*

3 “(4) *a survey of the cost and affordability of*
4 *health care insurance provided under the Exchanges*
5 *for owners and employees of small business concerns*
6 *(as defined under section 3 of the Small Business Act*
7 *(15 U.S.C. 632)), including data on enrollees in Ex-*
8 *changes and individuals purchasing health insurance*
9 *coverage outside of Exchanges; and”.*

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

11 (1) *by redesignating paragraph (3) as para-*
12 *graph (4); and*

13 (2) *by inserting after paragraph (2), the fol-*
14 *lowing:*

15 “(3) *REPAYMENT OF LOANS AND GRANTS.—Not*
16 *later than July 1, 2013, and prior to awarding loans*
17 *and grants under the CO-OP program, the Secretary*
18 *shall promulgate regulations with respect to the re-*
19 *payment of such loans and grants in a manner that*
20 *is consistent with State solvency regulations and*
21 *other similar State laws that may apply. In promul-*
22 *gating such regulations, the Secretary shall provide*
23 *that such loans shall be repaid within 5 years and*
24 *such grants shall be repaid within 15 years, taking*
25 *into consideration any appropriate State reserve re-*

1 *quirements, solvency regulations, and requisite sur-*
2 *plus note arrangements that must be constructed in a*
3 *State to provide for such repayment prior to award-*
4 *ing such loans and grants.”.*

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

7 *(n) Section 1324(a) of this Act is amended by striking*
8 *“, a community health” and all that follows through*
9 *“1333(b)” and inserting “, or a multi-State qualified health*
10 *plan under section 1334”.*

11 *(o) Section 1331 of this Act is amended—*

12 *(1) in subsection (d)(3)(A)(i), by striking “85”*
13 *and inserting “95”; and*

14 *(2) in subsection (e)(1)(B), by inserting before*
15 *the semicolon the following: “, or, in the case of an*
16 *alien lawfully present in the United States, whose in-*
17 *come is not greater than 133 percent of the poverty*
18 *line for the size of the family involved but who is not*
19 *eligible for the Medicaid program under title XIX of*
20 *the Social Security Act by reason of such alien sta-*
21 *tus”.*

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

24 *(q) Part IV of subtitle D of title I of this Act is amend-*
25 *ed by adding at the end the following:*

1 **“SEC. 1334. MULTI-STATE PLANS.**

2 “(a) *OVERSIGHT BY THE OFFICE OF PERSONNEL MAN-*
3 *AGEMENT.*—

4 “(1) *IN GENERAL.*—*The Director of the Office of*
5 *Personnel Management (referred to in this section as*
6 *the ‘Director’) shall enter into contracts with health*
7 *insurance issuers (which may include a group of*
8 *health insurance issuers affiliated either by common*
9 *ownership and control or by the common use of a na-*
10 *tionally licensed service mark), without regard to sec-*
11 *tion 5 of title 41, United States Code, or other stat-*
12 *utes requiring competitive bidding, to offer at least 2*
13 *multi-State qualified health plans through each Ex-*
14 *change in each State. Such plans shall provide indi-*
15 *vidual, or in the case of small employers, group cov-*
16 *erage.*

17 “(2) *TERMS.*—*Each contract entered into under*
18 *paragraph (1) shall be for a uniform term of at least*
19 *1 year, but may be made automatically renewable*
20 *from term to term in the absence of notice of termi-*
21 *nation by either party. In entering into such con-*
22 *tracts, the Director shall ensure that health benefits*
23 *coverage is provided in accordance with the types of*
24 *coverage provided for under section 2701(a)(1)(A)(i)*
25 *of the Public Health Service Act.*

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

5 “(4) *ADMINISTRATION.*—*The Director shall im-*
6 *plement this subsection in a manner similar to the*
7 *manner in which the Director implements the con-*
8 *tracting provisions with respect to carriers under the*
9 *Federal employees health benefit program under chap-*
10 *ter 89 of title 5, United States Code, including*
11 *(through negotiating with each multi-state plan)—*

12 “(A) *a medical loss ratio;*

13 “(B) *a profit margin;*

14 “(C) *the premiums to be charged; and*

15 “(D) *such other terms and conditions of*
16 *coverage as are in the interests of enrollees in*
17 *such plans.*

18 “(5) *AUTHORITY TO PROTECT CONSUMERS.*—*The*
19 *Director may prohibit the offering of any multi-State*
20 *health plan that does not meet the terms and condi-*
21 *tions defined by the Director with respect to the ele-*
22 *ments described in subparagraphs (A) through (D) of*
23 *paragraph (4).*

24 “(6) *ASSURED AVAILABILITY OF VARIED COV-*
25 *ERAGE.*—*In entering into contracts under this sub-*

1 *section, the Director shall ensure that with respect to*
2 *multi-State qualified health plans offered in an Ex-*
3 *change, there is at least one such plan that does not*
4 *provide coverage of services described in section*
5 *1303(b)(1)(B)(i).*

6 “(7) *WITHDRAWAL.—Approval of a contract*
7 *under this subsection may be withdrawn by the Direc-*
8 *tor only after notice and opportunity for hearing to*
9 *the issuer concerned without regard to subchapter II*
10 *of chapter 5 and chapter 7 of title 5, United States*
11 *Code.*

12 “(b) *ELIGIBILITY.—A health insurance issuer shall be*
13 *eligible to enter into a contract under subsection (a)(1) if*
14 *such issuer—*

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

18 “(2) *is licensed in each State and is subject to*
19 *all requirements of State law not inconsistent with*
20 *this section, including the standards and require-*
21 *ments that a State imposes that do not prevent the*
22 *application of a requirement of part A of title XXVII*
23 *of the Public Health Service Act or a requirement of*
24 *this title;*

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

6 “(4) meets such other requirements as determined
7 appropriate by the Director, in consultation with the
8 Secretary.

9 “(c) *REQUIREMENTS FOR MULTI-STATE QUALIFIED*
10 *HEALTH PLAN.*—

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

14 “(A) the plan offers a benefits package that
15 is uniform in each State and consists of the es-
16 sential benefits described in section 1302;

17 “(B) the plan meets all requirements of this
18 title with respect to a qualified health plan, in-
19 cluding requirements relating to the offering of
20 the bronze, silver, and gold levels of coverage and
21 catastrophic coverage in each State Exchange;

22 “(C) except as provided in paragraph (5),
23 the issuer provides for determinations of pre-
24 miums for coverage under the plan on the basis

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

3 *“(D) the issuer offers the plan in all geo-*
4 *graphic regions, and in all States that have*
5 *adopted adjusted community rating before the*
6 *date of enactment of this Act.*

7 *“(2) STATES MAY OFFER ADDITIONAL BENE-*
8 *FITS.—Nothing in paragraph (1)(A) shall preclude a*
9 *State from requiring that benefits in addition to the*
10 *essential health benefits required under such para-*
11 *graph be provided to enrollees of a multi-State quali-*
12 *fied health plan offered in such State.*

13 *“(3) CREDITS.—*

14 *“(A) IN GENERAL.—An individual enrolled*
15 *in a multi-State qualified health plan under this*
16 *section shall be eligible for credits under section*
17 *36B of the Internal Revenue Code of 1986 and*
18 *cost sharing assistance under section 1402 in the*
19 *same manner as an individual who is enrolled*
20 *in a qualified health plan.*

21 *“(B) NO ADDITIONAL FEDERAL COST.—A*
22 *requirement by a State under paragraph (2)*
23 *that benefits in addition to the essential health*
24 *benefits required under paragraph (1)(A) be pro-*
25 *vided to enrollees of a multi-State qualified*

1 *health plan shall not affect the amount of a pre-*
2 *mium tax credit provided under section 36B of*
3 *the Internal Revenue Code of 1986 with respect*
4 *to such plan.*

5 “(4) *STATE MUST ASSUME COST.*—*A State shall*
6 *make payments—*

7 “(A) *to an individual enrolled in a multi-*
8 *State qualified health plan offered in such State;*
9 *or*

10 “(B) *on behalf of an individual described in*
11 *subparagraph (A) directly to the multi-State*
12 *qualified health plan in which such individual is*
13 *enrolled;*

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

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

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

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

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

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

10 “(2) *with respect to the second such year, such*
11 *issuer offers the plan in at least 70 percent of the*
12 *States;*

13 “(3) *with respect to the third such year, such*
14 *issuer offers the plan in at least 85 percent of the*
15 *States; and*

16 “(4) *with respect to each subsequent year, such*
17 *issuer offers the plan in all States.*

18 “(f) *APPLICABILITY.—The requirements under chapter*
19 *89 of title 5, United States Code, applicable to health bene-*
20 *fits plans under such chapter shall apply to multi-State*
21 *qualified health plans provided for under this section to the*
22 *extent that such requirements do not conflict with a provi-*
23 *sion of this title.*

24 “(g) *CONTINUED SUPPORT FOR FEHBP.—*

1 “(1) *MAINTENANCE OF EFFORT.*—*Nothing in*
2 *this section shall be construed to permit the Director*
3 *to allocate fewer financial or personnel resources to*
4 *the functions of the Office of Personnel Management*
5 *related to the administration of the Federal Employ-*
6 *ees Health Benefit Program under chapter 89 of title*
7 *5, United States Code.*

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

13 “(3) *AUTHORITY TO ESTABLISH SEPARATE ENTI-*
14 *TIES.*—*The Director may establish such separate*
15 *units or offices within the Office of Personnel Man-*
16 *agement as the Director determines to be appropriate*
17 *to ensure that the administration of multi-State*
18 *qualified health plans under this section does not*
19 *interfere with the effective administration of the Fed-*
20 *eral Employees Health Benefit Program under chap-*
21 *ter 89 of title 5, United States Code.*

22 “(4) *EFFECTIVE OVERSIGHT.*—*The Director may*
23 *appoint such additional personnel as may be nec-*
24 *essary to enable the Director to carry out activities*
25 *under this section.*

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

9 “(6) *FEHBP PLANS NOT REQUIRED TO PARTICI-*
10 *PATE.*—*Nothing in this section shall require that a*
11 *carrier offering coverage under the Federal Employees*
12 *Health Benefit Program under chapter 89 of title 5,*
13 *United States Code, also offer a multi-State qualified*
14 *health plan under this section.*

15 “(h) *ADVISORY BOARD.*—*The Director shall establish*
16 *an advisory board to provide recommendations on the ac-*
17 *tivities described in this section. A significant percentage*
18 *of the members of such board shall be comprised of enrollees*
19 *in a multi-State qualified health plan, or representatives*
20 *of such enrollees.*

21 “(i) *AUTHORIZATION OF APPROPRIATIONS.*—*There is*
22 *authorized to be appropriated, such sums as may be nec-*
23 *essary to carry out this section.”.*

24 (r) *Section 1341 of this Act is amended—*

1 (1) *in the section heading, by striking “AND*
2 *SMALL GROUP MARKETS” and inserting “MAR-*
3 *KET”;*

4 (2) *in subsection (b)(2)(B), by striking “para-*
5 *graph (1)(A)” and inserting “paragraph (1)(B)”;* and

6 (3) *in subsection (c)(1)(A), by striking “and*
7 *small group markets” and inserting “market”.*

8 **SEC. 10105. AMENDMENTS TO SUBTITLE E.**

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

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

16 (c) *Section 36B(c)(2)(C)(iv) of the Internal Revenue*
17 *Code of 1986, as added by section 1401(a) of this Act, is*
18 *amended by striking “subsection (b)(3)(A)(ii)” and insert-*
19 *ing “subsection (b)(3)(A)(iii)”.*

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

22 *“(3) Section 6211(b)(4)(A) of the Internal Rev-*
23 *enue Code of 1986 is amended by inserting ‘36B,’*
24 *after ‘36A,.’.”.*

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

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

6 “(i) 2010, 2011, 2012, AND 2013.—The
7 dollar amount in effect under this para-
8 graph for taxable years beginning in 2010,
9 2011, 2012, or 2013 is \$25,000.

10 “(ii) SUBSEQUENT YEARS.—In the
11 case of a taxable year beginning in a cal-
12 endar year after 2013, the dollar amount in
13 effect under this paragraph shall be equal to
14 \$25,000, multiplied by the cost-of-living ad-
15 justment under section 1(f)(3) for the cal-
16 endar year, determined by substituting ‘cal-
17 endar year 2012’ for ‘calendar year 1992’
18 in subparagraph (B) thereof.”.

19 (2) Subsection (g) of section 45R of the Internal Rev-
20 enue Code of 1986, as added by section 1421(a) of this Act,
21 is amended by striking “2011” both places it appears and
22 inserting “2010, 2011”.

23 (3) Section 280C(h) of the Internal Revenue Code of
24 1986, as added by section 1421(d)(1) of this Act, is amended
25 by striking “2011” and inserting “2010, 2011”.

1 (4) *Section 1421(f) of this Act is amended by striking*
2 *“2010” both places it appears and inserting “2009”.*

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

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

8 **“SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN APPLICA-**
9 **TION OF FPL.**

10 “(a) *IN GENERAL.—The Secretary shall conduct a*
11 *study to examine the feasibility and implication of adjust-*
12 *ing the application of the Federal poverty level under this*
13 *subtitle (and the amendments made by this subtitle) for dif-*
14 *ferent geographic areas so as to reflect the variations in*
15 *cost-of-living among different areas within the United*
16 *States. If the Secretary determines that an adjustment is*
17 *feasible, the study should include a methodology to make*
18 *such an adjustment. Not later than January 1, 2013, the*
19 *Secretary shall submit to Congress a report on such study*
20 *and shall include such recommendations as the Secretary*
21 *determines appropriate.*

22 “(b) *INCLUSION OF TERRITORIES.—*

23 “(1) *IN GENERAL.—The Secretary shall ensure*
24 *that the study under subsection (a) covers the terri-*
25 *tories of the United States and that special attention*

1 *is paid to the disparity that exists among poverty lev-*
2 *els and the cost of living in such territories and to the*
3 *impact of such disparity on efforts to expand health*
4 *coverage and ensure health care.*

5 “(2) *TERRITORIES DEFINED.*—*In this subsection,*
6 *the term ‘territories of the United States’ includes the*
7 *Commonwealth of Puerto Rico, the United States Vir-*
8 *gin Islands, Guam, the Northern Mariana Islands,*
9 *and any other territory or possession of the United*
10 *States.”.*

11 **SEC. 10106. AMENDMENTS TO SUBTITLE F.**

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

14 “(2) *EFFECTS ON THE NATIONAL ECONOMY AND*
15 *INTERSTATE COMMERCE.*—*The effects described in*
16 *this paragraph are the following:*

17 “(A) *The requirement regulates activity that*
18 *is commercial and economic in nature: economic*
19 *and financial decisions about how and when*
20 *health care is paid for, and when health insur-*
21 *ance is purchased. In the absence of the require-*
22 *ment, some individuals would make an economic*
23 *and financial decision to forego health insurance*
24 *coverage and attempt to self-insure, which in-*

1 *creases financial risks to households and medical*
2 *providers.*

3 “(B) *Health insurance and health care serv-*
4 *ices are a significant part of the national econ-*
5 *omy. National health spending is projected to in-*
6 *crease from \$2,500,000,000,000, or 17.6 percent*
7 *of the economy, in 2009 to \$4,700,000,000,000 in*
8 *2019. Private health insurance spending is pro-*
9 *jected to be \$854,000,000,000 in 2009, and pays*
10 *for medical supplies, drugs, and equipment that*
11 *are shipped in interstate commerce. Since most*
12 *health insurance is sold by national or regional*
13 *health insurance companies, health insurance is*
14 *sold in interstate commerce and claims pay-*
15 *ments flow through interstate commerce.*

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

22 “(D) *The requirement achieves near-uni-*
23 *versal coverage by building upon and strength-*
24 *ening the private employer-based health insur-*
25 *ance system, which covers 176,000,000 Ameri-*

1 *cans nationwide. In Massachusetts, a similar re-*
2 *quirement has strengthened private employer-*
3 *based coverage: despite the economic downturn,*
4 *the number of workers offered employer-based*
5 *coverage has actually increased.*

6 “(E) *The economy loses up to*
7 *\$207,000,000,000 a year because of the poorer*
8 *health and shorter lifespan of the uninsured. By*
9 *significantly reducing the number of the unin-*
10 *sured, the requirement, together with the other*
11 *provisions of this Act, will significantly reduce*
12 *this economic cost.*

13 “(F) *The cost of providing uncompensated*
14 *care to the uninsured was \$43,000,000,000 in*
15 *2008. To pay for this cost, health care providers*
16 *pass on the cost to private insurers, which pass*
17 *on the cost to families. This cost-shifting in-*
18 *creases family premiums by on average over*
19 *\$1,000 a year. By significantly reducing the*
20 *number of the uninsured, the requirement, to-*
21 *gether with the other provisions of this Act, will*
22 *lower health insurance premiums.*

23 “(G) *62 percent of all personal bankruptcies*
24 *are caused in part by medical expenses. By sig-*
25 *nificantly increasing health insurance coverage,*

1 *the requirement, together with the other provi-*
2 *sions of this Act, will improve financial security*
3 *for families.*

4 *“(H) Under the Employee Retirement In-*
5 *come Security Act of 1974 (29 U.S.C. 1001 et*
6 *seq.), the Public Health Service Act (42 U.S.C.*
7 *201 et seq.), and this Act, the Federal Govern-*
8 *ment has a significant role in regulating health*
9 *insurance. The requirement is an essential part*
10 *of this larger regulation of economic activity,*
11 *and the absence of the requirement would under-*
12 *cut Federal regulation of the health insurance*
13 *market.*

14 *“(I) Under sections 2704 and 2705 of the*
15 *Public Health Service Act (as added by section*
16 *1201 of this Act), if there were no requirement,*
17 *many individuals would wait to purchase health*
18 *insurance until they needed care. By signifi-*
19 *cantly increasing health insurance coverage, the*
20 *requirement, together with the other provisions of*
21 *this Act, will minimize this adverse selection and*
22 *broaden the health insurance risk pool to include*
23 *healthy individuals, which will lower health in-*
24 *surance premiums. The requirement is essential*
25 *to creating effective health insurance markets in*

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

4 “(J) *Administrative costs for private health*
5 *insurance, which were \$90,000,000,000 in 2006,*
6 *are 26 to 30 percent of premiums in the current*
7 *individual and small group markets. By signifi-*
8 *cantly increasing health insurance coverage and*
9 *the size of purchasing pools, which will increase*
10 *economies of scale, the requirement, together with*
11 *the other provisions of this Act, will significantly*
12 *reduce administrative costs and lower health in-*
13 *surance premiums. The requirement is essential*
14 *to creating effective health insurance markets*
15 *that do not require underwriting and eliminate*
16 *its associated administrative costs.”.*

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

20 “(1) *IN GENERAL.—If a taxpayer who is an ap-*
21 *plicable individual, or an applicable individual for*
22 *whom the taxpayer is liable under paragraph (3),*
23 *fails to meet the requirement of subsection (a) for 1*
24 *or more months, then, except as provided in sub-*
25 *section (e), there is hereby imposed on the taxpayer*

1 *a penalty with respect to such failures in the amount*
2 *determined under subsection (c).”.*

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

6 *“(1) IN GENERAL.—The amount of the penalty*
7 *imposed by this section on any taxpayer for any tax-*
8 *able year with respect to failures described in sub-*
9 *section (b)(1) shall be equal to the lesser of—*

10 *“(A) the sum of the monthly penalty*
11 *amounts determined under paragraph (2) for*
12 *months in the taxable year during which 1 or*
13 *more such failures occurred, or*

14 *“(B) an amount equal to the national aver-*
15 *age premium for qualified health plans which*
16 *have a bronze level of coverage, provide coverage*
17 *for the applicable family size involved, and are*
18 *offered through Exchanges for plan years begin-*
19 *ning in the calendar year with or within which*
20 *the taxable year ends.*

21 *“(2) MONTHLY PENALTY AMOUNTS.—For pur-*
22 *poses of paragraph (1)(A), the monthly penalty*
23 *amount with respect to any taxpayer for any month*
24 *during which any failure described in subsection*

1 **(b)(1)** *occurred is an amount equal to $\frac{1}{12}$ of the*
2 *greater of the following amounts:*

3 “(A) *FLAT DOLLAR AMOUNT.*—*An amount*
4 *equal to the lesser of—*

5 “(i) *the sum of the applicable dollar*
6 *amounts for all individuals with respect to*
7 *whom such failure occurred during such*
8 *month, or*

9 “(ii) *300 percent of the applicable dol-*
10 *lar amount (determined without regard to*
11 *paragraph (3)(C)) for the calendar year*
12 *with or within which the taxable year ends.*

13 “(B) *PERCENTAGE OF INCOME.*—*An*
14 *amount equal to the following percentage of the*
15 *taxpayer’s household income for the taxable year:*

16 “(i) *0.5 percent for taxable years be-*
17 *ginning in 2014.*

18 “(ii) *1.0 percent for taxable years be-*
19 *ginning in 2015.*

20 “(iii) *2.0 percent for taxable years be-*
21 *ginning after 2015.”.*

22 **(3)** *Section 5000A(c)(3) of the Internal Revenue Code*
23 *of 1986, as added by section 1501(b) of this Act, is amended*
24 *by striking “\$350” and inserting “\$495”.*

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

4 “(A) *RELIGIOUS CONSCIENCE EXEMP-*
5 *TION.*—Such term shall not include any indi-
6 *vidual for any month if such individual has in*
7 *effect an exemption under section 1311(d)(4)(H)*
8 *of the Patient Protection and Affordable Care*
9 *Act which certifies that such individual is—*

10 “(i) *a member of a recognized religious*
11 *sect or division thereof which is described in*
12 *section 1402(g)(1), and*

13 “(ii) *an adherent of established tenets*
14 *or teachings of such sect or division as de-*
15 *scribed in such section.”.*

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

19 “(C) *SPECIAL RULES FOR INDIVIDUALS RE-*
20 *LATED TO EMPLOYEES.*—For purposes of sub-
21 *paragraph (B)(i), if an applicable individual is*
22 *eligible for minimum essential coverage through*
23 *an employer by reason of a relationship to an*
24 *employee, the determination under subparagraph*

1 (A) shall be made by reference to required con-
2 tribution of the employee.”.

3 (e) Section 4980H(b) of the Internal Revenue Code of
4 1986, as added by section 1513(a) of this Act, is amended
5 to read as follows:

6 “(b) *LARGE EMPLOYERS WITH WAITING PERIODS EX-*
7 *CEEDING 60 DAYS.*—

8 “(1) *IN GENERAL.*—*In the case of any applicable*
9 *large employer which requires an extended waiting*
10 *period to enroll in any minimum essential coverage*
11 *under an employer-sponsored plan (as defined in sec-*
12 *tion 5000A(f)(2)), there is hereby imposed on the em-*
13 *ployer an assessable payment of \$600 for each full-*
14 *time employee of the employer to whom the extended*
15 *waiting period applies.*

16 “(2) *EXTENDED WAITING PERIOD.*—*The term*
17 *‘extended waiting period’ means any waiting period*
18 *(as defined in section 2701(b)(4) of the Public Health*
19 *Service Act) which exceeds 60 days.”.*

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

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

4 “(D) *APPLICATION TO CONSTRUCTION IN-*
5 *DUSTRY EMPLOYERS.—In the case of any em-*
6 *ployer the substantial annual gross receipts of*
7 *which are attributable to the construction indus-*
8 *try—*

9 “(i) *subparagraph (A) shall be applied*
10 *by substituting ‘who employed an average of*
11 *at least 5 full-time employees on business*
12 *days during the preceding calendar year*
13 *and whose annual payroll expenses exceed*
14 *\$250,000 for such preceding calendar year’*
15 *for ‘who employed an average of at least 50*
16 *full-time employees on business days during*
17 *the preceding calendar year’, and*

18 “(ii) *subparagraph (B) shall be ap-*
19 *plied by substituting ‘5’ for ‘50’.*”

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

22 (g) *Section 6056(b) of the Internal Revenue Code of*
23 *1986, as added by section 1514(a) of the Act, is amended*
24 *by adding at the end the following new flush sentence:*

1 *“The Secretary shall have the authority to review the accu-*
2 *racy of the information provided under this subsection, in-*
3 *cluding the applicable large employer’s share under para-*
4 *graph (2)(C)(iv).”.*

5 **SEC. 10107. AMENDMENTS TO SUBTITLE G.**

6 *(a) Section 1562 of this Act is amended, in the amend-*
7 *ment made by subsection (a)(2)(B)(iii), by striking “sub-*
8 *part 1” and inserting “subparts I and II”; and*

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

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

12 *(2) by inserting after section 1561 the following:*

13 **“SEC. 1562. GAO STUDY REGARDING THE RATE OF DENIAL**
14 **OF COVERAGE AND ENROLLMENT BY HEALTH**
15 **INSURANCE ISSUERS AND GROUP HEALTH**
16 **PLANS.**

17 *“(a) IN GENERAL.—The Comptroller General of the*
18 *United States (referred to in this section as the ‘Comptroller*
19 *General’) shall conduct a study of the incidence of denials*
20 *of coverage for medical services and denials of applications*
21 *to enroll in health insurance plans, as described in sub-*
22 *section (b), by group health plans and health insurance*
23 *issuers.*

24 *“(b) DATA.—*

1 “(1) *IN GENERAL.*—*In conducting the study de-*
2 *scribed in subsection (a), the Comptroller General*
3 *shall consider samples of data concerning the fol-*
4 *lowing:*

5 “(A)(i) *denials of coverage for medical serv-*
6 *ices to a plan enrollees, by the types of services*
7 *for which such coverage was denied; and*

8 “(i) *the reasons such coverage was denied;*
9 *and*

10 “(B)(i) *incidents in which group health*
11 *plans and health insurance issuers deny the ap-*
12 *plication of an individual to enroll in a health*
13 *insurance plan offered by such group health plan*
14 *or issuer; and*

15 “(i) *the reasons such applications are de-*
16 *nied.*

17 “(2) *SCOPE OF DATA.*—

18 “(A) *FAVORABLY RESOLVED DISPUTES.*—
19 *The data that the Comptroller General considers*
20 *under paragraph (1) shall include data con-*
21 *cerning denials of coverage for medical services*
22 *and denials of applications for enrollment in a*
23 *plan by a group health plan or health insurance*
24 *issuer, where such group health plan or health*

1 *insurance issuer later approves such coverage or*
2 *application.*

3 “(B) *ALL HEALTH PLANS.—The study*
4 *under this section shall consider data from var-*
5 *ied group health plans and health insurance*
6 *plans offered by health insurance issuers, includ-*
7 *ing qualified health plans and health plans that*
8 *are not qualified health plans.*

9 “(c) *REPORT.—Not later than one year after the date*
10 *of enactment of this Act, the Comptroller General shall sub-*
11 *mit to the Secretaries of Health and Human Services and*
12 *Labor a report describing the results of the study conducted*
13 *under this section.*

14 “(d) *PUBLICATION OF REPORT.—The Secretaries of*
15 *Health and Human Services and Labor shall make the re-*
16 *port described in subsection (c) available to the public on*
17 *an Internet website.*

18 **“SEC. 1563. SMALL BUSINESS PROCUREMENT.**

19 “*Part 19 of the Federal Acquisition Regulation, section*
20 *15 of the Small Business Act (15 U.S.C. 644), and any*
21 *other applicable laws or regulations establishing procure-*
22 *ment requirements relating to small business concerns (as*
23 *defined in section 3 of the Small Business Act (15 U.S.C.*
24 *632)) may not be waived with respect to any contract*

1 *awarded under any program or other authority under this*
2 *Act or an amendment made by this Act.”.*

3 **SEC. 10108. FREE CHOICE VOUCHERS.**

4 (a) *IN GENERAL.*—*An offering employer shall provide*
5 *free choice vouchers to each qualified employee of such em-*
6 *ployer.*

7 (b) *OFFERING EMPLOYER.*—*For purposes of this sec-*
8 *tion, the term “offering employer” means any employer*
9 *who—*

10 (1) *offers minimum essential coverage to its em-*
11 *ployees consisting of coverage through an eligible em-*
12 *ployer-sponsored plan; and*

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

14 (c) *QUALIFIED EMPLOYEE.*—*For purposes of this sec-*
15 *tion—*

16 (1) *IN GENERAL.*—*The term “qualified em-*
17 *ployee” means, with respect to any plan year of an*
18 *offering employer, any employee—*

19 (A) *whose required contribution (as deter-*
20 *mined under section 5000A(e)(1)(B)) for min-*
21 *imum essential coverage through an eligible em-*
22 *ployer-sponsored plan—*

23 (i) *exceeds 8 percent of such employee’s*
24 *household income for the taxable year de-*

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

3 (ii) does not exceed 9.8 percent of such
4 employee's household income for such tax-
5 able year;

6 (B) whose household income for such taxable
7 year is not greater than 400 percent of the pov-
8 erty line for a family of the size involved; and

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

11 (2) INDEXING.—In the case of any calendar year
12 beginning after 2014, the Secretary shall adjust the 8
13 percent under paragraph (1)(A)(i) and 9.8 percent
14 under paragraph (1)(A)(ii) for the calendar year to
15 reflect the rate of premium growth between the pre-
16 ceding calendar year and 2013 over the rate of in-
17 come growth for such period.

18 (d) FREE CHOICE VOUCHER.—

19 (1) AMOUNT.—

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

1 to which the employer pays the largest portion of
2 the cost of the plan. Such amount shall be equal
3 to the amount the employer would pay for an
4 employee with self-only coverage unless such em-
5 ployee elects family coverage (in which case such
6 amount shall be the amount the employer would
7 pay for family coverage).

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

15 (2) USE OF VOUCHERS.—An Exchange shall
16 credit the amount of any free choice voucher provided
17 under subsection (a) to the monthly premium of any
18 qualified health plan in the Exchange in which the
19 qualified employee is enrolled and the offering em-
20 ployer shall pay any amounts so credited to the Ex-
21 change.

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

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

3 *(e) OTHER DEFINITIONS.—Any term used in this sec-*
4 *tion which is also used in section 5000A of the Internal*
5 *Revenue Code of 1986 shall have the meaning given such*
6 *term under such section 5000A.*

7 *(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—*

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

12 **“SEC. 139D. FREE CHOICE VOUCHERS.**

13 *“Gross income shall not include the amount of any free*
14 *choice voucher provided by an employer under section*
15 *10108 of the Patient Protection and Affordable Care Act*
16 *to the extent that the amount of such voucher does not exceed*
17 *the amount paid for a qualified health plan (as defined in*
18 *section 1301 of such Act) by the taxpayer.”.*

19 *(2) CLERICAL AMENDMENT.—The table of sec-*
20 *tions for part III of subchapter B of chapter 1 of such*
21 *Code is amended by inserting after the item relating*
22 *to section 139C the following new item:*

“Sec. 139D. Free choice vouchers.”.

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

1 (g) *DEDUCTION ALLOWED TO EMPLOYER.*—

2 (1) *IN GENERAL.*—Section 162(a) of the Internal
3 Revenue Code of 1986 is amended by adding at the
4 end the following new sentence: “For purposes of
5 paragraph (1), the amount of a free choice voucher
6 provided under section 10108 of the Patient Protec-
7 tion and Affordable Care Act shall be treated as an
8 amount for compensation for personal services actu-
9 ally rendered.”.

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

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

15 (1) *IN GENERAL.*—Subsection (c)(2) of section
16 36B of the Internal Revenue Code of 1986, as added
17 by section 1401, is amended by adding at the end the
18 following new subparagraph:

19 “(D) *EXCEPTION FOR INDIVIDUAL RECEIV-*
20 *ING FREE CHOICE VOUCHERS.*—The term ‘cov-
21 erage month’ shall not include any month in
22 which such individual has a free choice voucher
23 provided under section 10108 of the Patient Pro-
24 tection and Affordable Care Act.”.

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

4 (i) *COORDINATION WITH EMPLOYER RESPONSIBIL-*
5 *ITIES.*—

6 (1) *SHARED RESPONSIBILITY PENALTY.*—

7 (A) *IN GENERAL.*—*Subsection (c) of section*
8 *4980H of the Internal Revenue Code of 1986, as*
9 *added by section 1513, is amended by adding at*
10 *the end the following new paragraph:*

11 “(3) *SPECIAL RULES FOR EMPLOYERS PRO-*
12 *VIDING FREE CHOICE VOUCHERS.*—*No assessable pay-*
13 *ment shall be imposed under paragraph (1) for any*
14 *month with respect to any employee to whom the em-*
15 *ployer provides a free choice voucher under section*
16 *10108 of the Patient Protection and Affordable Care*
17 *Act for such month.”.*

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

21 (2) *NOTIFICATION REQUIREMENT.*—*Section*
22 *18B(a)(3) of the Fair Labor Standards Act of 1938,*
23 *as added by section 1512, is amended—*

1 (A) by inserting “and the employer does not
2 offer a free choice voucher” after “Exchange”;
3 and

4 (B) by striking “will lose” and inserting
5 “may lose”.

6 (j) *EMPLOYER REPORTING.*—

7 (1) *IN GENERAL.*—Subsection (a) of section 6056
8 of the Internal Revenue Code of 1986, as added by
9 section 1514, is amended by inserting “and every of-
10 fering employer” before “shall”.

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

14 “(f) *DEFINITIONS.*—For purposes of this section—

15 “(1) *OFFERING EMPLOYER.*—

16 “(A) *IN GENERAL.*—The term ‘offering em-
17 ployer’ means any offering employer (as defined
18 in section 10108(b) of the Patient Protection and
19 Affordable Care Act) if the required contribution
20 (within the meaning of section
21 5000A(e)(1)(B)(i)) of any employee exceeds 8
22 percent of the wages (as defined in section
23 3121(a)) paid to such employee by such em-
24 ployer.

1 “(B) *INDEXING.*—*In the case of any cal-*
2 *endar year beginning after 2014, the 8 percent*
3 *under subparagraph (A) shall be adjusted for the*
4 *calendar year to reflect the rate of premium*
5 *growth between the preceding calendar year and*
6 *2013 over the rate of income growth for such pe-*
7 *riod.*

8 “(2) *OTHER DEFINITIONS.*—*Any term used in*
9 *this section which is also used in section 4980H shall*
10 *have the meaning given such term by section*
11 *4980H.”.*

12 (3) *CONFORMING AMENDMENTS.*—

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

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

18 (i) *by inserting “in the case of an ap-*
19 *plicable large employer,” before “the length”*
20 *in clause (i);*

21 (ii) *by striking “and” at the end of*
22 *clause (iii);*

23 (iii) *by striking “applicable large em-*
24 *ployer” in clause (iv) and inserting “em-*
25 *ployer”;*

1 *(iv) by inserting “and” at the end of*
2 *clause (iv); and*

3 *(v) by inserting at the end the fol-*
4 *lowing new clause:*

5 *“(v) in the case of an offering em-*
6 *ployer, the option for which the employer*
7 *pays the largest portion of the cost of the*
8 *plan and the portion of the cost paid by the*
9 *employer in each of the enrollment cat-*
10 *egories under such option,”.*

11 *(C) Section 6056(d)(2) of such Code is*
12 *amended by inserting “or offering employer”*
13 *after “applicable large employer”.*

14 *(D) Section 6056(e) of such Code is amend-*
15 *ed by inserting “or offering employer” after “ap-*
16 *plicable large employer”.*

17 *(E) Section 6724(d)(1)(B)(xxv) of such*
18 *Code, as added by section 1514, is amended by*
19 *striking “large” and inserting “certain”.*

20 *(F) Section 6724(d)(2)(HH) of such Code,*
21 *as added by section 1514, is amended by striking*
22 *“large” and inserting “certain”.*

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

1 by striking “Large employers” in the item relat-
 2 ing to section 6056 and inserting “Certain em-
 3 ployers”.

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

7 **SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL**
 8 **AND ADMINISTRATIVE TRANSACTIONS.**

9 (a) *ADDITIONAL TRANSACTION STANDARDS AND OP-*
 10 *ERATING RULES.*—

11 (1) *DEVELOPMENT OF ADDITIONAL TRANSACTION*
 12 *STANDARDS AND OPERATING RULES.*—Section
 13 1173(a) of the Social Security Act (42 U.S.C. 1320d-
 14 2(a)), as amended by section 1104(b)(2), is amend-
 15 ed—

16 (A) in paragraph (1)(B), by inserting before
 17 the period the following: “, and subject to the re-
 18 quirements under paragraph (5)”;

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

21 “(5) *CONSIDERATION OF STANDARDIZATION OF*
 22 *ACTIVITIES AND ITEMS.*—

23 “(A) *IN GENERAL.*—For purposes of car-
 24 rying out paragraph (1)(B), the Secretary shall
 25 solicit, not later than January 1, 2012, and not

1 *less than every 3 years thereafter, input from en-*
2 *tities described in subparagraph (B) on—*

3 *“(i) whether there could be greater uni-*
4 *formity in financial and administrative ac-*
5 *tivities and items, as determined appro-*
6 *priate by the Secretary; and*

7 *“(ii) whether such activities should be*
8 *considered financial and administrative*
9 *transactions (as described in paragraph*
10 *(1)(B)) for which the adoption of standards*
11 *and operating rules would improve the op-*
12 *eration of the health care system and reduce*
13 *administrative costs.*

14 *“(B) SOLICITATION OF INPUT.—For pur-*
15 *poses of subparagraph (A), the Secretary shall*
16 *seek input from—*

17 *“(i) the National Committee on Vital*
18 *and Health Statistics, the Health Informa-*
19 *tion Technology Policy Committee, and the*
20 *Health Information Technology Standards*
21 *Committee; and*

22 *“(ii) standard setting organizations*
23 *and stakeholders, as determined appropriate*
24 *by the Secretary.”.*

1 **(b) ACTIVITIES AND ITEMS FOR INITIAL CONSIDER-**
2 *ATION.—For purposes of section 1173(a)(5) of the Social*
3 *Security Act, as added by subsection (a), the Secretary of*
4 *Health and Human Services (in this section referred to as*
5 *the “Secretary”) shall, not later than January 1, 2012, seek*
6 *input on activities and items relating to the following*
7 *areas:*

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

12 (2) *Whether standards and operating rules de-*
13 *scribed in section 1173 of the Social Security Act*
14 *should apply to the health care transactions of auto-*
15 *mobile insurance, worker’s compensation, and other*
16 *programs or persons not described in section 1172(a)*
17 *of such Act (42 U.S.C. 1320d–1(a)).*

18 (3) *Whether standardized forms could apply to*
19 *financial audits required by health plans, Federal*
20 *and State agencies (including State auditors, the Of-*
21 *fice of the Inspector General of the Department of*
22 *Health and Human Services, and the Centers for*
23 *Medicare & Medicaid Services), and other relevant*
24 *entities as determined appropriate by the Secretary.*

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

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

8 (c) *ICD CODING CROSSWALKS.*—

9 (1) *ICD–9 TO ICD–10 CROSSWALK.*—*The Sec-*
10 *retary shall task the ICD–9–CM Coordination and*
11 *Maintenance Committee to convene a meeting, not*
12 *later than January 1, 2011, to receive input from ap-*
13 *propriate stakeholders (including health plans, health*
14 *care providers, and clinicians) regarding the cross-*
15 *walk between the Ninth and Tenth Revisions of the*
16 *International Classification of Diseases (ICD–9 and*
17 *ICD–10, respectively) that is posted on the website of*
18 *the Centers for Medicare & Medicaid Services, and*
19 *make recommendations about appropriate revisions to*
20 *such crosswalk.*

21 (2) *REVISION OF CROSSWALK.*—*For purposes of*
22 *the crosswalk described in paragraph (1), the Sec-*
23 *retary shall make appropriate revisions and post any*
24 *such revised crosswalk on the website of the Centers*
25 *for Medicare & Medicaid Services.*

1 (3) *USE OF REVISED CROSSWALK.*—*For purposes*
2 *of paragraph (2), any revised crosswalk shall be treat-*
3 *ed as a code set for which a standard has been adopt-*
4 *ed by the Secretary for purposes of section*
5 *1173(c)(1)(B) of the Social Security Act (42 U.S.C.*
6 *1320d–2(c)(1)(B)).*

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

18 ***Subtitle B—Provisions Relating to***
19 ***Title II***

20 ***PART I—MEDICAID AND CHIP***

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

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

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“(IX) who—

“(aa) are under 26 years of age;

“(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

“(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

“(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;”.

23 (2) Section 1902(a)(10) of the Social Security Act (42
24 U.S.C. 1396a(a)(10), as amended by section 2001(a)(5)(A),
25 is amended in the matter following subparagraph (G), by

1 *striking “and (XV)” and inserting “(XV)”, and by insert-*
2 *ing “and (XVI) if an individual is described in subclause*
3 *(IX) of subparagraph (A)(i) and is also described in sub-*
4 *clause (VIII) of that subparagraph, the medical assistance*
5 *shall be made available to the individual through subclause*
6 *(IX) instead of through subclause (VIII)” before the semi-*
7 *colon.*

8 (3) *Section 2004(d) of this Act is amended by striking*
9 *“2019” and inserting “2014”.*

10 (b) *Section 1902(k)(2) of the Social Security Act (42*
11 *U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A), is*
12 *amended by striking “January 1, 2011” and inserting*
13 *“April 1, 2010”.*

14 (c) *Section 1905 of the Social Security Act (42 U.S.C.*
15 *1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C),*
16 *2006, and 4107(a)(2), is amended—*

17 (1) *in subsection (a), in the matter preceding*
18 *paragraph (1), by inserting in clause (xiv), “or*
19 *1902(a)(10)(A)(i)(IX)” before the comma;*

20 (2) *in subsection (b), in the first sentence, by in-*
21 *serting “, (z),” before “and (aa)”;*

22 (3) *in subsection (y)—*

23 (A) *in paragraph (1)(B)(ii)(II), in the first*
24 *sentence, by inserting “includes inpatient hos-*

1 *pital services,” after “100 percent of the poverty*
2 *line, that”;* and

3 (B) in paragraph (2)(A), by striking “on
4 *the date of enactment of the Patient Protection*
5 *and Affordable Care Act” and inserting “as of*
6 *December 1, 2009”;*

7 (4) by inserting after subsection (y) the fol-
8 *lowing:*

9 “(z) *EQUITABLE SUPPORT FOR CERTAIN STATES.—*

10 “(1)(A) *During the period that begins on Janu-*
11 *ary 1, 2014, and ends on September 30, 2019, not-*
12 *withstanding subsection (b), the Federal medical as-*
13 *sistance percentage otherwise determined under sub-*
14 *section (b) with respect to a fiscal year occurring dur-*
15 *ing that period shall be increased by 2.2 percentage*
16 *points for any State described in subparagraph (B)*
17 *for amounts expended for medical assistance for indi-*
18 *viduals who are not newly eligible (as defined in sub-*
19 *section (y)(2)) individuals described in subclause*
20 *(VIII) of section 1902(a)(10)(A)(i).*

21 “(B) *For purposes of subparagraph (A), a State*
22 *described in this subparagraph is a State that—*

23 “(i) *is an expansion State described in sub-*
24 *section (y)(1)(B)(ii)(II);*

1 “(i) the Secretary determines will not re-
2 ceive any payments under this title on the basis
3 of an increased Federal medical assistance per-
4 centage under subsection (y) for expenditures for
5 medical assistance for newly eligible individuals
6 (as so defined); and

7 “(iii) has not been approved by the Sec-
8 retary to divert a portion of the DSH allotment
9 for a State to the costs of providing medical as-
10 sistance or other health benefits coverage under a
11 waiver that is in effect on July 2009.

12 “(2)(A) During the period that begins on January 1,
13 2014, and ends on December 31, 2016, notwithstanding sub-
14 section (b), the Federal medical assistance percentage other-
15 wise determined under subsection (b) with respect to all or
16 any portion of a fiscal year occurring during that period
17 shall be increased by .5 percentage point for a State de-
18 scribed in subparagraph (B) for amounts expended for med-
19 ical assistance under the State plan under this title or
20 under a waiver of that plan during that period.

21 “(B) For purposes of subparagraph (A), a State de-
22 scribed in this subparagraph is a State that—

23 “(i) is described in clauses (i) and (ii) of para-
24 graph (1)(B); and

1 “(ii) is the State with the highest percentage of
2 its population insured during 2008, based on the Cur-
3 rent Population Survey.

4 “(3) Notwithstanding subsection (b) and paragraphs
5 (1) and (2) of this subsection, the Federal medical assist-
6 ance percentage otherwise determined under subsection (b)
7 with respect to all or any portion of a fiscal year that begins
8 on or after January 1, 2017, for the State of Nebraska, with
9 respect to amounts expended for newly eligible individuals
10 described in subclause (VIII) of section 1902(a)(10)(A)(i),
11 shall be determined as provided for under subsection
12 (y)(1)(A) (notwithstanding the period provided for in such
13 paragraph).

14 “(4) The increase in the Federal medical assistance
15 percentage for a State under paragraphs (1), (2), or (3)
16 shall apply only for purposes of this title and shall not
17 apply with respect to—

18 “(A) disproportionate share hospital payments
19 described in section 1923;

20 “(B) payments under title IV;

21 “(C) payments under title XXI; and

22 “(D) payments under this title that are based on
23 the enhanced FMAP described in section 2105(b).”;

24 (5) in subsection (aa), is amended by striking
25 “without regard to this subsection and subsection (y)”

1 and inserting “without regard to this subsection, sub-
2 section (y), subsection (z), and section 10202 of the
3 Patient Protection and Affordable Care Act” each
4 place it appears;

5 (6) by adding after subsection (bb), the following:

6 “(cc) *REQUIREMENT FOR CERTAIN STATES.*—Notwith-
7 standing subsections (y), (z), and (aa), in the case of a State
8 that requires political subdivisions within the State to con-
9 tribute toward the non-Federal share of expenditures re-
10 quired under the State plan under section 1902(a)(2), the
11 State shall not be eligible for an increase in its Federal
12 medical assistance percentage under such subsections if it
13 requires that political subdivisions pay a greater percentage
14 of the non-Federal share of such expenditures, or a greater
15 percentage of the non-Federal share of payments under sec-
16 tion 1923, than the respective percentages that would have
17 been required by the State under the State plan under this
18 title, State law, or both, as in effect on December 31, 2009,
19 and without regard to any such increase. Voluntary con-
20 tributions by a political subdivision to the non-Federal
21 share of expenditures under the State plan under this title
22 or to the non-Federal share of payments under section 1923,
23 shall not be considered to be required contributions for pur-
24 poses of this subsection. The treatment of voluntary con-
25 tributions, and the treatment of contributions required by

1 *a State under the State plan under this title, or State law,*
2 *as provided by this subsection, shall also apply to the in-*
3 *creases in the Federal medical assistance percentage under*
4 *section 5001 of the American Recovery and Reinvestment*
5 *Act of 2009.”.*

6 *(d) Section 1108(g)(4)(B) of the Social Security Act*
7 *(42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b), is*
8 *amended by striking “income eligibility level in effect for*
9 *that population under title XIX or under a waiver” and*
10 *inserting “the highest income eligibility level in effect for*
11 *parents under the commonwealth’s or territory’s State plan*
12 *under title XIX or under a waiver of the plan”.*

13 *(e)(1) Section 1923(f) of the Social Security Act (42*
14 *U.S.C. 1396r-4(f)), as amended by section 2551, is amend-*
15 *ed—*

16 *(A) in paragraph (6)—*

17 *(i) by striking the paragraph heading and*
18 *inserting the following: “ALLOTMENT ADJUST-*
19 *MENTS”; and*

20 *(ii) in subparagraph (B), by adding at the*
21 *end the following:*

22 *“(iii) ALLOTMENT FOR 2D, 3RD, AND*
23 *4TH QUARTER OF FISCAL YEAR 2012, FISCAL*
24 *YEAR 2013, AND SUCCEEDING FISCAL*

1 YEARS.—Notwithstanding the table set forth
2 in paragraph (2) or paragraph (7):

3 “(I) 2D, 3RD, AND 4TH QUARTER
4 OF FISCAL YEAR 2012.—The DSH allot-
5 ment for Hawaii for the 2d, 3rd, and
6 4th quarters of fiscal year 2012 shall
7 be \$7,500,000.

8 “(II) TREATMENT AS A LOW-DSH
9 STATE FOR FISCAL YEAR 2013 AND SUC-
10 CEEDING FISCAL YEARS.—With respect
11 to fiscal year 2013, and each fiscal
12 year thereafter, the DSH allotment for
13 Hawaii shall be increased in the same
14 manner as allotments for low DSH
15 States are increased for such fiscal
16 year under clause (iii) of paragraph
17 (5)(B).

18 “(III) CERTAIN HOSPITAL PAY-
19 MENTS.—The Secretary may not im-
20 pose a limitation on the total amount
21 of payments made to hospitals under
22 the QUEST section 1115 Demonstra-
23 tion Project except to the extent that
24 such limitation is necessary to ensure
25 that a hospital does not receive pay-

1 *ments in excess of the amounts de-*
2 *scribed in subsection (g), or as nec-*
3 *essary to ensure that such payments*
4 *under the waiver and such payments*
5 *pursuant to the allotment provided in*
6 *this clause do not, in the aggregate in*
7 *any year, exceed the amount that the*
8 *Secretary determines is equal to the*
9 *Federal medical assistance percentage*
10 *component attributable to dispropor-*
11 *tionate share hospital payment adjust-*
12 *ments for such year that is reflected in*
13 *the budget neutrality provision of the*
14 *QUEST Demonstration Project.”; and*

15 *(B) in paragraph (7)—*

16 *(i) in subparagraph (A), in the matter pre-*
17 *ceding clause (i), by striking “subparagraph*
18 *(E)” and inserting “subparagraphs (E) and*
19 *(G)”;*

20 *(ii) in subparagraph (B)—*

21 *(I) in clause (i), by striking subclauses*
22 *(I) and (II), and inserting the following:*

23 *“(I) if the State is a low DSH*
24 *State described in paragraph (5)(B)*
25 *and has spent not more than 99.90*

1 *percent of the DSH allotments for the*
2 *State on average for the period of fiscal*
3 *years 2004 through 2008, as of Sep-*
4 *tember 30, 2009, the applicable per-*
5 *centage is equal to 25 percent;*

6 *“(II) if the State is a low DSH*
7 *State described in paragraph (5)(B)*
8 *and has spent more than 99.90 percent*
9 *of the DSH allotments for the State on*
10 *average for the period of fiscal years*
11 *2004 through 2008, as of September*
12 *30, 2009, the applicable percentage is*
13 *equal to 17.5 percent;*

14 *“(III) if the State is not a low*
15 *DSH State described in paragraph*
16 *(5)(B) and has spent not more than*
17 *99.90 percent of the DSH allotments*
18 *for the State on average for the period*
19 *of fiscal years 2004 through 2008, as of*
20 *September 30, 2009, the applicable*
21 *percentage is equal to 50 percent; and*

22 *“(IV) if the State is not a low*
23 *DSH State described in paragraph*
24 *(5)(B) and has spent more than 99.90*
25 *percent of the DSH allotments for the*

1 *State on average for the period of fiscal*
2 *years 2004 through 2008, as of Sep-*
3 *tember 30, 2009, the applicable per-*
4 *centage is equal to 35 percent.”;*

5 *(II) in clause (ii), by striking sub-*
6 *clauses (I) and (II), and inserting the fol-*
7 *lowing:*

8 *“(I) if the State is a low DSH*
9 *State described in paragraph (5)(B)*
10 *and has spent not more than 99.90*
11 *percent of the DSH allotments for the*
12 *State on average for the period of fiscal*
13 *years 2004 through 2008, as of Sep-*
14 *tember 30, 2009, the applicable per-*
15 *centage is equal to the product of the*
16 *percentage reduction in uncovered in-*
17 *dividuals for the fiscal year from the*
18 *preceding fiscal year and 27.5 percent;*

19 *“(II) if the State is a low DSH*
20 *State described in paragraph (5)(B)*
21 *and has spent more than 99.90 percent*
22 *of the DSH allotments for the State on*
23 *average for the period of fiscal years*
24 *2004 through 2008, as of September*
25 *30, 2009, the applicable percentage is*

1 *equal to the product of the percentage*
2 *reduction in uncovered individuals for*
3 *the fiscal year from the preceding fiscal*
4 *year and 20 percent;*

5 *“(III) if the State is not a low*
6 *DSH State described in paragraph*
7 *(5)(B) and has spent not more than*
8 *99.90 percent of the DSH allotments*
9 *for the State on average for the period*
10 *of fiscal years 2004 through 2008, as of*
11 *September 30, 2009, the applicable*
12 *percentage is equal to the product of*
13 *the percentage reduction in uncovered*
14 *individuals for the fiscal year from the*
15 *preceding fiscal year and 55 percent;*
16 *and*

17 *“(IV) if the State is not a low*
18 *DSH State described in paragraph*
19 *(5)(B) and has spent more than 99.90*
20 *percent of the DSH allotments for the*
21 *State on average for the period of fiscal*
22 *years 2004 through 2008, as of Sep-*
23 *tember 30, 2009, the applicable per-*
24 *centage is equal to the product of the*
25 *percentage reduction in uncovered in-*

1 *dividuals for the fiscal year from the*
2 *preceding fiscal year and 40 percent.”;*
3 *(III) in subparagraph (E), by striking*
4 *“35 percent” and inserting “50 percent”;*
5 *and*
6 *(IV) by adding at the end the fol-*
7 *lowing:*

8 *“(G) NONAPPLICATION.—The preceding pro-*
9 *visions of this paragraph shall not apply to the*
10 *DSH allotment determined for the State of Ha-*
11 *waii for a fiscal year under paragraph (6).”.*

12 *(f) Section 2551 of this Act is amended by striking*
13 *subsection (b).*

14 *(g) Section 2105(d)(3)(B) of the Social Security Act*
15 *(42 U.S.C. 1397ee(d)(3)(B)), as added by section*
16 *2101(b)(1), is amended by adding at the end the following:*
17 *“For purposes of eligibility for premium assistance for the*
18 *purchase of a qualified health plan under section 36B of*
19 *the Internal Revenue Code of 1986 and reduced cost-sharing*
20 *under section 1402 of the Patient Protection and Affordable*
21 *Care Act, children described in the preceding sentence shall*
22 *be deemed to be ineligible for coverage under the State child*
23 *health plan.”.*

1 *(h) Clause (i) of subparagraph (C) of section 513(b)(2)*
2 *of the Social Security Act, as added by section 2953 of this*
3 *Act, is amended to read as follows:*

4 *“(i) Healthy relationships, including*
5 *marriage and family interactions.”.*

6 *(i) Section 1115 of the Social Security Act (42 U.S.C.*
7 *1315) is amended by inserting after subsection (c) the fol-*
8 *lowing:*

9 *“(d)(1) An application or renewal of any experi-*
10 *mental, pilot, or demonstration project undertaken under*
11 *subsection (a) to promote the objectives of title XIX or XXI*
12 *in a State that would result in an impact on eligibility,*
13 *enrollment, benefits, cost-sharing, or financing with respect*
14 *to a State program under title XIX or XXI (in this sub-*
15 *section referred to as a ‘demonstration project’) shall be con-*
16 *sidered by the Secretary in accordance with the regulations*
17 *required to be promulgated under paragraph (2).*

18 *“(2) Not later than 180 days after the date of enact-*
19 *ment of this subsection, the Secretary shall promulgate reg-*
20 *ulations relating to applications for, and renewals of, a*
21 *demonstration project that provide for—*

22 *“(A) a process for public notice and comment at*
23 *the State level, including public hearings, sufficient to*
24 *ensure a meaningful level of public input;*

25 *“(B) requirements relating to—*

1 “(i) the goals of the program to be imple-
2 mented or renewed under the demonstration
3 project;

4 “(ii) the expected State and Federal costs
5 and coverage projections of the demonstration
6 project; and

7 “(iii) the specific plans of the State to en-
8 sure that the demonstration project will be in
9 compliance with title XIX or XXI;

10 “(C) a process for providing public notice and
11 comment after the application is received by the Sec-
12 retary, that is sufficient to ensure a meaningful level
13 of public input;

14 “(D) a process for the submission to the Sec-
15 retary of periodic reports by the State concerning the
16 implementation of the demonstration project; and

17 “(E) a process for the periodic evaluation by the
18 Secretary of the demonstration project.

19 “(3) The Secretary shall annually report to Congress
20 concerning actions taken by the Secretary with respect to
21 applications for demonstration projects under this section.”.

22 (j) Subtitle F of title III of this Act is amended by
23 adding at the end the following:

1 **“SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF AC-**
2 **TION.**

3 “(a) *STUDY.*—

4 “(1) *IN GENERAL.*—*The Comptroller General of*
5 *the United States shall conduct a study of whether the*
6 *development, recognition, or implementation of any*
7 *guideline or other standards under a provision de-*
8 *scribed in paragraph (2) would result in the estab-*
9 *lishment of a new cause of action or claim.*

10 “(2) *PROVISIONS DESCRIBED.*—*The provisions*
11 *described in this paragraph include the following:*

12 “(A) *Section 2701 (adult health quality*
13 *measures).*

14 “(B) *Section 2702 (payment adjustments*
15 *for health care acquired conditions).*

16 “(C) *Section 3001 (Hospital Value-Based*
17 *Purchase Program).*

18 “(D) *Section 3002 (improvements to the*
19 *Physician Quality Reporting Initiative).*

20 “(E) *Section 3003 (improvements to the*
21 *Physician Feedback Program).*

22 “(F) *Section 3007 (value based payment*
23 *modifier under physician fee schedule).*

24 “(G) *Section 3008 (payment adjustment for*
25 *conditions acquired in hospitals).*

1 “(H) Section 3013 (quality measure devel-
2 opment).

3 “(I) Section 3014 (quality measurement).

4 “(J) Section 3021 (Establishment of Center
5 for Medicare and Medicaid Innovation).

6 “(K) Section 3025 (hospital readmission re-
7 duction program).

8 “(L) Section 3501 (health care delivery sys-
9 tem research, quality improvement).

10 “(M) Section 4003 (Task Force on Clinical
11 and Preventive Services).

12 “(N) Section 4301 (research to optimize de-
13 liver of public health services).

14 “(b) REPORT.—Not later than 2 years after the date
15 of enactment of this Act, the Comptroller General of the
16 United States shall submit to the appropriate committees
17 of Congress, a report containing the findings made by the
18 Comptroller General under the study under subsection (a).”.

19 **SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND**
20 **COMMUNITY-BASED SERVICES AS A LONG-**
21 **TERM CARE ALTERNATIVE TO NURSING**
22 **HOMES.**

23 (a) STATE BALANCING INCENTIVE PAYMENTS PRO-
24 GRAM.—Notwithstanding section 1905(b) of the Social Se-
25 curity Act (42 U.S.C. 1396d(b)), in the case of a balancing

1 *incentive payment State, as defined in subsection (b), that*
2 *meets the conditions described in subsection (c), during the*
3 *balancing incentive period, the Federal medical assistance*
4 *percentage determined for the State under section 1905(b)*
5 *of such Act and, if applicable, increased under subsection*
6 *(z) or (aa) shall be increased by the applicable percentage*
7 *points determined under subsection (d) with respect to eligi-*
8 *ble medical assistance expenditures described in subsection*
9 *(e).*

10 (b) *BALANCING INCENTIVE PAYMENT STATE.*—A bal-
11 *ancing incentive payment State is a State—*

12 (1) *in which less than 50 percent of the total ex-*
13 *penditures for medical assistance under the State*
14 *Medicaid program for a fiscal year for long-term*
15 *services and supports (as defined by the Secretary*
16 *under subsection (f)(1)) are for non-institutionally-*
17 *based long-term services and supports described in*
18 *subsection (f)(1)(B);*

19 (2) *that submits an application and meets the*
20 *conditions described in subsection (c); and*

21 (3) *that is selected by the Secretary to partici-*
22 *rate in the State balancing incentive payment pro-*
23 *gram established under this section.*

24 (c) *CONDITIONS.*—*The conditions described in this*
25 *subsection are the following:*

1 (1) *APPLICATION.*—*The State submits an appli-*
2 *cation to the Secretary that includes, in addition to*
3 *such other information as the Secretary shall re-*
4 *quire—*

5 (A) *a proposed budget that details the*
6 *State’s plan to expand and diversify medical as-*
7 *sistance for non-institutionally-based long-term*
8 *services and supports described in subsection*
9 *(f)(1)(B) under the State Medicaid program dur-*
10 *ing the balancing incentive period and achieve*
11 *the target spending percentage applicable to the*
12 *State under paragraph (2), including through*
13 *structural changes to how the State furnishes*
14 *such assistance, such as through the establish-*
15 *ment of a “no wrong door—single entry point*
16 *system”, optional presumptive eligibility, case*
17 *management services, and the use of core stand-*
18 *ardized assessment instruments, and that in-*
19 *cludes a description of the new or expanded of-*
20 *ferings of such services that the State will pro-*
21 *vide and the projected costs of such services; and*

22 (B) *in the case of a State that proposes to*
23 *expand the provision of home and community-*
24 *based services under its State Medicaid program*
25 *through a State plan amendment under section*

1 *1915(i) of the Social Security Act, at the option*
2 *of the State, an election to increase the income*
3 *eligibility for such services from 150 percent of*
4 *the poverty line to such higher percentage as the*
5 *State may establish for such purpose, not to ex-*
6 *ceed 300 percent of the supplemental security in-*
7 *come benefit rate established by section*
8 *1611(b)(1) of the Social Security Act (42 U.S.C.*
9 *1382(b)(1)).*

10 *(2) TARGET SPENDING PERCENTAGES.—*

11 *(A) In the case of a balancing incentive*
12 *payment State in which less than 25 percent of*
13 *the total expenditures for long-term services and*
14 *supports under the State Medicaid program for*
15 *fiscal year 2009 are for home and community-*
16 *based services, the target spending percentage for*
17 *the State to achieve by not later than October 1,*
18 *2015, is that 25 percent of the total expenditures*
19 *for long-term services and supports under the*
20 *State Medicaid program are for home and com-*
21 *munity-based services.*

22 *(B) In the case of any other balancing in-*
23 *centive payment State, the target spending per-*
24 *centage for the State to achieve by not later than*
25 *October 1, 2015, is that 50 percent of the total*

1 *expenditures for long-term services and supports*
2 *under the State Medicaid program are for home*
3 *and community-based services.*

4 (3) *MAINTENANCE OF ELIGIBILITY REQUIRE-*
5 *MENTS.—The State does not apply eligibility stand-*
6 *ards, methodologies, or procedures for determining eli-*
7 *gibility for medical assistance for non-institutionally-*
8 *based long-term services and supports described in*
9 *subsection (f)(1)(B) under the State Medicaid pro-*
10 *gram that are more restrictive than the eligibility*
11 *standards, methodologies, or procedures in effect for*
12 *such purposes on December 31, 2010.*

13 (4) *USE OF ADDITIONAL FUNDS.—The State*
14 *agrees to use the additional Federal funds paid to the*
15 *State as a result of this section only for purposes of*
16 *providing new or expanded offerings of non-institu-*
17 *tionally-based long-term services and supports de-*
18 *scribed in subsection (f)(1)(B) under the State Med-*
19 *icaid program.*

20 (5) *STRUCTURAL CHANGES.—The State agrees to*
21 *make, not later than the end of the 6-month period*
22 *that begins on the date the State submits an applica-*
23 *tion under this section, the following changes:*

24 (A) *“NO WRONG DOOR—SINGLE ENTRY*
25 *POINT SYSTEM”.—Development of a statewide*

1 *system to enable consumers to access all long-*
2 *term services and supports through an agency,*
3 *organization, coordinated network, or portal, in*
4 *accordance with such standards as the State*
5 *shall establish and that shall provide informa-*
6 *tion regarding the availability of such services,*
7 *how to apply for such services, referral services*
8 *for services and supports otherwise available in*
9 *the community, and determinations of financial*
10 *and functional eligibility for such services and*
11 *supports, or assistance with assessment processes*
12 *for financial and functional eligibility.*

13 *(B) CONFLICT-FREE CASE MANAGEMENT*
14 *SERVICES.—Conflict-free case management serv-*
15 *ices to develop a service plan, arrange for serv-*
16 *ices and supports, support the beneficiary (and,*
17 *if appropriate, the beneficiary’s caregivers) in*
18 *directing the provision of services and supports*
19 *for the beneficiary, and conduct ongoing moni-*
20 *toring to assure that services and supports are*
21 *delivered to meet the beneficiary’s needs and*
22 *achieve intended outcomes.*

23 *(C) CORE STANDARDIZED ASSESSMENT IN-*
24 *STRUMENTS.—Development of core standardized*
25 *assessment instruments for determining eligi-*

1 *bility for non-institutionally-based long-term*
2 *services and supports described in subsection*
3 *(f)(1)(B), which shall be used in a uniform man-*
4 *ner throughout the State, to determine a bene-*
5 *ficiary's needs for training, support services,*
6 *medical care, transportation, and other services,*
7 *and develop an individual service plan to ad-*
8 *dress such needs.*

9 (6) *DATA COLLECTION.*—*The State agrees to col-*
10 *lect from providers of services and through such other*
11 *means as the State determines appropriate the fol-*
12 *lowing data:*

13 (A) *SERVICES DATA.*—*Services data from*
14 *providers of non-institutionally-based long-term*
15 *services and supports described in subsection*
16 *(f)(1)(B) on a per-beneficiary basis and in ac-*
17 *cordance with such standardized coding proce-*
18 *dures as the State shall establish in consultation*
19 *with the Secretary.*

20 (B) *QUALITY DATA.*—*Quality data on a se-*
21 *lected set of core quality measures agreed upon*
22 *by the Secretary and the State that are linked to*
23 *population-specific outcomes measures and acces-*
24 *sible to providers.*

1 (C) *OUTCOMES MEASURES.*—*Outcomes*
2 *measures data on a selected set of core popu-*
3 *lation-specific outcomes measures agreed upon by*
4 *the Secretary and the State that are accessible to*
5 *providers and include—*

6 (i) *measures of beneficiary and family*
7 *caregiver experience with providers;*

8 (ii) *measures of beneficiary and family*
9 *caregiver satisfaction with services; and*

10 (iii) *measures for achieving desired*
11 *outcomes appropriate to a specific bene-*
12 *ficiary, including employment, participa-*
13 *tion in community life, health stability, and*
14 *prevention of loss in function.*

15 (d) *APPLICABLE PERCENTAGE POINTS INCREASE IN*
16 *FMAP.*—*The applicable percentage points increase is—*

17 (1) *in the case of a balancing incentive payment*
18 *State subject to the target spending percentage de-*
19 *scribed in subsection (c)(2)(A), 5 percentage points;*
20 *and*

21 (2) *in the case of any other balancing incentive*
22 *payment State, 2 percentage points.*

23 (e) *ELIGIBLE MEDICAL ASSISTANCE EXPENDI-*
24 *TURES.*—

1 (1) *IN GENERAL.*—Subject to paragraph (2),
2 *medical assistance described in this subsection is med-*
3 *ical assistance for non-institutionally-based long-term*
4 *services and supports described in subsection (f)(1)(B)*
5 *that is provided by a balancing incentive payment*
6 *State under its State Medicaid program during the*
7 *balancing incentive payment period.*

8 (2) *LIMITATION ON PAYMENTS.*—In no case may
9 *the aggregate amount of payments made by the Sec-*
10 *retary to balancing incentive payment States under*
11 *this section during the balancing incentive period ex-*
12 *ceed \$3,000,000,000.*

13 (f) *DEFINITIONS.*—In this section:

14 (1) *LONG-TERM SERVICES AND SUPPORTS DE-*
15 *FINED.*—The term “long-term services and supports”
16 *has the meaning given that term by Secretary and*
17 *may include any of the following (as defined for pur-*
18 *poses of State Medicaid programs):*

19 (A) *INSTITUTIONALLY-BASED LONG-TERM*
20 *SERVICES AND SUPPORTS.*—Services provided in
21 *an institution, including the following:*

22 (i) *Nursing facility services.*

23 (ii) *Services in an intermediate care*
24 *facility for the mentally retarded described*

1 *in subsection (a)(15) of section 1905 of such*
2 *Act.*

3 (B) *NON-INSTITUTIONALLY-BASED LONG-*
4 *TERM SERVICES AND SUPPORTS.—Services not*
5 *provided in an institution, including the fol-*
6 *lowing:*

7 (i) *Home and community-based serv-*
8 *ices provided under subsection (c), (d), or*
9 *(i) of section 1915 of such Act or under a*
10 *waiver under section 1115 of such Act.*

11 (ii) *Home health care services.*

12 (iii) *Personal care services.*

13 (iv) *Services described in subsection*
14 *(a)(26) of section 1905 of such Act (relating*
15 *to PACE program services).*

16 (v) *Self-directed personal assistance*
17 *services described in section 1915(j) of such*
18 *Act.*

19 (2) *BALANCING INCENTIVE PERIOD.—The term*
20 *“balancing incentive period” means the period that*
21 *begins on October 1, 2011, and ends on September 30,*
22 *2015.*

23 (3) *POVERTY LINE.—The term “poverty line”*
24 *has the meaning given that term in section 2110(c)(5)*
25 *of the Social Security Act (42 U.S.C. 1397jj(c)(5)).*

1 (4) *STATE MEDICAID PROGRAM.*—*The term*
2 *“State Medicaid program” means the State program*
3 *for medical assistance provided under a State plan*
4 *under title XIX of the Social Security Act and under*
5 *any waiver approved with respect to such State plan.*

6 **SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH**
7 **FISCAL YEAR 2015 AND OTHER CHIP-RELATED**
8 **PROVISIONS.**

9 (a) *Section 1311(c)(1) of this Act is amended by strik-*
10 *ing “and” at the end of subparagraph (G), by striking the*
11 *period at the end of subparagraph (H) and inserting “;*
12 *and”, and by adding at the end the following:*

13 *“(I) report to the Secretary at least annu-*
14 *ally and in such manner as the Secretary shall*
15 *require, pediatric quality reporting measures*
16 *consistent with the pediatric quality reporting*
17 *measures established under section 1139A of the*
18 *Social Security Act.”.*

19 (b) *Effective as if included in the enactment of the*
20 *Children’s Health Insurance Program Reauthorization Act*
21 *of 2009 (Public Law 111–3):*

22 (1) *Section 1906(e)(2) of the Social Security Act*
23 (42 U.S.C. 1396e(e)(2)) *is amended by striking*
24 *“means” and all that follows through the period and*

1 *inserting “has the meaning given that term in section*
2 *2105(c)(3)(A).”.*

3 *(2)(A) Section 1906A(a) of the Social Security*
4 *Act (42 U.S.C. 1396e–1(a)), is amended by inserting*
5 *before the period the following: “and the offering of*
6 *such a subsidy is cost-effective, as defined for purposes*
7 *of section 2105(c)(3)(A).”.*

8 *(B) This Act shall be applied without regard to*
9 *subparagraph (A) of section 2003(a)(1) of this Act*
10 *and that subparagraph and the amendment made by*
11 *that subparagraph are hereby deemed null, void, and*
12 *of no effect.*

13 *(3) Section 2105(c)(10) of the Social Security*
14 *Act (42 U.S.C. 1397ee(c)(10)) is amended—*

15 *(A) in subparagraph (A), in the first sen-*
16 *tence, by inserting before the period the fol-*
17 *lowing: “if the offering of such a subsidy is cost-*
18 *effective, as defined for purposes of paragraph*
19 *(3)(A).”;*

20 *(B) by striking subparagraph (M); and*

21 *(C) by redesignating subparagraph (N) as*
22 *subparagraph (M).*

23 *(4) Section 2105(c)(3)(A) of the Social Security*
24 *Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—*

1 (A) *in the matter preceding clause (i), by*
2 *striking “to” and inserting “to—”; and*

3 (B) *in clause (ii), by striking the period*
4 *and inserting a semicolon.*

5 (c) *Section 2105 of the Social Security Act (42 U.S.C.*
6 *1397ee), as amended by section 2101, is amended—*

7 (1) *in subsection (b), in the second sentence, by*
8 *striking “2013” and inserting “2015”; and*

9 (2) *in subsection (d)(3)—*

10 (A) *in subparagraph (A)—*

11 (i) *in the first sentence, by inserting*
12 *“as a condition of receiving payments*
13 *under section 1903(a),” after “2019,”;*

14 (ii) *in clause (i), by striking “or” at*
15 *the end;*

16 (iii) *by redesignating clause (ii) as*
17 *clause (iii); and*

18 (iv) *by inserting after clause (i), the*
19 *following:*

20 *“(ii) after September 30, 2015, enroll-*
21 *ing children eligible to be targeted low-in-*
22 *come children under the State child health*
23 *plan in a qualified health plan that has*
24 *been certified by the Secretary under sub-*
25 *paragraph (C); or”;*

1 (B) in subparagraph (B), by striking “pro-
2 vided coverage” and inserting “screened for eligi-
3 bility for medical assistance under the State
4 plan under title XIX or a waiver of that plan
5 and, if found eligible, enrolled in such plan or a
6 waiver. In the case of such children who, as a re-
7 sult of such screening, are determined to not be
8 eligible for medical assistance under the State
9 plan or a waiver under title XIX, the State shall
10 establish procedures to ensure that the children
11 are enrolled in a qualified health plan that has
12 been certified by the Secretary under subpara-
13 graph (C) and is offered”; and

14 (C) by adding at the end the following:

15 “(C) CERTIFICATION OF COMPARABILITY OF
16 PEDIATRIC COVERAGE OFFERED BY QUALIFIED
17 HEALTH PLANS.—With respect to each State, the
18 Secretary, not later than April 1, 2015, shall re-
19 view the benefits offered for children and the
20 cost-sharing imposed with respect to such bene-
21 fits by qualified health plans offered through an
22 Exchange established by the State under section
23 1311 of the Patient Protection and Affordable
24 Care Act and shall certify those plans that offer
25 benefits for children and impose cost-sharing

1 *with respect to such benefits that the Secretary*
2 *determines are at least comparable to the benefits*
3 *offered and cost-sharing protections provided*
4 *under the State child health plan.”.*

5 *(d)(1) Section 2104(a) of such Act (42 U.S.C.*
6 *1397dd(a)) is amended—*

7 *(A) in paragraph (15), by striking “and” at the*
8 *end; and*

9 *(B) by striking paragraph (16) and inserting the*
10 *following:*

11 *“(16) for fiscal year 2013, \$17,406,000,000;*

12 *“(17) for fiscal year 2014, \$19,147,000,000; and*

13 *“(18) for fiscal year 2015, for purposes of mak-*
14 *ing 2 semi-annual allotments—*

15 *“(A) \$2,850,000,000 for the period begin-*
16 *ning on October 1, 2014, and ending on March*
17 *31, 2015, and*

18 *“(B) \$2,850,000,000 for the period begin-*
19 *ning on April 1, 2015, and ending on September*
20 *30, 2015.”.*

21 *(2)(A) Section 2104(m) of such Act (42 U.S.C.*
22 *1397dd(m)), as amended by section 2102(a)(1), is amend-*
23 *ed—*

24 *(i) in the subsection heading, by striking “2013”*
25 *and inserting “2015”;*

1 (ii) in paragraph (2)—

2 (I) in the paragraph heading, by striking
3 “2012” and inserting “2014”; and

4 (II) by adding at the end the following:

5 “(B) FISCAL YEARS 2013 AND 2014.—Subject
6 to paragraphs (4) and (6), from the amount
7 made available under paragraphs (16) and (17)
8 of subsection (a) for fiscal years 2013 and 2014,
9 respectively, the Secretary shall compute a State
10 allotment for each State (including the District
11 of Columbia and each commonwealth and terri-
12 tory) for each such fiscal year as follows:

13 “(i) REBASING IN FISCAL YEAR 2013.—
14 For fiscal year 2013, the allotment of the
15 State is equal to the Federal payments to
16 the State that are attributable to (and
17 countable towards) the total amount of al-
18 lotments available under this section to the
19 State in fiscal year 2012 (including pay-
20 ments made to the State under subsection
21 (n) for fiscal year 2012 as well as amounts
22 redistributed to the State in fiscal year
23 2012), multiplied by the allotment increase
24 factor under paragraph (5) for fiscal year
25 2013.

1 “(i) *GROWTH FACTOR UPDATE FOR*
2 *FISCAL YEAR 2014.*—*For fiscal year 2014,*
3 *the allotment of the State is equal to the*
4 *sum of—*

5 “(I) *the amount of the State allot-*
6 *ment under clause (i) for fiscal year*
7 *2013; and*

8 “(II) *the amount of any payments*
9 *made to the State under subsection (n)*
10 *for fiscal year 2013,*

11 *multiplied by the allotment increase factor*
12 *under paragraph (5) for fiscal year 2014.”;*
13 *(iii) in paragraph (3)—*

14 (I) *in the paragraph heading, by strik-*
15 *ing “2013” and inserting “2015”;*

16 (II) *in subparagraphs (A) and (B), by*
17 *striking “paragraph (16)” each place it ap-*
18 *pears and inserting “paragraph (18)”;*

19 (III) *in subparagraph (C)—*

20 (aa) *by striking “2012” each*
21 *place it appears and inserting “2014”;*
22 *and*

23 (bb) *by striking “2013” and in-*
24 *serting “2015”;* *and*

25 (IV) *in subparagraph (D)—*

1 (aa) in clause (i)(I), by striking
2 “subsection (a)(16)(A)” and inserting
3 “subsection (a)(18)(A)”; and

4 (bb) in clause (ii)(II), by striking
5 “subsection (a)(16)(B)” and inserting
6 “subsection (a)(18)(B)”; and

7 (iv) in paragraph (4), by striking “2013”
8 and inserting “2015”;

9 (v) in paragraph (6)—

10 (I) in subparagraph (A), by striking
11 “2013” and inserting “2015”; and

12 (II) in the flush language after and
13 below subparagraph (B)(ii), by striking “or
14 fiscal year 2012” and inserting “, fiscal
15 year 2012, or fiscal year 2014”; and

16 (vi) in paragraph (8)—

17 (I) in the paragraph heading, by strik-
18 ing “2013” and inserting “2015”; and

19 (II) by striking “2013” and inserting
20 “2015”.

21 (B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n))
22 is amended—

23 (i) in paragraph (2)—

24 (I) in subparagraph (A)(ii)—

1 (aa) by striking “2012” and inserting
2 “2014”; and

3 (bb) by striking “2013” and inserting
4 “2015”;

5 (II) in subparagraph (B)—

6 (aa) by striking “2012” and inserting
7 “2014”; and

8 (bb) by striking “2013” and inserting
9 “2015”; and

10 (ii) in paragraph (3)(A), by striking “or a semi-
11 annual allotment period for fiscal year 2013” and in-
12 serting “fiscal year 2013, fiscal year 2014, or a semi-
13 annual allotment period for fiscal year 2015”.

14 (C) Section 2105(g)(4) of such Act (42 U.S.C.
15 1397ee(g)(4)) is amended—

16 (i) in the paragraph heading, by striking “2013”
17 and inserting “2015”; and

18 (ii) in subparagraph (A), by striking “2013”
19 and inserting “2015”.

20 (D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b))
21 is amended—

22 (i) in paragraph (2)(B), by inserting “except as
23 provided in paragraph (6),” before “a child”; and

24 (ii) by adding at the end the following new
25 paragraph:

1 “(6) *EXCEPTIONS TO EXCLUSION OF CHILDREN*
2 *OF EMPLOYEES OF A PUBLIC AGENCY IN THE*
3 *STATE.—*

4 “(A) *IN GENERAL.—A child shall not be*
5 *considered to be described in paragraph (2)(B)*
6 *if—*

7 “(i) *the public agency that employs a*
8 *member of the child’s family to which such*
9 *paragraph applies satisfies subparagraph*
10 *(B); or*

11 “(ii) *subparagraph (C) applies to such*
12 *child.*

13 “(B) *MAINTENANCE OF EFFORT WITH RE-*
14 *SPECT TO PER PERSON AGENCY CONTRIBUTION*
15 *FOR FAMILY COVERAGE.—For purposes of sub-*
16 *paragraph (A)(i), a public agency satisfies this*
17 *subparagraph if the amount of annual agency*
18 *expenditures made on behalf of each employee en-*
19 *rolled in health coverage paid for by the agency*
20 *that includes dependent coverage for the most re-*
21 *cent State fiscal year is not less than the amount*
22 *of such expenditures made by the agency for the*
23 *1997 State fiscal year, increased by the percent-*
24 *age increase in the medical care expenditure cat-*
25 *egory of the Consumer Price Index for All-Urban*

1 Consumers (all items: U.S. City Average) for
2 such preceding fiscal year.

3 “(C) *HARDSHIP EXCEPTION.*—For purposes
4 of subparagraph (A)(ii), this subparagraph ap-
5 plies to a child if the State determines, on a
6 case-by-case basis, that the annual aggregate
7 amount of premiums and cost-sharing imposed
8 for coverage of the family of the child would ex-
9 ceed 5 percent of such family’s income for the
10 year involved.”.

11 (E) Section 2113 of such Act (42 U.S.C. 1397mm) is
12 amended—

13 (i) in subsection (a)(1), by striking “2013” and
14 inserting “2015”; and

15 (ii) in subsection (g), by striking “\$100,000,000
16 for the period of fiscal years 2009 through 2013” and
17 inserting “\$140,000,000 for the period of fiscal years
18 2009 through 2015”.

19 (F) Section 108 of Public Law 111–3 is amended by
20 striking “\$11,706,000,000” and all that follows through the
21 second sentence and inserting “\$15,361,000,000 to accom-
22 pany the allotment made for the period beginning on Octo-
23 ber 1, 2014, and ending on March 31, 2015, under section
24 2104(a)(18)(A) of the Social Security Act (42 U.S.C.
25 1397dd(a)(18)(A)), to remain available until expended.

1 *Such amount shall be used to provide allotments to States*
2 *under paragraph (3) of section 2104(m) of the Social Secu-*
3 *rity Act (42 U.S.C. 1397dd(m)) for the first 6 months of*
4 *fiscal year 2015 in the same manner as allotments are pro-*
5 *vided under subsection (a)(18)(A) of such section 2104 and*
6 *subject to the same terms and conditions as apply to the*
7 *allotments provided from such subsection (a)(18)(A).”.*

8 **PART II—SUPPORT FOR PREGNANT AND**
9 **PARENTING TEENS AND WOMEN**

10 **SEC. 10211. DEFINITIONS.**

11 *In this part:*

12 (1) *ACCOMPANIMENT.*—*The term “accompani-*
13 *ment” means assisting, representing, and accom-*
14 *panying a woman in seeking judicial relief for child*
15 *support, child custody, restraining orders, and res-*
16 *titution for harm to persons and property, and in fil-*
17 *ing criminal charges, and may include the payment*
18 *of court costs and reasonable attorney and witness*
19 *fees associated therewith.*

20 (2) *ELIGIBLE INSTITUTION OF HIGHER EDU-*
21 *CATION.*—*The term “eligible institution of higher edu-*
22 *cation” means an institution of higher education (as*
23 *such term is defined in section 101 of the Higher*
24 *Education Act of 1965 (20 U.S.C. 1001)) that has es-*
25 *tablished and operates, or agrees to establish and op-*

1 *erate upon the receipt of a grant under this part, a*
2 *pregnant and parenting student services office.*

3 (3) *COMMUNITY SERVICE CENTER.*—*The term*
4 *“community service center” means a non-profit orga-*
5 *nization that provides social services to residents of a*
6 *specific geographical area via direct service or by con-*
7 *tract with a local governmental agency.*

8 (4) *HIGH SCHOOL.*—*The term “high school”*
9 *means any public or private school that operates*
10 *grades 10 through 12, inclusive, grades 9 through 12,*
11 *inclusive or grades 7 through 12, inclusive.*

12 (5) *INTERVENTION SERVICES.*—*The term “inter-*
13 *vention services” means, with respect to domestic vio-*
14 *lence, sexual violence, sexual assault, or stalking, 24-*
15 *hour telephone hotline services for police protection*
16 *and referral to shelters.*

17 (6) *SECRETARY.*—*The term “Secretary” means*
18 *the Secretary of Health and Human Services.*

19 (7) *STATE.*—*The term “State” includes the Dis-*
20 *trict of Columbia, any commonwealth, possession, or*
21 *other territory of the United States, and any Indian*
22 *tribe or reservation.*

23 (8) *SUPPORTIVE SOCIAL SERVICES.*—*The term*
24 *“supportive social services” means transitional and*
25 *permanent housing, vocational counseling, and indi-*

1 *vidual and group counseling aimed at preventing do-*
2 *mestic violence, sexual violence, sexual assault, or*
3 *stalking.*

4 (9) *VIOLENCE.*—*The term “violence” means ac-*
5 *tual violence and the risk or threat of violence.*

6 **SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE**
7 **FUND.**

8 (a) *IN GENERAL.*—*The Secretary, in collaboration and*
9 *coordination with the Secretary of Education (as appro-*
10 *priate), shall establish a Pregnancy Assistance Fund to be*
11 *administered by the Secretary, for the purpose of awarding*
12 *competitive grants to States to assist pregnant and par-*
13 *enting teens and women.*

14 (b) *USE OF FUND.*—*A State may apply for a grant*
15 *under subsection (a) to carry out any activities provided*
16 *for in section 10213.*

17 (c) *APPLICATIONS.*—*To be eligible to receive a grant*
18 *under subsection (a), a State shall submit to the Secretary*
19 *an application at such time, in such manner, and con-*
20 *taining such information as the Secretary may require, in-*
21 *cluding a description of the purposes for which the grant*
22 *is being requested and the designation of a State agency*
23 *for receipt and administration of funding received under*
24 *this part.*

1 **SEC. 10213. PERMISSIBLE USES OF FUND.**

2 (a) *IN GENERAL.*—A State shall use amounts received
3 under a grant under section 10212 for the purposes de-
4 scribed in this section to assist pregnant and parenting
5 teens and women.

6 (b) *INSTITUTIONS OF HIGHER EDUCATION.*—

7 (1) *IN GENERAL.*—A State may use amounts re-
8 ceived under a grant under section 10212 to make
9 funding available to eligible institutions of higher
10 education to enable the eligible institutions to estab-
11 lish, maintain, or operate pregnant and parenting
12 student services. Such funding shall be used to supple-
13 ment, not supplant, existing funding for such services.

14 (2) *APPLICATION.*—An eligible institution of
15 higher education that desires to receive funding under
16 this subsection shall submit an application to the des-
17 ignated State agency at such time, in such manner,
18 and containing such information as the State agency
19 may require.

20 (3) *MATCHING REQUIREMENT.*—An eligible insti-
21 tution of higher education that receives funding under
22 this subsection shall contribute to the conduct of the
23 pregnant and parenting student services office sup-
24 ported by the funding an amount from non-Federal
25 funds equal to 25 percent of the amount of the fund-
26 ing provided. The non-Federal share may be in cash

1 *or in-kind, fairly evaluated, including services, facili-*
2 *ties, supplies, or equipment.*

3 (4) *USE OF FUNDS FOR ASSISTING PREGNANT*
4 *AND PARENTING COLLEGE STUDENTS.—An eligible in-*
5 *stitution of higher education that receives funding*
6 *under this subsection shall use such funds to establish,*
7 *maintain or operate pregnant and parenting student*
8 *services and may use such funding for the following*
9 *programs and activities:*

10 (A) *Conduct a needs assessment on campus*
11 *and within the local community—*

12 (i) *to assess pregnancy and parenting*
13 *resources, located on the campus or within*
14 *the local community, that are available to*
15 *meet the needs described in subparagraph*
16 *(B); and*

17 (ii) *to set goals for—*

18 (I) *improving such resources for*
19 *pregnant, parenting, and prospective*
20 *parenting students; and*

21 (II) *improving access to such re-*
22 *sources.*

23 (B) *Annually assess the performance of the*
24 *eligible institution in meeting the following needs*

1 *of students enrolled in the eligible institution*
2 *who are pregnant or are parents:*

3 *(i) The inclusion of maternity coverage*
4 *and the availability of riders for additional*
5 *family members in student health care.*

6 *(ii) Family housing.*

7 *(iii) Child care.*

8 *(iv) Flexible or alternative academic*
9 *scheduling, such as telecommuting pro-*
10 *grams, to enable pregnant or parenting stu-*
11 *dents to continue their education or stay in*
12 *school.*

13 *(v) Education to improve parenting*
14 *skills for mothers and fathers and to*
15 *strengthen marriages.*

16 *(vi) Maternity and baby clothing, baby*
17 *food (including formula), baby furniture,*
18 *and similar items to assist parents and pro-*
19 *spective parents in meeting the material*
20 *needs of their children.*

21 *(vii) Post-partum counseling.*

22 *(C) Identify public and private service pro-*
23 *viders, located on the campus of the eligible in-*
24 *stitution or within the local community, that are*
25 *qualified to meet the needs described in subpara-*

1 *graph (B), and establishes programs with quali-*
2 *fied providers to meet such needs.*

3 *(D) Assist pregnant and parenting students,*
4 *fathers or spouses in locating and obtaining serv-*
5 *ices that meet the needs described in subpara-*
6 *graph (B).*

7 *(E) If appropriate, provide referrals for*
8 *prenatal care and delivery, infant or foster care,*
9 *or adoption, to a student who requests such in-*
10 *formation. An office shall make such referrals*
11 *only to service providers that serve the following*
12 *types of individuals:*

13 *(i) Parents.*

14 *(ii) Prospective parents awaiting*
15 *adoption.*

16 *(iii) Women who are pregnant and*
17 *plan on parenting or placing the child for*
18 *adoption.*

19 *(iv) Parenting or prospective par-*
20 *enting couples.*

21 *(5) REPORTING.—*

22 *(A) ANNUAL REPORT BY INSTITUTIONS.—*

23 *(i) IN GENERAL.—For each fiscal year*
24 *that an eligible institution of higher edu-*
25 *cation receives funds under this subsection,*

1 *the eligible institution shall prepare and*
2 *submit to the State, by the date determined*
3 *by the State, a report that—*

4 *(I) itemizes the pregnant and par-*
5 *enting student services office's expendi-*
6 *tures for the fiscal year;*

7 *(II) contains a review and evalua-*
8 *tion of the performance of the office in*
9 *fulfilling the requirements of this sec-*
10 *tion, using the specific performance*
11 *criteria or standards established under*
12 *subparagraph (B)(i); and*

13 *(III) describes the achievement of*
14 *the office in meeting the needs listed in*
15 *paragraph (4)(B) of the students served*
16 *by the eligible institution, and the fre-*
17 *quency of use of the office by such stu-*
18 *dents.*

19 *(ii) PERFORMANCE CRITERIA.—Not*
20 *later than 180 days before the date the an-*
21 *nuual report described in clause (i) is sub-*
22 *mitted, the State—*

23 *(I) shall identify the specific per-*
24 *formance criteria or standards that*
25 *shall be used to prepare the report; and*

1 (II) may establish the form or for-
2 mat of the report.

3 (B) *REPORT BY STATE.*—The State shall
4 annually prepare and submit a report on the
5 findings under this subsection, including the
6 number of eligible institutions of higher edu-
7 cation that were awarded funds and the number
8 of students served by each pregnant and par-
9 enting student services office receiving funds
10 under this section, to the Secretary.

11 (c) *SUPPORT FOR PREGNANT AND PARENTING*
12 *TEENS.*—A State may use amounts received under a grant
13 under section 10212 to make funding available to eligible
14 high schools and community service centers to establish,
15 maintain or operate pregnant and parenting services in the
16 same general manner and in accordance with all conditions
17 and requirements described in subsection (b), except that
18 paragraph (3) of such subsection shall not apply for pur-
19 poses of this subsection.

20 (d) *IMPROVING SERVICES FOR PREGNANT WOMEN*
21 *WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIO-*
22 *LENCE, SEXUAL ASSAULT, AND STALKING.*—

23 (1) *IN GENERAL.*—A State may use amounts re-
24 ceived under a grant under section 10212 to make

1 *funding available to its State Attorney General to as-*
2 *ist Statewide offices in providing—*

3 *(A) intervention services, accompaniment,*
4 *and supportive social services for eligible preg-*
5 *nant women who are victims of domestic vio-*
6 *lence, sexual violence, sexual assault, or stalking.*

7 *(B) technical assistance and training (as*
8 *described in subsection (c)) relating to violence*
9 *against eligible pregnant women to be made*
10 *available to the following:*

11 *(i) Federal, State, tribal, territorial,*
12 *and local governments, law enforcement*
13 *agencies, and courts.*

14 *(ii) Professionals working in legal, so-*
15 *cial service, and health care settings.*

16 *(iii) Nonprofit organizations.*

17 *(iv) Faith-based organizations.*

18 *(2) ELIGIBILITY.—To be eligible for a grant*
19 *under paragraph (1), a State Attorney General shall*
20 *submit an application to the designated State agency*
21 *at such time, in such manner, and containing such*
22 *information, as specified by the State.*

23 *(3) TECHNICAL ASSISTANCE AND TRAINING DE-*
24 *SCRIBED.—For purposes of paragraph (1)(B), tech-*
25 *nical assistance and training is—*

1 (A) *the identification of eligible pregnant*
2 *women experiencing domestic violence, sexual vi-*
3 *olence, sexual assault, or stalking;*

4 (B) *the assessment of the immediate and*
5 *short-term safety of such a pregnant woman, the*
6 *evaluation of the impact of the violence or stalk-*
7 *ing on the pregnant woman’s health, and the as-*
8 *sistance of the pregnant woman in developing a*
9 *plan aimed at preventing further domestic vio-*
10 *lence, sexual violence, sexual assault, or stalking,*
11 *as appropriate;*

12 (C) *the maintenance of complete medical or*
13 *forensic records that include the documentation*
14 *of any examination, treatment given, and refer-*
15 *als made, recording the location and nature of*
16 *the pregnant woman’s injuries, and the establish-*
17 *ment of mechanisms to ensure the privacy and*
18 *confidentiality of those medical records; and*

19 (D) *the identification and referral of the*
20 *pregnant woman to appropriate public and pri-*
21 *vate nonprofit entities that provide intervention*
22 *services, accompaniment, and supportive social*
23 *services.*

24 (4) *ELIGIBLE PREGNANT WOMAN.—In this sub-*
25 *section, the term “eligible pregnant woman” means*

1 *any woman who is pregnant on the date on which*
2 *such woman becomes a victim of domestic violence,*
3 *sexual violence, sexual assault, or stalking or who was*
4 *pregnant during the one-year period before such date.*

5 *(e) PUBLIC AWARENESS AND EDUCATION.—A State*
6 *may use amounts received under a grant under section*
7 *10212 to make funding available to increase public aware-*
8 *ness and education concerning any services available to*
9 *pregnant and parenting teens and women under this part,*
10 *or any other resources available to pregnant and parenting*
11 *women in keeping with the intent and purposes of this part.*
12 *The State shall be responsible for setting guidelines or limits*
13 *as to how much of funding may be utilized for public*
14 *awareness and education in any funding award.*

15 **SEC. 10214. APPROPRIATIONS.**

16 *There is authorized to be appropriated, and there are*
17 *appropriated, \$25,000,000 for each of fiscal years 2010*
18 *through 2019, to carry out this part.*

19 **PART III—INDIAN HEALTH CARE IMPROVEMENT**

20 **SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.**

21 *(a) IN GENERAL.—Except as provided in subsection*
22 *(b), S. 1790 entitled “A bill to amend the Indian Health*
23 *Care Improvement Act to revise and extend that Act, and*
24 *for other purposes.”, as reported by the Committee on In-*