

AMENDMENT NO. _____ Calendar No. _____

Purpose: To modify provisions relating to titles I and VI.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

S. _____

To make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce.

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

1 Strike section 1 and all that follows through subtitle

2 G of title I and insert the following:

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Affordable Health Choices Act”.

6 (b) **TABLE OF CONTENTS.**—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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Subtitle A—Effective Coverage for All Americans

PART I—PROVISIONS APPLICABLE TO THE INDIVIDUAL AND GROUP
MARKETS

Sec. 101. Amendment to the Public Health Service Act.

“PART A—INDIVIDUAL AND GROUP MARKET REFORMS

“SUBPART 1—GENERAL REFORM

“Sec. 2705. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 2701. Fair insurance coverage.

“Sec. 2702. Guaranteed availability of coverage.

“Sec. 2703. Guaranteed renewability of coverage.

“Sec. 2704. Bringing down the cost of health care coverage.

“Sec. 2706. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 2707. Ensuring the quality of care.

“Sec. 2708. Coverage of preventive health services.

“Sec. 2709. Extension of dependent coverage.

“Sec. 2710. No lifetime or annual limits.

“Sec. 2711. Notification by plans not providing minimum qualifying coverage.

PART II—PROVISION APPLICABLE TO THE GROUP MARKET

Sec. 121. Amendment to the Public Health Service Act.

“Sec. 2719. Prohibition of discrimination based on salary.

PART III—OTHER PROVISIONS

Sec. 131. No changes to existing coverage.

Sec. 132. Applicability.

Sec. 133. Conforming amendments.

Sec. 134. Effective dates.

Subtitle B—Available Coverage for All Americans

Sec. 141. Building on the success of the Federal Employees Health Benefit Program so all Americans have affordable health benefit choices.

Sec. 142. Affordable health choices for all Americans.

“TITLE XXXI—AFFORDABLE HEALTH CHOICES FOR ALL
AMERICANS

“Subtitle A—Affordable Choices

“Sec. 3101. Affordable choices of health benefit plans.

“Sec. 3102. Financial integrity.

“Sec. 3103. Program design.

“Sec. 3104. Allowing State flexibility.

“Sec. 3105. Navigators.

“Sec. 3106. Community health insurance option.

Subtitle C—Affordable Coverage for All Americans

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- Sec. 151. Support for affordable health coverage.
 Sec. 152. Program integrity.

“Subtitle B—Making Coverage Affordable

- “Sec. 3111. Support for affordable health coverage.
 “Sec. 3112. Small business health options program credit.

Subtitle D—Shared Responsibility for Health Care

- Sec. 161. Individual responsibility.
 Sec. 162. Notification on the availability of affordable health choices.
 Sec. 163. Shared responsibility of employers.
 “Sec. 3115. Shared responsibility of employers.
 “Sec. 3116. Definitions.

Subtitle E—Improving Access to Health Care Services

- Sec. 171. Spending for Federally Qualified Health Centers (FQHCs).
 Sec. 172. Other provisions.
 Sec. 173. Funding for National Health Service Corps.
 Sec. 174. Negotiated rulemaking for development of methodology and criteria
 for designating medically underserved populations and health
 professions shortage areas.
 Sec. 175. Equity for certain eligible survivors.
 Sec. 176. Reauthorization of the Wakefield Emergency Medical Services for
 Children Program.

Subtitle F—Making Health Care More Affordable for Retirees

- Sec. 181. Reinsurance for retirees.

Subtitle G—Improving the Use of Health Information Technology for
Enrollment; Miscellaneous Provisions

- Sec. 185. Health information technology enrollment standards and protocols.

“Subtitle C—Other Provisions

- Sec. 186. Rule of construction regarding Hawaii’s Prepaid Health Care Act.
 Sec. 187. Key National indicators.

Subtitle H—CLASS Act

- Sec. 190. Short title of subtitle.

PART I—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

- Sec. 191. Establishment of national voluntary insurance program for pur-
 chasing community living assistance services and support.

“TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND
SUPPORTS

- “Sec. 3201. Purpose.
 “Sec. 3202. Definitions.
 “Sec. 3203. CLASS Independence Benefit Plan.
 “Sec. 3204. Enrollment and disenrollment requirements.
 “Sec. 3205. Benefits.

- “Sec. 3206. CLASS Independence Fund.
- “Sec. 3207. CLASS Independence Advisory Council.
- “Sec. 3208. Regulations; annual report.
- “Sec. 3209. Tax treatment of program.

PART II—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

- Sec. 195. Credit for costs of employers who elect to automatically enroll employees and withhold class premiums from wages.
- Sec. 196. Long-term care insurance includible in cafeteria plans.

TITLE II—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—National Strategy to Improve Health Care Quality

- Sec. 201. National strategy.
- Sec. 202. Interagency Working Group on Health Care Quality.
- Sec. 203. Quality measure development.
- Sec. 204. Quality measure endorsement; public reporting; data collection.
- Sec. 205. Collection and analysis of quality measure data.

Subtitle B—Health Care Quality Improvements

- Sec. 211. Health care delivery system research; Quality improvement technical assistance.
- Sec. 212. Grants to establish community health teams to support a medical home model.
- Sec. 213. Grants to implement medication management services in treatment of chronic disease.
- Sec. 214. Design and implementation of regionalized systems for emergency care.
- Sec. 215. Trauma care centers and service availability.
- Sec. 216. Reducing and reporting hospital readmissions.
- Sec. 217. Program to facilitate shared decision-making.
- Sec. 218. Presentation of drug information.
- Sec. 219. Center for health outcomes research and evaluation.
- Sec. 220. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.
- Sec. 221. Office of women’s health.
- Sec. 222. Administrative simplification.

TITLE III—IMPROVING THE HEALTH OF THE AMERICAN PEOPLE

Subtitle A—Modernizing Disease Prevention of Public Health Systems

- Sec. 301. National Prevention, Health Promotion and public health council.
- Sec. 302. Prevention and Public Health Investment Fund.
- Sec. 303. Clinical and community Preventive Services.
- Sec. 304. Education and outreach campaign regarding preventive benefits.

Subtitle B—Increasing Access to Clinical Preventive Services

- Sec. 311. Right choices program.
- Sec. 312. School-based health clinics.
- Sec. 313. Oral healthcare prevention activities.
- Sec. 314. Oral health improvement.

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Subtitle C—Creating Healthier Communities

- Sec. 321. Community transformation grants.
- Sec. 322. Healthy aging, living well.
- Sec. 323. Wellness for individuals with disabilities.
- Sec. 324. Immunizations.
- Sec. 325. Nutrition labeling of standard menu items at Chain Restaurants and of articles of food sold from vending machines.

Subtitle D—Support for Prevention and Public Health Information

- Sec. 331. Research on optimizing the delivery of public health services.
- Sec. 332. Understanding health disparities: data collection and analysis.
- Sec. 333. Health impact assessments.
- Sec. 334. CDC and employer-based wellness programs.

TITLE IV—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

- Sec. 401. Purpose.
- Sec. 402. Definitions.

Subtitle B—Innovations in the Health Care Workforce

- Sec. 411. National health care workforce commission.
- Sec. 412. State health care workforce development grants.
- Sec. 413. Health care workforce program assessment.

Subtitle C—Increasing the Supply of the Health Care Workforce

- Sec. 421. Federally supported student loan funds.
- Sec. 422. Nursing student loan program.
- Sec. 423. Health care workforce loan repayment programs.
- Sec. 424. Public health workforce recruitment and retention programs.
- Sec. 425. Allied health workforce recruitment and retention programs.
- Sec. 426. Grants for State and local programs.
- Sec. 427. Funding for National Health Service Corps.
- Sec. 428. Nurse-managed health clinics.
- Sec. 429. Elimination of cap on commissioned corp.
- Sec. 430. Establishing a Ready Reserve Corps.

Subtitle D—Enhancing Health Care Workforce Education and Training

- Sec. 431. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.
- Sec. 432. Training opportunities for direct care workers.
- Sec. 433. Training in general, pediatric, and public health dentistry.
- Sec. 434. Alternative dental health care providers demonstration project.
- Sec. 435. Geriatric education and training; career awards; comprehensive geriatric education.
- Sec. 436. Mental and behavioral health education and training grants.
- Sec. 437. Cultural competency, prevention and public health and individuals with disabilities training.
- Sec. 438. Advanced nursing education grants.
- Sec. 439. Nurse education, practice, and retention grants.
- Sec. 440. Loan repayment and scholarship program.
- Sec. 441. Nurse faculty loan program.

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- Sec. 442. Authorization of appropriations for parts B through D of title VIII.
 Sec. 443. Grants to promote the community health workforce.
 Sec. 444. Youth public health program.
 Sec. 445. Fellowship training in public health.

Subtitle E—Supporting the Existing Health Care Workforce

- Sec. 451. Centers of excellence.
 Sec. 452. Health care professionals training for diversity.
 Sec. 453. Interdisciplinary, community-based linkages.
 Sec. 454. Workforce diversity grants.
 Sec. 455. Primary care extension program.

Subtitle F—General Provisions

- Sec. 461. Reports.

TITLE V—PREVENTING FRAUD AND ABUSE

Subtitle A—Establishment of New Health and Human Services and
 Department of Justice Health Care Fraud Positions

- Sec. 501. Health and Human Services Senior Advisor.
 Sec. 502. Department of Justice Position.

Subtitle B—Health Care Program Integrity Coordinating Council

- Sec. 511. Establishment.

Subtitle C—False Statements and Representations

- Sec. 521. Prohibition on false statements and representations.

Subtitle D—Federal Health Care Offense

- Sec. 531. Clarifying definition.

Subtitle E—Uniformity in Fraud and Abuse Reporting

- Sec. 541. Development of model uniform report form.

Subtitle F—Applicability of State Law to Combat Fraud and Abuse

- Sec. 551. Applicability of State law to combat fraud and abuse.

Subtitle G—Enabling the Department of Labor to Issue Administrative Sum-
 mary Cease and Desist Orders and Summary Seizures Orders Against
 Plans That Are in Financially Hazardous Condition

- Sec. 561. Enabling the Department of Labor to issue administrative summary
 cease and desist orders and summary seizures orders against
 plans that are in financially hazardous condition.

Subtitle H—Requiring Multiple Employer Welfare Arrangement (MEWA)
 Plans to File a Registration Form With the Department of Labor Prior to
 Enrolling Anyone in the Plan

- Sec. 571. MEWA plan registration with Department of Labor.

Subtitle I—Permitting Evidentiary Privilege and Confidential Communications

Sec. 581. Permitting evidentiary privilege and confidential communications.

TITLE VI—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

Subtitle B—More Affordable Medicines for Children and Underserved Communities

Sec. 611. Expanded participation in 340B program.

Sec. 612. Improvements to 340B program integrity.

1 **TITLE I—QUALITY, AFFORDABLE**
2 **HEALTH CARE FOR ALL**
3 **AMERICANS**

4 **Subtitle A—Effective Coverage for**
5 **All Americans**

6 **PART I—PROVISIONS APPLICABLE TO THE**
7 **INDIVIDUAL AND GROUP MARKETS**

8 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
9 **ACT.**

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

12 (1) by striking the part heading and heading
13 for subpart 1 and inserting the following:

14 **“PART A—INDIVIDUAL AND GROUP MARKET**
15 **REFORMS**

16 **“Subpart 1—General Reform”;**

17 (2) in section 2701 (42 U.S.C. 300gg)—

18 (A) by striking the section heading and
19 subsection (a) and inserting the following:

1 **“SEC. 2705. PROHIBITION OF PREEXISTING CONDITION EX-**
2 **CLUSIONS OR OTHER DISCRIMINATION**
3 **BASED ON HEALTH STATUS.**

4 “(a) IN GENERAL.—A group health plan and a health
5 insurance issuer offering group or individual health insur-
6 ance coverage may not impose any preexisting condition
7 exclusion with respect to such plan or coverage.”; and

8 (B) by transferring the remainder of sec-
9 tion so as to appear after the section 2704 as
10 added by paragraph (5);

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

12 (A) by striking the section heading and all
13 that follows through subsection (a)—

14 (B) in subsection (b)—

15 (i) by striking “health insurance
16 issuer offering health insurance coverage in
17 connection with a group health plan” each
18 place that such appears and inserting
19 “health insurance issuer offering group or
20 individual health insurance coverage”;

21 (ii) in paragraph (2)(A)—

22 (I) by inserting “or individual”
23 after “employer”; and

24 (II) by inserting “or individual
25 health coverage, as the case may be”
26 before the semicolon; and

1 (iii) by transferring the remainder of
2 such section to appear at the end of sec-
3 tion 2706 (as added by paragraph (5));

4 (4) by redesignating existing sections 2704
5 through 2707 and sections 2711 through 2713 as
6 sections 2715 through 2718 and sections 2712
7 through 2714, respectively; and

8 (5) by inserting after the subpart heading (as
9 added by paragraph (1)) the following:

10 **“SEC. 2701. FAIR INSURANCE COVERAGE.**

11 “(a) IN GENERAL.—With respect to the premium
12 rate charged by a health insurance issuer for health insur-
13 ance coverage offered in the individual or group market—

14 “(1) such rate shall vary with respect to the
15 particular plan or coverage involved only by—

16 “(A) family structure;

17 “(B) community rating area;

18 “(C) the actuarial value of the benefit;

19 “(D) age, except that such rate shall not
20 vary by more than 2 to 1; and

21 “(2) such rate shall not vary with respect to the
22 particular plan or coverage involved by health sta-
23 tus-related factors, gender, class of business, claims
24 experience, or any other factor not described in
25 paragraph (1).

1 “(b) COMMUNITY RATING AREA.—Taking into ac-
2 count the applicable recommendations of the National As-
3 sociation of Insurance Commissioners, the Secretary shall
4 by regulation establish a minimum size for community rat-
5 ing areas for purposes of this section.

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

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

13 “(b) ENROLLMENT.—

14 “(1) RESTRICTION.—A health insurance issuer
15 described in subsection (a) may restrict enrollment
16 in coverage described in such subsection to open or
17 special enrollment periods.

18 “(2) ESTABLISHMENT.—A health insurance
19 issuer described in subsection (a) shall, in accord-
20 ance with the regulations promulgated under para-
21 graph (3), establish special enrollment periods for
22 qualifying events (under section 603 of the Em-
23 ployee Retirement Income Security Act of 1974).

24 “(3) REGULATIONS.—Not later than 1 year
25 after the date of enactment of this section, the Sec-

1 retary shall promulgate regulations with respect to
2 enrollment periods under paragraphs (1) and (2).

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

4 “Except as provided in this section, if a health insur-
5 ance issuer offers health insurance coverage in the indi-
6 vidual or group market, the issuer must renew or continue
7 in force such coverage at the option of the plan sponsor
8 or the individual, as applicable.

9 **“SEC. 2704. BRINGING DOWN THE COST OF HEALTH CARE**
10 **COVERAGE.**

11 “(a) CLEAR ACCOUNTING FOR COSTS.—A health in-
12 surance issuer offering group or individual health insur-
13 ance coverage shall publicly report (in a manner to be es-
14 tablished by the Secretary through regulation) the per-
15 centage of total premium revenue that such coverage ex-
16 pends—

17 “(1) on reimbursement for clinical services pro-
18 vided to enrollees under such plan or coverage;

19 “(2) for activities that improve health care
20 quality; and

21 “(3) on all other non-claims costs, including an
22 explanation of the nature of such costs.

23 “(b) DEFINITION.—In this section, the term ‘activi-
24 ties to improve health care quality’ means activities de-
25 scribed in section 2707.

1 “(c) EXCEPTION TO REQUIREMENTS.—The informa-
2 tion provided in the report as described in subsection
3 (a)(3) shall not include income or other taxes, license or
4 regulatory fee costs, or the cost of any surcharge imposed
5 by a Gateway under title XXXI.

6 “(d) PROCESSES AND METHODS.—The Secretary
7 shall develop a methodology for calculating the percentage
8 described in subsection (a)(3). Such methodology may pro-
9 vide for a requirement that a report described in sub-
10 section (a)(1) include an actuarial certification of the in-
11 formation included in such report.

12 **“SEC. 2706. PROHIBITING DISCRIMINATION AGAINST INDI-**
13 **VIDUAL PARTICIPANTS AND BENEFICIARIES**
14 **BASED ON HEALTH STATUS.**

15 “(a) IN GENERAL.—A group health plan and a health
16 insurance issuer offering group or individual health insur-
17 ance coverage, may not establish rules for eligibility (in-
18 cluding continued eligibility) of any individual to enroll
19 under the terms of the plan or coverage based on any of
20 the following health status-related factors in relation to
21 the individual or a dependent of the individual:

22 “(1) Health status.

23 “(2) Medical condition (including both physical
24 and mental illnesses).

25 “(3) Claims experience.

1 “(4) Receipt of health care.

2 “(5) Medical history.

3 “(6) Genetic information.

4 “(7) Evidence of insurability (including condi-
5 tions arising out of acts of domestic violence).

6 “(8) Disability.

7 “(9) Any other health status-related factor de-
8 termined appropriate by the Secretary.

9 **“SEC. 2707. ENSURING THE QUALITY OF CARE.**

10 “(a) IN GENERAL.—Except as provided in subsection
11 (b), a group health plan and a health insurance issuer of-
12 fering group or individual health insurance coverage shall
13 develop and implement a reimbursement structure for
14 making payments to health care providers that provides
15 incentives for—

16 “(1) the provision of high quality health care
17 under the plan or coverage in a manner that in-
18 cludes—

19 “(A) the implementation of case manage-
20 ment, care coordination, chronic disease man-
21 agement, and medication and care compliance
22 activities that includes the use of the medical
23 home model as defined in section 212 of the Af-
24 fordable Health Choices Act for treatment or
25 services under the plan or coverage;

1 “(B) the implementation of activities to
2 prevent hospital readmissions through a com-
3 prehensive program for hospital discharge that
4 includes patient-centered education and coun-
5 seling, comprehensive discharge planning, and
6 post-discharge reinforcement by an appropriate
7 health care professional;

8 “(C) the implementation of activities to
9 improve patient safety and reduce medical er-
10 rors through the appropriate use of best clinical
11 practices, evidence based medicine, and health
12 information technology under the plan or cov-
13 erage;

14 “(D) the implementation of wellness and
15 health promotion activities;

16 “(E) child health measures under section
17 1139A of the Social Security Act; and

18 “(F) culturally and linguistically appro-
19 priate care, as defined by the Secretary; and

20 “(2) payment policies that substantially reflects
21 the payment policy of the Medicare program under
22 title XVIII of the Social Security Act and the Chil-
23 dren’s Health Insurance Program under title XXI of
24 such Act with respect to any generally implemented
25 incentive policy to promote high quality health care.

1 “(b) EXCEPTIONS.—In promulgating regulations
2 under subsection (c), the Secretary may provide for excep-
3 tions to the requirements of subsection (a) for insurers
4 that substantially meet the goals of this section.

5 “(c) REGULATIONS.—Not later than 180 days after
6 the date of enactment of the Affordable Health Choices
7 Act, the Secretary shall promulgate regulations—

8 “(1) that define the term ‘generally imple-
9 mented’ for purposes of subsection (a)(2);

10 “(2) that require the expiration of a minimum
11 period of time between the date on which a policy
12 is generally implemented for purposes of subsection
13 (a)(2) and the date on which such policy shall apply
14 with respect to health insurance coverage offered in
15 the individual or group market; and

16 “(3) that provide criteria for determining
17 whether a payment policy is described in subsection
18 (a).

19 **“SEC. 2708. COVERAGE OF PREVENTIVE HEALTH SERVICES.**

20 “(a) IN GENERAL.—A group health plan and a health
21 insurance issuer offering group or individual health insur-
22 ance coverage shall provide coverage for and shall not im-
23 pose any cost sharing requirements (other than minimal
24 cost sharing in accordance with guidelines developed by
25 the Secretary) for—

1 “(1) items or services that have in effect a rat-
2 ing of ‘A’ or ‘B’ in the current recommendations of
3 the United States Preventive Services Task Force;

4 “(2) immunizations that have in effect a rec-
5 ommendation from the Advisory Committee on Im-
6 munization Practices of the Centers for Disease
7 Control and Prevention with respect to the indi-
8 vidual involved; and

9 “(3) with respect to infants, children and ado-
10 lescents, preventive care and screenings provided for
11 in the comprehensive guidelines supported by the
12 Health Resources and Services Administration.

13 “(b) INTERVAL.—

14 “(1) IN GENERAL.—The Secretary shall estab-
15 lish a minimum interval between the date on which
16 a recommendation described in subsection (a)(1) or
17 (a)(2) or a guideline under subsection (a)(3) is
18 issued and the plan year with respect to which the
19 requirement described in subsection (a) is effective
20 with respect to the service described in such rec-
21 ommendation or guideline.

22 “(2) MINIMUM.—The Secretary shall provide
23 that the interval described in paragraph (1) is not
24 less than 1 year.

1 “(c) SPECIAL RULE FOR INITIAL RECOMMENDA-
2 TIONS.—Subsection (b) shall apply with respect to any
3 recommendations described in subsection (a)(1) or (2) and
4 any guidelines described in subsection (a)(3) on plan years
5 beginning on and after January 1, 2010.

6 **“SEC. 2709. EXTENSION OF DEPENDENT COVERAGE.**

7 “(a) IN GENERAL.—A group health plan and a health
8 insurance issuer offering group or individual health insur-
9 ance coverage that provides dependant coverage of chil-
10 dren shall continue to make such coverage available for
11 an adult child until the child turns 26 years of age.

12 “(b) REGULATIONS.—The Secretary shall promul-
13 gate regulations to define the scope of the dependants to
14 which coverage shall be made available under subsection
15 (a).

16 **“SEC. 2710. NO LIFETIME OR ANNUAL LIMITS.**

17 “A group health plan and a health insurance issuer
18 offering group or individual health insurance coverage
19 may not establish lifetime or annual limits on the dollar
20 value of benefits for any participant or beneficiary.

21 **“SEC. 2711. NOTIFICATION BY PLANS NOT PROVIDING MIN-
22 IMUM QUALIFYING COVERAGE.**

23 “(a) IN GENERAL.—Not later than 1 year after the
24 date on which the Secretary establishes criteria with re-
25 spect to minimum qualifying coverage under section 3103,

1 a group health plan and a health insurance issuer offering
2 group or individual health insurance coverage that fails
3 to provide such minimum qualifying coverage to enrollees
4 under such plan or coverage shall notify, in such manner
5 as may be required by the Secretary, such enrollees of
6 such failure prior to enrollment or re-enrollment.

7 “(b) MODIFICATIONS.—If the Secretary modifies the
8 criteria with respect to minimum qualifying coverage
9 under section 3103, a group health plan or health insur-
10 ance issuer that fails to provide such modified minimum
11 qualifying coverage shall provide the notice required under
12 subsection (a) within 60 days of the date of such modifica-
13 tion.”.

14 **PART II—PROVISION APPLICABLE TO THE**
15 **GROUP MARKET**
16 **SEC. 121. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
17 **ACT.**

18 Subpart 2 of part A of title XXVII of the Public
19 Health Service Act (42 U.S.C. 300gg-4 et seq.) is amend-
20 ed by adding at the end the following:

21 **“SEC. 2719. PROHIBITION OF DISCRIMINATION BASED ON**
22 **SALARY.**

23 “(a) IN GENERAL.—A group health plan and a health
24 insurance issuer offering group health insurance coverage
25 may not establish rules relating to the health insurance

1 coverage eligibility (including continued eligibility) of any
2 full-time employee under the terms of the plan that are
3 based on the total hourly or annual salary of the employee.

4 “(b) **LIMITATION.**—Subsection (a) shall not be con-
5 strued to prohibit a group health plan or health insurance
6 issuer from establishing contribution requirements for en-
7 rollment in the plan or coverage that provide for the pay-
8 ment by employees with lower hourly or annual compensa-
9 tion of a lower dollar or percentage contribution than the
10 payment required of a similarly situated employees with
11 a higher hourly or annual compensation.”.

12 **PART III—OTHER PROVISIONS**

13 **SEC. 131. NO CHANGES TO EXISTING COVERAGE.**

14 (a) **OPTION TO RETAIN CURRENT INSURANCE COV-**
15 **ERAGE.**—

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

22 (2) **CONTINUATION OF COVERAGE.**—With re-
23 spect to a group health plan or health insurance cov-
24 erage in which an individual was enrolled prior to
25 the date of enactment of this title, this subtitle (and

1 the amendments made by this subtitle) shall not
2 apply to such plan or coverage, regardless of wheth-
3 er the individual renews such coverage after such
4 date of enactment.

5 (b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN
6 CURRENT COVERAGE.—With respect to a group health
7 plan or health insurance coverage in which an individual
8 was enrolled prior to the date of enactment of this title
9 and which is renewed after such date, family members of
10 such individual shall be permitted to enroll in such plan
11 or coverage.

12 (c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN
13 CURRENT PLAN.—A group health plan that provides cov-
14 erage on the date of enactment of this Act may provide
15 for the enrolling of new employees (and their families) in
16 such plan, and this subtitle (and the amendments made
17 by this subtitle) shall not apply with respect to such plan
18 and such new employees (and their families).

19 (d) NO ADDITIONAL BENEFIT.—Subsections (b) and
20 (c) shall only apply to individuals described in such sub-
21 sections and the family members of such individuals (as
22 provided for in such subsections).

23 (e) LIMITATION.—Subsections (a) through (d) shall
24 not apply to any group health plan or health insurance
25 coverage that has been modified to a significant extent

1 with respect to the benefits or cost sharing requirements
2 after the date of enactment of this Act. The Secretary
3 shall by regulation establish criteria to determine whether
4 a plan or health insurance coverage has been modified to
5 a significant extent under the preceding sentence.

6 (f) EFFECT ON COLLECTIVE BARGAINING AGREE-
7 MENTS.—In the case of health insurance coverage main-
8 tained pursuant to one or more collective bargaining
9 agreements between employee representatives and one or
10 more employers that was ratified before the date of enact-
11 ment of this title, the provisions of this subtitle (and the
12 amendments made by this subtitle) shall not apply until
13 the date on which the last of the collective bargaining
14 agreements relating to the coverage terminates. Any cov-
15 erage amendment made pursuant to a collective bar-
16 gaining agreement relating to the coverage which amends
17 the coverage solely to conform to any requirement added
18 by this subtitle (or amendments) shall not be treated as
19 a termination of such collective bargaining agreement.

20 (g) RISK ADJUSTMENT.—The provisions of section
21 3101(c)(6) of the Public Health Service Act (as added by
22 section 143) shall not apply to a group health plan or
23 health insurance coverage to which this section applies.

1 **SEC. 132. APPLICABILITY.**

2 Section 2721 of the Public Health Service Act (42
3 U.S.C. 300gg-21) is amended—

4 (1) by striking subsection (a);

5 (2) in subsection (b)—

6 (A) in paragraph (1), by striking “1
7 through 3” and inserting “1 and 2”; and

8 (B) in paragraph (2)—

9 (i) in subparagraph (A), by striking
10 “subparagraph (D)” and inserting “sub-
11 paragraph (D) or (E)”;

12 (ii) by striking “1 through 3” and in-
13 serting “1 and 2”; and

14 (iii) by adding at the end the fol-
15 lowing:

16 “(E) ELECTION NOT APPLICABLE.—The
17 election described in subparagraph (A) shall not
18 be available with respect to the provisions of
19 subpart 1.”;

20 (3) in subsection (c), by striking “1 through 3
21 shall not apply to any group” and inserting “1 and
22 2 shall not apply to any individual coverage or any
23 group”; and

24 (4) in subsection (d)—

25 (A) in paragraph (1), by striking “1
26 through 3 shall not apply to any group” and in-

1 serting “1 and 2 shall not apply to any indi-
2 vidual coverage or any group”;

3 (B) in paragraph (2)—

4 (i) in the matter preceding subpara-
5 graph (A), by striking “1 through 3 shall
6 not apply to any group” and inserting “1
7 and 2 shall not apply to any individual cov-
8 erage or any group”; and

9 (ii) in subparagraph (C), by inserting
10 “or, with respect to individual coverage,
11 under any health insurance coverage main-
12 tained by the same health insurance
13 issuer”; and

14 (C) in paragraph (3), by striking “any
15 group” and inserting “any individual coverage
16 or any group”.

17 **SEC. 133. CONFORMING AMENDMENTS.**

18 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of
19 the Public Health Service Act (42 U.S.C. 300gg et seq.)
20 is amended—

21 (1) in section 2705 (42 U.S.C. 300gg), as so
22 redesignated by section 101—

23 (A) in subsection (c)—

24 (i) in paragraph (2), by striking
25 “group health plan” each place that such

1 appears and inserting “group or individual
2 health plan”; and

3 (ii) in paragraph (3)—

4 (I) by striking “group health in-
5 surance” each place that such appears
6 and inserting “group or individual
7 health insurance”; and

8 (II) in subparagraph (D), by
9 striking “small or large” and insert-
10 ing “individual or group”;

11 (B) in subsection (d), by striking “group
12 health insurance” each place that such appears
13 and inserting “group or individual health insur-
14 ance”; and

15 (C) in subsection (e)(1)(A), by striking
16 “group health insurance” and inserting “group
17 or individual health insurance”;

18 (2) by striking the heading for subpart 2 of
19 part A;

20 (3) in section 2715 (42 U.S.C. 300gg-4), as so
21 redesignated—

22 (A) in subsection (a), by striking “health
23 insurance issuer offering group health insur-
24 ance coverage” and inserting “health insurance

1 issuer offering group or individual health insur-
2 ance coverage”;

3 (B) in subsection (b)—

4 (i) by striking “health insurance
5 issuer offering group health insurance cov-
6 erage in connection with a group health
7 plan” in the matter preceding paragraph
8 (1) and inserting “health insurance issuer
9 offering group or individual health insur-
10 ance coverage”; and

11 (ii) in paragraph (1), by striking
12 “plan” and inserting “plan or coverage”;

13 (C) in subsection (c)—

14 (i) in paragraph (2), by striking
15 “group health insurance coverage offered
16 by a health insurance issuer” and inserting
17 “health insurance issuer offering group or
18 individual health insurance coverage”; and

19 (ii) in paragraph (3), by striking
20 “issuer” and inserting “health insurance
21 issuer”; and

22 (D) in subsection (e), by striking “health
23 insurance issuer offering group health insur-
24 ance coverage” and inserting “health insurance

1 issuer offering group or individual health insur-
2 ance coverage”;

3 (4) in section 2716 (42 U.S.C. 300gg-5), as so
4 redesignated—

5 (A) in subsection (a), by striking “(or
6 health insurance coverage offered in connection
7 with such a plan)” each place that such appears
8 and inserting “or a health insurance issuer of-
9 fering group or individual health insurance cov-
10 erage”;

11 (B) in subsection (b), by striking “(or
12 health insurance coverage offered in connection
13 with such a plan)” each place that such appears
14 and inserting “or a health insurance issuer of-
15 fering group or individual health insurance cov-
16 erage”; and

17 (C) in subsection (c)—

18 (i) in paragraph (1), by striking “(and
19 group health insurance coverage offered in
20 connection with a group health plan)” and
21 inserting “and a health insurance issuer
22 offering group or individual health insur-
23 ance coverage”;

24 (ii) in paragraph (2), by striking “(or
25 health insurance coverage offered in con-

1 nection with such a plan)” each place that
2 such appears and inserting “or a health in-
3 surance issuer offering group or individual
4 health insurance coverage”;

5 (5) in section 2717 (42 U.S.C. 300gg-6), as so
6 redesignated, by striking “health insurance issuers
7 providing health insurance coverage in connection
8 with group health plans” and inserting “and health
9 insurance issuers offering group or individual health
10 insurance coverage”;

11 (6) in section 2718 (42 U.S.C. 300gg-7), as so
12 redesignated—

13 (A) in subsection (a), by striking “health
14 insurance coverage offered in connection with
15 such plan” and inserting “individual health in-
16 surance coverage”;

17 (B) in subsection (b)—

18 (i) in paragraph (1), by striking “or a
19 health insurance issuer that provides
20 health insurance coverage in connection
21 with a group health plan” and inserting
22 “or a health insurance issuer that offers
23 group or individual health insurance cov-
24 erage”;

1 (ii) in paragraph (2), by striking
2 “health insurance coverage offered in con-
3 nection with the plan” and inserting “indi-
4 vidual health insurance coverage”; and

5 (iii) in paragraph (3), by striking
6 “health insurance coverage offered by an
7 issuer in connection with such plan” and
8 inserting “individual health insurance cov-
9 erage”;

10 (C) in subsection (e), by striking “health
11 insurance issuer providing health insurance cov-
12 erage in connection with a group health plan”
13 and inserting “health insurance issuer that of-
14 fers group or individual health insurance cov-
15 erage”; and

16 (D) in subsection (e)(1), by striking
17 “health insurance coverage offered in connec-
18 tion with such a plan” and inserting “individual
19 health insurance coverage”;

20 (7) by striking the heading for subpart 3;

21 (8) in section 2712 (42 U.S.C. 300gg-11), as so
22 redesignated—

23 (A) by striking the section heading and all
24 that follows through subsection (b);

25 (B) in subsection (c)—

1 (i) in paragraph (1)—

2 (I) in the matter preceding sub-
3 paragraph (A), by striking “small
4 group” and inserting “group and indi-
5 vidual”; and

6 (II) in subparagraph (B)—

7 (aa) in the matter preceding
8 clause (i), by inserting “and indi-
9 viduals” after “employers”;

10 (bb) in clause (i), by insert-
11 ing “or any additional individ-
12 uals” after “additional groups”;
13 and

14 (cc) in clause (ii), by strik-
15 ing “without regard to the claims
16 experience of those employers
17 and their employees (and their
18 dependents) or any health status-
19 related factor relating to such”
20 and inserting “and individuals
21 without regard to the claims ex-
22 perience of those individuals, em-
23 ployers and their employees (and
24 their dependents) or any health

1 status-related factor relating to
2 such individuals”; and

3 (ii) in paragraph (2), by striking
4 “small group” and inserting “group or in-
5 dividual”;

6 (C) in subsection (d)—

7 (i) by striking “small group” each
8 place that such appears and inserting
9 “group or individual”; and

10 (ii) in paragraph (1)(B)—

11 (I) by striking “all employers”
12 and inserting “all employers and indi-
13 viduals”;

14 (II) by striking “those employ-
15 ers” and inserting “those individuals,
16 employers”; and

17 (III) by striking “such employ-
18 ees” and inserting “such individuals,
19 employees”;

20 (D) by striking subsection (e);

21 (E) by redesignating subsection (f) as sub-
22 section (e); and

23 (F) by transferring the remainder of such
24 section to appear at the end of section 2702 (as
25 added by section 101(5));

1 (9) in section 2713 (42 U.S.C. 300gg-12), as so
2 redesignated—

3 (A) by striking the section heading and all
4 that follows through subsection (a);

5 (B) in subsection (b)—

6 (i) in the matter preceding paragraph
7 (1), by striking “group health plan in the
8 small or large group market” and inserting
9 “health insurance coverage offered in the
10 group or individual market”;

11 (ii) in paragraph (1), by inserting “,
12 or individual, as applicable,” after “plan
13 sponsor”;

14 (iii) in paragraph (2), by inserting “,
15 or individual, as applicable,” after “plan
16 sponsor”; and

17 (iv) by striking paragraph (3) and in-
18 serting the following:

19 “(3) VIOLATION OF PARTICIPATION OR CON-
20 TRIBUTION RATES.—In the case of a group health
21 plan, the plan sponsor has failed to comply with a
22 material plan provision relating to employer con-
23 tribution or group participation rules, pursuant to
24 applicable State law.”;

25 (C) in subsection (c)—

1 (i) in paragraph (1)—

2 (I) in the matter preceding sub-
3 paragraph (A), by striking “group
4 health insurance coverage offered in
5 the small or large group market” and
6 inserting “group or individual health
7 insurance coverage”;

8 (II) in subparagraph (A), by in-
9 serting “or individual, as applicable,”
10 after “plan sponsor”;

11 (III) in subparagraph (B)—

12 (aa) by inserting “or indi-
13 vidual, as applicable,” after “plan
14 sponsor”; and

15 (bb) by inserting “or indi-
16 vidual health insurance cov-
17 erage”; and

18 (IV) in subparagraph (C), by in-
19 serting “or individuals, as applicable,”
20 after “those sponsors”; and

21 (ii) in paragraph (2)(A)—

22 (I) in the matter preceding clause
23 (i), by striking “small group market
24 or the large group market, or both

1 markets,” and inserting “individual or
2 group market, or all markets,”; and

3 (II) in clause (i), by inserting “or
4 individual, as applicable,” after “plan
5 sponsor”; and

6 (D) by transferring the remainder of such
7 section to appear at the end of section 2702 (as
8 added by section 101(4));

9 (10) in section 2714 (42 U.S.C. 300gg-13), as
10 so redesignated—

11 (A) in subsection (a)—

12 (i) in the matter preceding paragraph
13 (1), by striking “small employer” and in-
14 serting “small employer or an individual”;

15 (ii) in paragraph (1), by inserting “,
16 or individual, as applicable,” after “em-
17 ployer” each place that such appears; and

18 (iii) in paragraph (2), by striking
19 “small employer” and inserting “employer,
20 or individual, as applicable,”;

21 (B) in subsection (b)—

22 (i) in paragraph (1)—

23 (I) in the matter preceding sub-
24 paragraph (A), by striking “small em-

1 ployer” and inserting “employer, or
2 individual, as applicable,”;

3 (II) in subparagraph (A), by add-
4 ing “and” at the end;

5 (III) by striking subparagraphs
6 (B) and (C); and

7 (IV) in subparagraph (D)—

8 (aa) by inserting “, or indi-
9 vidual, as applicable,” after “em-
10 ployer”; and

11 (bb) by redesignating such
12 subparagraph as subparagraph
13 (B);

14 (ii) in paragraph (2)—

15 (I) by striking “small employers”
16 each place that such appears and in-
17 serting “employers, or individuals, as
18 applicable,”; and

19 (II) by striking “small employer”
20 and inserting “employer, or indi-
21 vidual, as applicable,”; and

22 (C) by redesignating such section as sec-
23 tion 2712 and transferring such section to ap-
24 pear after section 2711 (as added by section
25 101(5));

1 (11) by redesignating subpart 4 as subpart 2;

2 (12) in section 2721 (42 U.S.C. 300gg-21)—

3 (A) by striking subsection (a);

4 (B) by striking “subparts 1 through 3”

5 each place that such appears and inserting

6 “subpart 1”; and

7 (C) by redesignating subsections (b)

8 through (e) as subsections (a) through (d), re-

9 spectively;

10 (13) in section 2722 (42 U.S.C. 300gg-22)—

11 (A) in subsection (a)—

12 (i) in paragraph (1), by striking

13 “small or large group markets” and insert-

14 ing “individual or group market”; and

15 (ii) in paragraph (2), by inserting “or

16 individual health insurance coverage” after

17 “group health plans”; and

18 (B) in subsection (b)(1)(B), by inserting

19 “individual health insurance coverage or” after

20 “respect to”; and

21 (14) in section 2723(a)(1) (42 U.S.C. 300gg-

22 23), by inserting “individual or” before “group

23 health insurance”.

24 (b) TECHNICAL AMENDMENT TO THE EMPLOYEE

25 RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart

1 B of part 7 of subtitle A of title I of the Employee Retirement
2 ment Income Security Act of 1974 (29 U.S.C. 1181 et.
3 seq.) is amended, by adding at the end the following:

4 **“SEC. 715. ADDITIONAL MARKET REFORMS.**

5 “(a) GENERAL RULE.—Except as provided in sub-
6 section (b)—

7 “(1) the provisions of subpart 1 of part A of
8 title XXVII of the Public Health Service Act (as
9 amended by the Affordable Health Choices Act)
10 shall apply to group health plans, and health insurance
11 issuers providing health insurance coverage in
12 connection with group health plans, as if included in
13 this subpart; and

14 “(2) to the extent that any provision of this
15 part conflicts with a provision of such subpart 1
16 with respect to group health plans, or health insurance
17 issuers providing health insurance coverage in
18 connection with group health plans, the provisions of
19 such subpart 1 shall apply.

20 “(b) EXCEPTION.—Notwithstanding subsection (a),
21 the provisions of sections 2701, 2702, and 2704 of title
22 XXVII of the Public Health Service Act (as amended by
23 the Affordable Health Choices Act) shall not apply with
24 respect to self-insured group health plans, and the provi-
25 sions of this part shall continue to apply to such plans

1 as if such sections of the Public Health Service Act (as
2 so amended) had not been enacted.”.

3 (c) TECHNICAL AMENDMENT TO THE INTERNAL
4 REVENUE CODE OF 1986.—Subchapter B of chapter 100
5 of the Internal Revenue Code of 1986 is amended by add-
6 ing at the end the following:

7 **“SEC. 9815. ADDITIONAL MARKET REFORMS.**

8 “(a) GENERAL RULE.—Except as provided in sub-
9 section (b)—

10 “(1) the provisions of subpart 1 of part A of
11 title XXVII of the Public Health Service Act (as
12 amended by the Affordable Health Choices Act)
13 shall apply to group health plans, and health insur-
14 ance issuers providing health insurance coverage in
15 connection with group health plans, as if included in
16 this subchapter; and

17 “(2) to the extent that any provision of this
18 subchapter conflicts with a provision of such subpart
19 1 with respect to group health plans, or health in-
20 surance issuers providing health insurance coverage
21 in connection with group health plans, the provisions
22 of such subpart 1 shall apply.

23 “(b) EXCEPTION.—Notwithstanding subsection (a),
24 the provisions of sections 2701, 2702, and 2704 of title
25 XXVII of the Public Health Service Act (as amended by

1 the Affordable Health Choices Act) shall not apply with
2 respect to self-insured group health plans, and the provi-
3 sions of this subchapter shall continue to apply to such
4 plans as if such sections of the Public Health Service Act
5 (as so amended) had not been enacted.”.

6 **SEC. 134. EFFECTIVE DATES.**

7 (a) IMMEDIATE APPLICABILITY.—Except as other-
8 wise provided in subsection (b), this subtitle (and the
9 amendments made by this subtitle) shall become effective
10 on the date of enactment of this Act.

11 (b) DELAYED APPLICABILITY.—Sections 2701, 2702,
12 2705, and 2706 of the Public Health Service Act (as
13 added by section 101) shall become effective with respect
14 to group health plans or health insurance coverage offered
15 in a State on the date on which such State becomes a
16 participating or establishing State under section 3104 of
17 the Public Health Service Act (as added by section 143).

18 **Subtitle B—Available Coverage for**
19 **All Americans**

20 **SEC. 141. BUILDING ON THE SUCCESS OF THE FEDERAL**
21 **EMPLOYEES HEALTH BENEFIT PROGRAM SO**
22 **ALL AMERICANS HAVE AFFORDABLE HEALTH**
23 **BENEFIT CHOICES.**

24 (a) FINDINGS.—The Senate finds that—

1 (1) the Federal employees health benefits pro-
2 gram under chapter 89 of title 5, United States
3 Code, allows Members of Congress to have afford-
4 able choices among competing health benefit plans;

5 (2) the Federal employees health benefits pro-
6 gram ensures that the health benefit plans available
7 to Members of Congress meet minimum standards of
8 quality and effectiveness;

9 (3) millions of Americans have no meaningful
10 choice in health benefits, because health benefit
11 plans are either unavailable or unaffordable; and

12 (4) all Americans should have the same kinds
13 of meaningful choices of health benefit plans that
14 Members of Congress, as Federal employees, enjoy
15 through the Federal employees health benefits pro-
16 gram.

17 (b) SENSE OF THE SENATE.—It is the sense of the
18 Senate that Congress should establish a means for all
19 Americans to enjoy affordable choices in health benefit
20 plans, in the same manner that Members of Congress have
21 such choices through the Federal employees health bene-
22 fits program.

1 **SEC. 142. AFFORDABLE HEALTH CHOICES FOR ALL AMERI-**
2 **CANS.**

3 (a) PURPOSE.—It is the purpose of this section to
4 facilitate the establishment of Affordable Health Benefit
5 Gateways in each State, with appropriate flexibility for
6 States in establishing and administering the Gateways.

7 (b) AMERICAN HEALTH BENEFIT GATEWAYS.—The
8 Public Health Service Act (42 U.S.C. 201 et seq.) is
9 amended by adding at the end the following:

10 **“TITLE XXXI—AFFORDABLE**
11 **HEALTH CHOICES FOR ALL**
12 **AMERICANS**

13 **“Subtitle A—Affordable Choices**

14 **“SEC. 3101. AFFORDABLE CHOICES OF HEALTH BENEFIT**
15 **PLANS.**

16 **“(a) ASSISTANCE TO STATES TO ESTABLISH AMER-**
17 **ICAN HEALTH BENEFIT GATEWAYS.—**

18 **“(1) PLANNING AND ESTABLISHMENT**
19 **GRANTS.—**Not later than 60 days after the date of
20 enactment of this section, the Secretary shall make
21 awards, from amounts appropriated under para-
22 graph (5), to States in the amount specified in para-
23 graph (2) for the uses described in paragraph (3).

24 **“(2) AMOUNT SPECIFIED.—**

25 **“(A) TOTAL DETERMINED.—**For each fis-
26 cal year, the Secretary shall determine the total

1 amount that the Secretary will make available
2 for grants under this subsection.

3 “(B) STATE AMOUNT.—For each State
4 that is awarded a grant under paragraph (1),
5 the amount of such grants shall be based on a
6 formula established by the Secretary under
7 which each State shall receive an award in an
8 amount that is based on the following two com-
9 ponents:

10 “(i) A minimum amount for each
11 State.

12 “(ii) An additional amount based on
13 population.

14 “(3) USE OF FUNDS.—A State shall use
15 amounts awarded under this subsection for activities
16 (including planning activities) related to establishing
17 an American Health Benefit Gateway, as described
18 in subsection (b).

19 “(4) RENEWABILITY OF GRANT.—

20 “(A) IN GENERAL.—The Secretary may
21 renew a grant awarded under paragraph (1) if
22 the State recipient of such grant—

23 “(i) is making progress, as determined
24 by the Secretary, toward—

25 “(I) establishing a Gateway; and

1 “(II) implementing the reforms
2 described subtitle A of title I of the
3 Affordable Health Choices Act; and

4 “(ii) is meeting such other bench-
5 marks as the Secretary may establish.

6 “(B) LIMITATION.—If a State is an estab-
7 lishing State or a participating State (as de-
8 fined in section 3104), such State shall not be
9 eligible for a grant renewal under subparagraph
10 (A) as of the second fiscal year following the
11 date on which such State was deemed to be an
12 establishing State or a participating State.

13 “(5) AUTHORIZATION OF APPROPRIATIONS.—
14 There are authorized to be appropriated such sums
15 as may be necessary to carry out this subsection in
16 each of fiscal years 2009 through 2014.

17 “(b) AMERICAN HEALTH BENEFIT GATEWAYS.—An
18 American Health Benefit Gateway (referred to in this sec-
19 tion as a ‘Gateway’) means a mechanism that—

20 “(1) facilitates the purchase of health insurance
21 coverage and related insurance products through the
22 Gateway at an affordable price by qualified individ-
23 uals and qualified employer groups; and

24 “(2) meets the requirements of subsection (c).

25 “(c) REQUIREMENTS.—

1 “(1) VOLUNTARY NATURE OF GATEWAY.—

2 “(A) CHOICE TO ENROLL OR NOT TO EN-
3 ROLL.—A qualified individual shall have the
4 choice to enroll or not to enroll in a qualified
5 health plan or to participate in a Gateway.

6 “(B) PROHIBITION ON COMPELLED EN-
7 ROLLMENT.—No individual shall be compelled
8 to enroll in a qualified health plan or to partici-
9 pate in a Gateway.

10 “(2) ESTABLISHMENT.—A Gateway shall be a
11 governmental agency or nonprofit entity that is es-
12 tablished by—

13 “(A) a State, in the case of an establishing
14 State (as described in section 3104); or

15 “(B) the Secretary, in the case of a par-
16 ticipating State (as described in section 3104).

17 “(3) OFFERING OF COVERAGE.—

18 “(A) IN GENERAL.—A Gateway shall make
19 available qualified health plans to qualified indi-
20 viduals and qualified employers.

21 “(B) INCLUSION.—In making available
22 coverage pursuant to subparagraph (A), a Gate-
23 way shall include a community health insurance
24 option (as described in section 3106).

1 “(C) LIMITATION.—A Gateway may not
2 make available any health plan or other health
3 insurance coverage that is not a qualified health
4 plan.

5 “(D) ALLOWANCE TO OFFER.—A Gateway
6 may make available a qualified health plan not-
7 withstanding any provision of law that may re-
8 quire benefits other than the essential health
9 benefits specified under section 3103(a).

10 “(E) STATES MAY REQUIRE ADDITIONAL
11 BENEFITS.—Subject to the requirements of
12 subparagraph (F), a State may require that a
13 qualified health plan offered in such State offer
14 benefits in addition to the essential health bene-
15 fits described in section 3103(a).

16 “(F) ADDITIONAL BENEFITS.—

17 “(i) NO ADDITIONAL FEDERAL
18 COST.—A requirement by a State under
19 subparagraph (E) that a qualified health
20 plan cover benefits in addition to the es-
21 sential health benefits required shall not
22 affect the amount of a credit provided
23 under section 3111 with respect to such
24 plan.

1 rated ‘A’ or ‘B’ by the U.S. Preventive
2 Services Task Force are utilized by enroll-
3 ees, a comparison of such data to the aver-
4 age frequency of preventive services uti-
5 lized by enrollees across all qualified health
6 plans, and whether ‘A’ and ‘B’ rated pre-
7 ventive services are utilized by enrollees as
8 frequently as recommended by the U.S.
9 Preventive Services Task Force; and

10 “(v) such other matters relating to
11 consumer costs and expected experience
12 under the plan as a Gateway may deter-
13 mine necessary;

14 “(C) utilize the administrative simplifica-
15 tion measures and standards developed under
16 section 222 of the Affordable Health Choices
17 Act;

18 “(D) enter into agreements, to the extent
19 determined appropriate by the Gateway, with
20 navigators, as described in section 3105;

21 “(E) facilitate the purchase of coverage for
22 long-term services and supports; and

23 “(F) collect, analyze, and respond to com-
24 plaints and concerns from enrollees regarding
25 coverage provided through the Gateway.

1 “(5) SURCHARGES.—

2 “(A) IN GENERAL.—A Gateway may as-
3 sess a surcharge on all health insurance issuers
4 offering qualified health plans through the
5 Gateway to pay for the administrative and oper-
6 ational expenses of the Gateway.

7 “(B) LIMITATION.—A surcharge described
8 in subparagraph (A) may not exceed 4 percent
9 of the premiums collected by a qualified health
10 plan.

11 “(6) RISK ADJUSTMENT PAYMENT.—

12 “(A) ESTABLISHING AND PARTICIPATING
13 STATES.—

14 “(i) LOW ACTUARIAL RISK PLANS.—
15 Using the criteria and methods developed
16 under subparagraph (B), each establishing
17 State or participating State (as defined in
18 section 3104) shall assess a charge on
19 health plans and health insurance issuers
20 (with respect to health insurance coverage)
21 described in subparagraph (C) if the actu-
22 arial risk of the enrollees of such plans or
23 coverage for a year is less than the average
24 actuarial risk of all enrollees in all plans or
25 coverage in such State for such year that

1 are not self-insured group health plans
2 (which are subject to the provisions of the
3 Employee Retirement Income Security Act
4 of 1974).

5 “(ii) HIGH ACTUARIAL RISK PLANS.—
6 Using the criteria and methods developed
7 under subparagraph (B), each establishing
8 State or participating State (as defined in
9 section 3104) shall provide a payment to
10 health plans and health insurance issuers
11 (with respect to health insurance coverage)
12 described in subparagraph (C) if the actu-
13 arial risk of the enrollees of such plans or
14 coverage for a year is greater than the av-
15 erage actuarial risk of all enrollees in all
16 plans and coverage in such State for such
17 year that are not self-insured group health
18 plans (which are subject to the provisions
19 of the Employee Retirement Income Secu-
20 rity Act of 1974).

21 “(B) CRITERIA AND METHODS.—The Sec-
22 retary, in consultation with States shall estab-
23 lish criteria and methods to be used in carrying
24 out the risk adjustment activities under this
25 paragraph. The Secretary may utilize criteria

1 and methods similar to the criteria and meth-
2 ods utilized under parts C and D of title XVIII
3 of the Social Security Act.

4 “(C) SCOPE.—A health plan or a health
5 insurance issuer is described in this subpara-
6 graph if such health plan or health insurance
7 issuer provides coverage for an individual or for
8 an employer group the size of which does not
9 exceed—

10 “(i) in the case of an employer with
11 its primary place of business located in an
12 establishing State, the criteria relating to
13 the size of employers established by such
14 State as described in section
15 3116(a)(2)(A)(ii)(I); or

16 “(ii) in the case of an employer with
17 its primary place of business located in a
18 participating State, the criteria relating to
19 the size of employers established by the
20 Secretary as described in section
21 3116(a)(2)(A)(ii)(II).

22 “(7) FACILITATING ENROLLMENT.—

23 “(A) IN GENERAL.—A Gateway shall
24 (through, to the extent practicable, the use of

1 information technology) implement policies and
2 procedures to—

3 “(i) facilitate the identification of in-
4 dividuals who lack qualifying coverage; and

5 “(ii) assist such individuals in enroll-
6 ing in—

7 “(I) a qualified health plan that
8 is affordable and available to such in-
9 dividual, if such individual is a quali-
10 fied individual;

11 “(II) the medicaid program
12 under title XIX of the Social Security
13 Act, if such individual is eligible for
14 such program;

15 “(III) the CHIP program under
16 title XXI of the Social Security Act, if
17 such individual is eligible for such
18 program; or

19 “(IV) other Federal programs in
20 which such individual is eligible to
21 participate.

22 “(B) CHOICE FOR INDIVIDUALS ELIGIBLE
23 FOR CHIP.—A qualified individual who is eligi-
24 ble for the Children’s Health Insurance Pro-
25 gram under title XXI of the Social Security Act

1 may elect to enroll in such program or in a
2 qualified health plan. Where such individual is
3 a minor child, such election shall be made by
4 the parent or guardian of such child.

5 “(C) OVERSIGHT.—The Secretary shall
6 oversee the implementation of subparagraph
7 (A)(ii) to ensure that individuals are directed to
8 enroll in the program most appropriate under
9 such subparagraph for each such individual.

10 “(D) ACCESSIBILITY OF MATERIALS.—Any
11 materials used by a Gateway to carry out this
12 paragraph shall be provided in a form and man-
13 ner calculated to be understood by individuals
14 who may apply to be enrollees in a qualified
15 health plan, taking into account potential lan-
16 guage barriers and disabilities of individuals.

17 “(8) CONSULTATION.—A Gateway shall consult
18 with stakeholders relevant to carrying out the activi-
19 ties under this subsection, including—

20 “(A) consumers who are enrollees in quali-
21 fied health plans;

22 “(B) individuals and entities with experi-
23 ence in facilitating enrollment in qualified
24 health plans;

25 “(C) State Medicaid offices; and

1 “(D) advocates for enrolling hard to reach
2 populations.

3 “(9) STANDARDS AND PROTOCOLS.—

4 “(A) IN GENERAL.—The Secretary, in con-
5 sultation with the Office of the National Coor-
6 dinator for Health Information Technology,
7 shall develop interoperable, secure, scalable, and
8 reusable standards and protocols that facilitate
9 enrollment of individuals in Federal and State
10 health and human services programs.

11 “(B) COORDINATION.—The Secretary shall
12 facilitate enrollment of individuals in programs
13 described in subparagraph (A) through methods
14 which shall include—

15 “(i) electronic matching against exist-
16 ing Federal and State data to serve as evi-
17 dence of eligibility and digital documenta-
18 tion in lieu of paper-based documentation;

19 “(ii) capability for individuals to
20 apply, recertify, and manage eligibility in-
21 formation online, including conducting
22 real-time queries against databases for ex-
23 isting eligibility prior to submitting appli-
24 cations; and

1 “(iii) other functionalities necessary to
2 provide eligible individuals with a stream-
3 lined enrollment process.

4 “(C) ASSISTANCE.—The Secretary shall
5 award grants to enhance community-based en-
6 rollment to—

7 “(i) States to assist such States in—

8 “(I) contracting with qualified
9 technology vendors to develop or ac-
10 quire electronic enrollment software
11 systems;

12 “(II) contracting with community
13 and consumer focused nonprofit orga-
14 nizations with experience working
15 with consumers, including the unin-
16 sured and the underinsured, to estab-
17 lish Statewide helplines for enrollment
18 assistance and referrals; and

19 “(III) establishing public edu-
20 cation campaigns through grants to
21 qualifying organizations for the design
22 and implementation of public edu-
23 cation campaigns targeting uninsured
24 and traditionally underserved commu-
25 nities; and

1 “(ii) community-based organizations
2 for infrastructure and training to establish
3 electronic assistance programs.

4 “(10) NOTIFICATION.—With respect to the
5 standards and protocols developed under subsection
6 (9), the Secretary—

7 “(A) shall notify States of such standards
8 and protocols; and

9 “(B) may require, as a condition of receiv-
10 ing Federal funds, that States or other entities
11 incorporate such standards and protocols into
12 such investments.

13 “(d) CERTIFICATION.—A Gateway may certify a
14 health plan if—

15 “(1) such health plan meets the requirements of
16 subsection (l); and

17 “(2) the Gateway determines that making avail-
18 able such health plan through such Gateway is in
19 the interests of qualified individuals and qualified
20 employers in the States or States in which such
21 Gateway operates.

22 “(e) GUIDANCE.—The Secretary shall develop guid-
23 ance that may be used by a Gateway to carry out the ac-
24 tivities described in subsection (c).

25 “(f) FLEXIBILITY.—

1 “(1) REGIONAL OR OTHER INTERSTATE GATE-
2 WAYS.—A Gateway may operate in more than one
3 State, provided that each State in which such Gate-
4 way operates permits such operation.

5 “(2) SUBSIDIARY GATEWAYS.—A State may es-
6 tablish one or more subsidiary Gateway, provided
7 that—

8 “(A) each such Gateway serves a geo-
9 graphically distinct area; and

10 “(B) the area served by each such Gate-
11 way is at least as large as a community rating
12 area described in section 2701.

13 “(g) PORTALS TO STATE GATEWAY.—The Secretary
14 shall establish a mechanism, including an Internet
15 website, through which a resident of any State may iden-
16 tify any Gateway operating in such State.

17 “(h) CHOICE.—

18 “(1) QUALIFIED INDIVIDUALS.—A qualified in-
19 dividual may enroll in any qualified health plan
20 available to such individual.

21 “(2) QUALIFIED EMPLOYERS.—

22 “(A) EMPLOYER MAY SPECIFY TIER.—A
23 qualified employer may select to provide sup-
24 port for coverage of employees under a qualified

1 health plan at any tier of cost sharing described
2 in section 3111(a)(1).

3 “(B) EMPLOYEE MAY CHOOSE PLANS
4 WITHIN A TIER.—Each employee of a qualified
5 employer may choose to enroll in a qualified
6 health plan that offers coverage at the tier of
7 cost sharing selected by an employer described
8 in subparagraph (A).

9 “(3) SELF-EMPLOYED INDIVIDUALS.—

10 “(A) DEEMING.—An individual who is self-
11 employed (as defined in section 401(c)(1) of the
12 Internal Revenue Code of 1986) shall be
13 deemed to be a qualified employer unless such
14 individual notifies the applicable Gateway that
15 such individual elects to be considered a quali-
16 fied individual.

17 “(B) ELIGIBILITY.—In the case of a self-
18 employed individual making the election de-
19 scribed in subparagraph (A)—

20 “(i) the income of such individual for
21 purposes of section 3111 shall be deemed
22 to be the total business income of such in-
23 dividual;

24 “(ii) premium payments made by such
25 individual to a qualified health plan shall

1 not be treated as employer-provided cov-
2 erage under section 106(a) of the Internal
3 Revenue Code of 1986; and

4 “(iii) the individual shall not be eligi-
5 ble for a credit under section 3112.

6 “(i) PAYMENT OF PREMIUMS BY QUALIFIED INDI-
7 VIDUALS.—A qualified individual enrolled in any qualified
8 health plan may pay any applicable premium owed by such
9 individual to the health insurance issuer issuing such
10 qualified health plan.

11 “(j) SINGLE RISK POOL.—

12 “(1) INDIVIDUAL MARKET.—A health insurance
13 issuer shall consider all enrollees in an individual
14 plan, including individuals who do not purchase such
15 a plan through the Gateway, to be a member of a
16 single risk pool.

17 “(2) GROUP HEALTH INSURANCE POLICIES.—A
18 health insurance issuer shall consider all enrollees in
19 a group health plan, other than a self-insured group
20 health plan, including individuals who do not pur-
21 chase such a plan through the Gateway, to be a
22 member of a single risk pool.

23 “(k) EMPOWERING CONSUMER CHOICE.—

24 “(1) CONTINUED OPERATION OF MARKET OUT-
25 SIDE GATEWAYS.—Nothing in this title shall be con-

1 strued to prohibit a health insurance issuer from of-
2 fering a health insurance policy or providing cov-
3 erage under such policy to a qualified individual
4 where such policy is not a qualified health plan.
5 Nothing in this title shall be construed to prohibit
6 a qualified individual from enrolling in a health in-
7 surance plan where such plan is not a qualified
8 health plan.

9 “(2) CONTINUED OPERATION OF STATE BEN-
10 EFIT REQUIREMENTS.—Nothing in this title shall be
11 construed to terminate, abridge, or limit the oper-
12 ation of any requirement under State law with re-
13 spect to any policy or plan that is not a qualified
14 health plan to offer benefits required under State
15 law.

16 “(1) CRITERIA FOR CERTIFICATION.—

17 “(1) IN GENERAL.—The Secretary shall, by
18 regulation, establish criteria for certification of
19 health plans as qualified health plans. Such criteria
20 shall require that, to be certified, a plan—

21 “(A) not employ marketing practices that
22 have the effect of discouraging the enrollment
23 in such plan by individuals with significant
24 health needs;

1 “(B) employ methods to ensure that insur-
2 ance products are simple, comparable, and
3 structured for ease of consumer choice;

4 “(C) ensure a wide choice of providers (in
5 a manner consistent with applicable network
6 adequacy provisions under section 2702(c));

7 “(D) make available to individuals enrolled
8 in, or seeking to enroll in, such plan a detailed
9 description of—

10 “(i) benefits offered, including maxi-
11 mums, limitations (including differential
12 cost-sharing for out of network services),
13 exclusions and other benefit limitations;

14 “(ii) the service area;

15 “(iii) required premiums;

16 “(iv) cost-sharing requirements;

17 “(v) the manner in which enrollees ac-
18 cess providers; and

19 “(vi) the grievance and appeals proce-
20 dures;

21 “(E) provide coverage for at least the es-
22 sential health care benefits established under
23 section 3103(a);

24 “(F)(i) is accredited by the National Com-
25 mittee for Quality Assurance or by any other

1 entity recognized by the Secretary for the ac-
2 creditation of health insurance issuers or plans;
3 or

4 “(ii) receives such accreditation within a
5 period established by a Gateway for such ac-
6 creditation that is applicable to all qualified
7 health plans;

8 “(G) implement a quality improvement
9 strategy described in subsection (m)(1);

10 “(H) have adequate procedures in place for
11 appeals of coverage determinations; and

12 “(I) may not establish a benefit design
13 that is likely to substantially discourage enroll-
14 ment by certain qualified individuals in such
15 plan.

16 “(2) REQUEST TO NATIONAL ASSOCIATION OF
17 INSURANCE COMMISSIONERS.—The Secretary shall
18 request the National Association of Insurance Com-
19 missioners to develop and submit to the Secretary
20 model criteria for the certification of qualified health
21 plans, that addresses the elements described in sub-
22 paragraphs (A) through (I) of paragraph (1). In de-
23 veloping such criteria, the National Association of
24 Insurance Commissioners shall consult with appro-

1 appropriate Federal agencies, consumer representatives,
2 insurance carriers, and other stakeholders.

3 “(3) REQUIRED CONSIDERATION.—If the model
4 criteria described in paragraph (2) are submitted to
5 the Secretary by the date that is 9 months after the
6 date on which a request is made under such para-
7 graph, the Secretary shall consider such model cri-
8 teria in promulgating the regulations under para-
9 graph (1).

10 “(m) REWARDING QUALITY THROUGH MARKET-
11 BASED INCENTIVES.—

12 “(1) STRATEGY DESCRIBED.—A strategy de-
13 scribed in this paragraph is a payment structure
14 that provides increased reimbursement or other in-
15 centives for—

16 “(A) improving health outcomes through
17 the implementation of activities that shall in-
18 clude quality reporting, effective case manage-
19 ment, care coordination, chronic disease man-
20 agement, medication and care compliance initia-
21 tives, including through the use of the medical
22 home model as defined in section 212 of the Af-
23 fordable Health Choices Act, for treatment or
24 services under the plan or coverage;

1 “(B) the implementation of activities to
2 prevent hospital readmissions through a com-
3 prehensive program for hospital discharge that
4 includes patient-centered education and coun-
5 seling, comprehensive discharge planning, and
6 post discharge reinforcement by an appropriate
7 health care professional;

8 “(C) the implementation of activities to
9 improve patient safety and reduce medical er-
10 rors through the appropriate use of best clinical
11 practices, evidence based medicine, and health
12 information technology under the plan or cov-
13 erage; and

14 “(D) the implementation of wellness and
15 health promotion activities.

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

20 “(3) REQUIREMENTS.—The guidelines devel-
21 oped under paragraph (2) shall require the periodic
22 reporting to the applicable Gateway of the activities
23 that a qualified health plan has conducted to imple-
24 ment a strategy described in paragraph (1).

1 “(n) NO INTERFERENCE WITH STATE REGULATORY
2 AUTHORITY.—Nothing in this title shall be construed to
3 preempt any State law that does not prevent the applica-
4 tion of the provisions of this title.

5 “(o) QUALITY IMPROVEMENT.—

6 “(1) ENHANCING PATIENT SAFETY.—Beginning
7 on January 1, 2012 a qualified health plan may con-
8 tract with—

9 “(A) a hospital with greater than 50 beds
10 only if such hospital—

11 “(i) utilizes a patient safety evaluation
12 system as described in part C of title IX;
13 and

14 “(ii) implements a mechanism to en-
15 sure that each patient receives a com-
16 prehensive program for hospital discharge
17 that includes patient-centered education
18 and counseling, comprehensive discharge
19 planning, and post discharge reinforcement
20 by an appropriate health care professional;
21 or

22 “(B) a health care provider if such pro-
23 vider implements such mechanisms to improve
24 health care quality as the Secretary may by reg-
25 ulation require.

1 “(2) EXCEPTIONS.—The Secretary may estab-
2 lish reasonable exceptions to the requirements de-
3 scribed in paragraph (1).

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

7 “(p) CONTINUED APPLICABILITY OF MENTAL
8 HEALTH PARITY.—Section 2716 shall apply to qualified
9 health plans in the same manner and to the same extent
10 as such section applies to health insurance issuers and
11 group health plans.

12 **“SEC. 3102. FINANCIAL INTEGRITY.**

13 “(a) ACCOUNTING FOR EXPENDITURES.—

14 “(1) IN GENERAL.—A Gateway shall keep an
15 accurate accounting of all activities, receipts, and ex-
16 penditures and shall annually submit to the Sec-
17 retary a report concerning such accountings.

18 “(2) INVESTIGATIONS.—The Secretary may in-
19 vestigate the affairs of a Gateway, may examine the
20 properties and records of a Gateway, and may re-
21 quire periodical reports in relation to activities un-
22 dertaken by a Gateway. A Gateway shall fully co-
23 operate in any investigation conducted under this
24 paragraph.

1 “(3) AUDITS.—A Gateway shall be subject to
2 annual audits by the Secretary.

3 “(4) PATTERN OF ABUSE.—If the Secretary de-
4 termines that a Gateway or a State has engaged in
5 serious misconduct with respect to compliance with,
6 or carrying out activities required, under this title,
7 the Secretary may rescind from payments otherwise
8 due to such State involved under this or any other
9 Act administered by the Secretary an amount not to
10 exceed 1 percent of such payments per year until
11 corrective actions are taken by the State that are de-
12 termined to be adequate by the Secretary.

13 “(5) PROTECTIONS AGAINST FRAUD AND
14 ABUSE.—With respect to activities carried out under
15 this title, the Secretary shall provide for the efficient
16 and non-discriminatory administration of Gateway
17 activities and implement any measure or procedure
18 that—

19 “(A) the Secretary determines is appro-
20 priate to reduce fraud and abuse in the admin-
21 istration of this title; and

22 “(B) the Secretary has authority for under
23 this title or any other Act;

24 “(b) GAO OVERSIGHT.—Not later than 5 years after
25 the date of enactment of this section, the Comptroller

1 General shall conduct an ongoing study of Gateway activi-
2 ties and the enrollees in qualified health plans offered
3 through Gateways. Such study shall review—

4 “(1) the operations and administration of Gate-
5 ways, including surveys and reports of qualified
6 health plans offered through Gateways and on the
7 experience of such plans (including data on enrollees
8 in Gateways and individuals purchasing health in-
9 surance coverage outside of Gateways), the expenses
10 of Gateways, claims statistics relating to qualified
11 health plans, complaints data relating to such plans,
12 and the manner in which Gateways meets their
13 goals;

14 “(2) any significant observations regarding the
15 utilization and adoption of Gateways; and

16 “(3) where appropriate, recommendations for
17 improvements in the operations or policies of Gate-
18 ways.

19 **“SEC. 3103. PROGRAM DESIGN.**

20 “(a) PROGRAM DESIGN.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish the following:

23 “(A) Subject to paragraph (2), the essen-
24 tial health care benefits eligible for credits

1 under section 3111, where such benefits shall
2 include at least the following general categories:

3 “(i) Ambulatory patient services.

4 “(ii) Emergency services.

5 “(iii) Hospitalization.

6 “(iv) Maternity and newborn care.

7 “(v) Mental health and substance
8 abuse services.

9 “(vi) Prescription drugs.

10 “(vii) Rehabilitative and habilitative
11 services and devices.

12 “(viii) Laboratory services.

13 “(ix) Preventive and wellness services.

14 “(x) Pediatric services, including oral
15 and vision care.

16 “(B) The criteria that coverage must meet
17 to be considered minimum qualifying coverage.

18 “(C) The conditions under which coverage
19 shall be considered affordable and available cov-
20 erage for individuals and families at different
21 income levels.

22 “(2) LIMITATION.—The Secretary shall ensure
23 that the scope of the essential health benefits under
24 paragraph (1)(A) is equal to the scope of benefits

1 provided under a typical employer plan, as deter-
2 mined by the Secretary.

3 “(3) CERTIFICATION.—In establishing the es-
4 sential health benefits described in paragraph (1),
5 the Secretary shall submit a report to the appro-
6 priate committees of Congress containing a certifi-
7 cation from the Chief Actuary of the Centers for
8 Medicare & Medicaid Services that such essential
9 health benefits meet the limitation described in para-
10 graph (2).

11 “(b) REQUIRED ELEMENTS FOR CONSIDERATION.—

12 “(1) ESSENTIAL HEALTH CARE BENEFITS.—In
13 establishing the essential health benefits under sub-
14 section (a)(1)(A), the Secretary shall—

15 “(A) ensure that such essential health ben-
16 efits reflect an appropriate balance among the
17 categories described in such subsection, so that
18 benefits are not unduly weighted toward any
19 category; and

20 “(B) take into account the health care
21 needs of diverse segments of the population, in-
22 cluding women, children, persons with disabili-
23 ties, and other groups.

1 “(2) MINIMUM QUALIFYING COVERAGE.—In es-
2 tablishing the criteria described in subsection
3 (a)(1)(B), the Secretary—

4 “(A) shall—

5 “(i) exclude from meeting such cri-
6 teria any coverage that—

7 “(I) provides reimbursement for
8 the treatment or mitigation of—

9 “(aa) a single disease or
10 condition; or

11 “(bb) an unreasonably lim-
12 ited set of diseases or conditions;
13 or

14 “(II) has an out of pocket limit
15 that exceeds the amount described in
16 section 223 of the Internal Revenue
17 Code of 1986 for the year involved;
18 and

19 “(ii) establish such criteria (taking
20 into account the requirements established
21 under clause (i)) in a manner that results
22 in the least practicable disruption of the
23 health care marketplace, consistent with
24 the goals and activities under this title;
25 and

1 “(B) may provide for the application of
2 different criteria with respect to young adults.

3 “(3) AFFORDABLE COVERAGE.—The Secretary
4 shall establish a standard under which coverage is
5 defined to be unaffordable only if the premium paid
6 by the individual is greater than 12.5 percent of the
7 adjusted gross income of the individual involved. Be-
8 ginning with calendar years after 2013, the Sec-
9 retary shall adjust the percentage described in this
10 paragraph by an amount that is equal to the per-
11 centage increase or decrease in the medical care
12 component of the Consumer Price Index for all
13 urban consumers (U.S. city average) during the pre-
14 ceding calendar year.

15 **“SEC. 3104. ALLOWING STATE FLEXIBILITY.**

16 “(a) OPTIONAL STATE ESTABLISHMENT OF GATE-
17 WAY.—During the 4-year period following the date of en-
18 actment of this section, a State may—

19 “(1)(A) establish a Gateway (as defined for
20 purposes of section 3101);

21 “(B) adopt the insurance reform provisions as
22 provided for in title I of the Affordable Health
23 Choices Act (and the amendments made by such
24 title); and

1 “(C) agree to make employers who are State or
2 local governments subject to sections 162 and 163 of
3 the Affordable Health Choices Act.

4 “(2)(A) request that the Secretary operate (for
5 a minimum period of 5 years) a Gateway in such
6 State;

7 “(B) adopt the insurance reform provisions as
8 provided for in subtitle A of title I of the Affordable
9 Health Choices Act (and the amendments made by
10 such subtitle); and

11 “(C) agree to make employers who are State or
12 local governments subject to sections 162 and 163 of
13 the Affordable Health Choices Act; or

14 “(3) elect not to take the actions described in
15 paragraph (1) or (2).

16 “(b) ESTABLISHING STATES.—

17 “(1) IN GENERAL.—If the Secretary determines
18 that a State has taken the actions described in sub-
19 section (a)(1), any resident of that State who is an
20 eligible individual shall be eligible for credits under
21 section 3111 beginning on the date that is 60 days
22 after the date of such determination.

23 “(2) CONTINUED REVIEW.—The Secretary shall
24 establish procedures to ensure continued review by
25 the Secretary of the compliance of a State with the

1 requirements of subsection (a). If the Secretary de-
2 termines that a State has failed to maintain compli-
3 ance with such requirements, the Secretary may re-
4 voke the determination under subparagraph (A).

5 “(3) DEEMING.—A State that is the subject of
6 a positive determination by the Secretary under
7 paragraph (1) (unless such determination is revoked
8 under paragraph (2)) shall be deemed to be an ‘es-
9 tablishing State’ beginning on the date that is 60
10 days after the date of such determination.

11 “(c) REQUEST FOR THE SECRETARY TO ESTABLISH
12 A GATEWAY.—

13 “(1) IN GENERAL.—In the case of a State that
14 makes the request described in subsection (a)(2), the
15 Secretary shall determine whether the State has en-
16 acted and has in effect the insurance reforms pro-
17 vided for in subtitle A of title I of the Affordable
18 Health Choices Act.

19 “(2) OPERATION OF GATEWAY.—

20 “(A) POSITIVE DETERMINATION.—If the
21 Secretary determines that the State has enacted
22 and has in effect the insurance reforms de-
23 scribed in paragraph (1), the Secretary shall es-
24 tablish a Gateway in such State as soon as
25 practicable after making such determination.

1 “(B) NEGATIVE DETERMINATION.—If the
2 Secretary determines that the State has not en-
3 acted or does not have in effect the insurance
4 reforms described in paragraph (1), the Sec-
5 retary shall establish a Gateway in such State
6 as soon as practicable after the Secretary deter-
7 mines that such State has enacted such re-
8 forms.

9 “(3) PARTICIPATING STATE.—The State shall
10 be deemed to be a ‘participating State’ on the date
11 on which the Gateway established by the Secretary
12 is in effect in such State.

13 “(4) ELIGIBILITY.—Any resident of a State de-
14 scribed in paragraph (3) who is an eligible individual
15 shall be eligible for credits under section 3111 begin-
16 ning on the date that is 60 days after the date on
17 which such Gateway is established in such State.

18 “(d) FEDERAL FALLBACK IN THE CASE OF STATES
19 THAT REFUSE TO IMPROVE HEALTH CARE COVERAGE.—

20 “(1) IN GENERAL.—Upon the expiration of the
21 4-year period following the date of enactment of this
22 section, in the case of a State that is not otherwise
23 a participating State or an establishing State—

24 “(A) the Secretary shall establish and op-
25 erate a Gateway in such State;

1 “(B) the insurance reform provisions pro-
2 vided for in subtitle A of title I of the Afford-
3 able Health Choices Act shall become effective
4 in such State, notwithstanding any contrary
5 provision of State law;

6 “(C) the State shall be deemed to be a
7 ‘participating State’; and

8 “(D) the residents of that State who are
9 eligible individuals shall be eligible for credits
10 under section 3111 beginning on the date that
11 is 60 days after the date on which such Gate-
12 way is established, if the State agrees to make
13 employers who are State or local governments
14 subject to sections 162 and 163 of the Afford-
15 able Health Choices Act.

16 “(2) ELIGIBILITY OF INDIVIDUALS FOR CRED-
17 ITS.—With respect to a State that makes the elec-
18 tion described in subsection (a)(3), the residents of
19 such State shall not be eligible for credits under sec-
20 tion 3111 until such State becomes a participating
21 State under paragraph (1).

22 **“SEC. 3105. NAVIGATORS.**

23 “(a) IN GENERAL.—The Secretary shall award
24 grants to establishing or participating States to enable
25 such States (or the Gateways operating in such States)

1 to enter into agreements with private and public entities
2 under which such entities will serve as navigators in ac-
3 cordance with this section.

4 “(b) ELIGIBILITY.—

5 “(1) IN GENERAL.—To be eligible to enter into
6 an agreement under subsection (a), an entity shall
7 demonstrate that the entity has existing relation-
8 ships with, or could readily establish relationships
9 with, employers and employees, consumers (includ-
10 ing the uninsured and the underinsured), and self-
11 employed individuals, likely to be eligible to partici-
12 pate in the program under this title.

13 “(2) TYPES.—Entities described in paragraph
14 (1) may include trade, industry and professional as-
15 sociations, commercial fishing industry organiza-
16 tions, ranching and farming organizations, commu-
17 nity and consumer-focused nonprofit groups, cham-
18 bers of commerce, unions, small business develop-
19 ment centers, and other entities that the Secretary
20 determines to be capable of carrying out the duties
21 described in subsection (c).

22 “(c) DUTIES.—An entity that serves as a navigator
23 under an agreement under subsection (a) shall—

24 “(1) conduct public education activities to raise
25 awareness of the program under this title;

1 “(2) distribute fair and impartial information
2 concerning enrollment in qualified health plans, and
3 the availability of credits under section 3111;

4 “(3) facilitate enrollment in a qualified health
5 plan; and

6 “(4) provide information in a manner deter-
7 mined by the Secretary to be culturally and linguis-
8 tically appropriate to the needs of the population
9 served by the Gateway.

10 “(d) STANDARDS.—

11 “(1) IN GENERAL.—The Secretary shall estab-
12 lish standards for navigators under this section, in-
13 cluding provisions to avoid conflicts of interest.
14 Under such standards, a navigator may not—

15 “(A) be a health insurance issuer; or

16 “(B) receive any consideration directly or
17 indirectly from any health insurance issuer in
18 connection with the participation of any em-
19 ployer in the program under this title or the en-
20 rollment of any eligible employee in health in-
21 surance coverage under this title.

22 “(2) FAIR AND IMPARTIAL INFORMATION AND
23 SERVICES.—The Secretary, in collaboration with
24 States, shall develop guidelines regarding the duties
25 described in subsection (c).

1 **“SEC. 3106. COMMUNITY HEALTH INSURANCE OPTION.**

2 “(a) VOLUNTARY NATURE.—

3 “(1) NO REQUIREMENT FOR HEALTH CARE
4 PROVIDERS TO PARTICIPATE.—Nothing in this sec-
5 tion shall be construed to require a health care pro-
6 vider to participate in a community health insurance
7 option, or to impose any penalty for non-participa-
8 tion.

9 “(2) NO REQUIREMENT FOR INDIVIDUALS TO
10 JOIN.—Nothing in this section shall be construed to
11 require an individual to participate in a community
12 health insurance option, or to impose any penalty for
13 non-participation.

14 “(b) ESTABLISHMENT OF COMMUNITY HEALTH IN-
15 SURANCE OPTION.—

16 “(1) ESTABLISHMENT.—The Secretary shall es-
17 tablish a community health insurance option to
18 offer, through each Gateway established under this
19 title, health care coverage that provides value,
20 choice, competition, and stability of affordable, high
21 quality coverage throughout the United States.

22 “(2) COMMUNITY HEALTH INSURANCE OP-
23 TION.—In this section, the term ‘community health
24 insurance option’ means health insurance coverage
25 that—

1 “(A) except as specifically provided for in
2 this section, complies with the requirements for
3 being a qualified health plan;

4 “(B) provides high value for the premium
5 charged;

6 “(C) reduces administrative costs and pro-
7 motes administrative simplification for bene-
8 ficiaries;

9 “(D) promotes high quality clinical care;

10 “(E) provides high quality customer service
11 to beneficiaries; and

12 “(F) offers a wide choice of providers.

13 “(3) ESSENTIAL HEALTH BENEFITS.—

14 “(A) GENERAL RULE.—Except as provided
15 in subparagraph (B), the community health in-
16 surance option offered under this section shall
17 provide coverage only for the essential health
18 benefits described in section 3103.

19 “(B) STATES MAY OFFER ADDITIONAL
20 BENEFITS.—A State may require that a com-
21 munity health insurance option offered in such
22 State offer benefits in addition to the essential
23 health benefits required under subparagraph
24 (A).

25 “(C) CREDITS.—

1 “(i) IN GENERAL.—An individual en-
2 rolled in a community health insurance op-
3 tion under this section shall be eligible for
4 credits under section 3111 in the same
5 manner as an individual who is enrolled in
6 a qualified health plan.

7 “(ii) NO ADDITIONAL FEDERAL
8 COST.—A requirement by a State under
9 subparagraph (B) that a community health
10 insurance option cover benefits in addition
11 to the essential health benefits required
12 under subparagraph (A) shall not affect
13 the amount of a credit provided under sec-
14 tion 3111 with respect to such plan.

15 “(D) STATE MUST ASSUME COST.—A
16 State shall make payments to or on behalf of
17 an eligible individual to defray the cost of any
18 additional benefits described in subparagraph
19 (B).

20 “(4) COST SHARING.—A community health in-
21 surance option shall offer coverage at each of the
22 cost sharing tiers described in section 3111(b).

23 “(5) PREMIUMS.—

24 “(A) PREMIUMS SUFFICIENT TO COVER
25 COSTS.—The Secretary shall set premium rates

1 in an amount sufficient to cover expected costs
2 (including claims and administrative costs)
3 using methods in general use by qualified
4 health plans.

5 “(B) APPLICABLE RULES.—The provisions
6 of title XXVII relating to premiums shall apply
7 to community health insurance options under
8 this section, including modified community rat-
9 ing provisions under section 2701.

10 “(C) COLLECTION OF DATA.—The Sec-
11 retary shall collect data as necessary to set pre-
12 mium rates under subparagraph (A).

13 “(D) CONTINGENCY MARGIN.—In estab-
14 lishing premium rates under subparagraph (A),
15 the Secretary shall include an appropriate
16 amount for a contingency margin.

17 “(6) REIMBURSEMENT RATES.—

18 “(A) NEGOTIATED RATES.—The Secretary
19 shall negotiate rates for the reimbursement of
20 health care providers for benefits covered under
21 a community health insurance option.

22 “(B) LIMITATION.—The rates described in
23 subparagraph (A) shall not be higher, in aggre-
24 gate, than the average reimbursement rates

1 paid by health insurance issuers offering quali-
2 fied health plans through the Gateway.

3 “(C) INNOVATION.—Subject to the limits
4 contained in subparagraph (A), a State Advi-
5 sory Council established or designated under
6 subsection (e)(7)(D) may develop or encourage
7 the use of innovative payment policies that pro-
8 mote quality, efficiency and savings to con-
9 sumers.

10 “(7) SOLVENCY AND CONSUMER PROTEC-
11 TION.—

12 “(A) SOLVENCY.—The Secretary shall es-
13 tablish a Federal solvency standard to be ap-
14 plied with respect to the community health in-
15 surance option. A community health insurance
16 option shall also be subject to the solvency
17 standard of each State in which such commu-
18 nity health insurance option is offered.

19 “(B) MINIMUM REQUIRED.—In estab-
20 lishing the standard described under subpara-
21 graph (A), the Secretary shall require a reserve
22 fund that shall be equal to at least the dollar
23 value of the incurred but not reported claims of
24 a community health insurance option.

1 “(C) CONSUMER PROTECTIONS.—The con-
2 sumer protection laws of a State shall apply to
3 a community health insurance option (as de-
4 fined by the Secretary).

5 “(8) REQUIREMENTS ESTABLISHED IN PART-
6 NERSHIP WITH INSURANCE COMMISSIONERS.—

7 “(A) IN GENERAL.—The Secretary, in col-
8 laboration with the National Association of In-
9 surance Commissioners (in this paragraph re-
10 ferred to as the ‘NAIC’), may promulgate regu-
11 lations to establish additional requirements for
12 a community health insurance option.

13 “(B) APPLICABILITY.—Any requirement
14 promulgated under subparagraph (A) shall be
15 applicable to such option beginning 90 days
16 after the date on which the regulation involved
17 becomes final.

18 “(9) OMBUDSMAN.—In establishing community
19 health insurance options, the Secretary shall estab-
20 lish an ombudsman or similar mechanism to provide
21 assistance to consumers with respect to disputes,
22 grievances, or appeals.

23 “(c) START-UP FUND.—

24 “(1) ESTABLISHMENT OF FUND.—

1 “(A) IN GENERAL.—There is established in
2 the Treasury of the United States a trust fund
3 to be known as the ‘Health Benefit Plan Start-
4 Up Fund’ (referred to in this section as the
5 ‘Start-Up Fund’), that shall consist of such
6 amounts as may be appropriated or credited to
7 the Start-Up Fund as provided for in this sub-
8 section to provide loans for the initial oper-
9 ations of a community health insurance option.
10 Such amounts shall remain available until ex-
11 pended.

12 “(B) FUNDING.—There are hereby appro-
13 priated to the Start-Up Fund, out of any mon-
14 eys in the Treasury not otherwise appropriated
15 an amount requested by the Secretary of
16 Health and Human Services as necessary to—

17 “(i) pay the start-up costs associated
18 with the initial operations of a community
19 health insurance option;

20 “(ii) pay the costs of making pay-
21 ments on claims submitted during the pe-
22 riod that is not more than 90 days from
23 the date on which such option is offered;
24 and

1 “(iii) make payments under para-
2 graph (3).

3 “(2) USE OF START-UP FUND.—The Secretary
4 shall use amounts contained in the Start-Up Fund
5 to make payments (subject to the repayment re-
6 quirements in paragraph (5)) to qualified carriers
7 for the purposes described in paragraph (1)(B).

8 “(3) RISK CORRIDOR PAYMENTS.—

9 “(A) IN GENERAL.—In any case in which
10 the Secretary has entered into a contract with
11 a contracting administrator, the Secretary shall
12 use amounts contained in the Start-Up Fund to
13 make risk corridor payments to such adminis-
14 trator for premiums during the 2-year period
15 beginning on the date on which such adminis-
16 trator enters into a contract under subsection
17 (e). Such payments shall be based on the risk
18 corridors in effect during fiscal years 2006 and
19 2007 for making payments under section
20 1860D-15(e) of the Social Security Act.

21 “(B) SUBSEQUENT YEAR.—In years after
22 the expiration of the period referred to in sub-
23 paragraph (A), the Secretary may extend or in-
24 crease the risk corridors and payments provided
25 for under subparagraph (A).

1 “(C) AMOUNT USED TO REDUCE COSTS.—

2 The Secretary shall deposit any payments re-
3 ceived from a contracting administrator under
4 subparagraph (A) into the Start-Up Fund.

5 “(4) PASS THROUGH OF REBATES.—The Sec-
6 retary may establish procedures for reducing the
7 amount of payments to a contracting administrator
8 to take into account any rebates or price conces-
9 sions.

10 “(5) REPAYMENT.—

11 “(A) IN GENERAL.—The community health
12 insurance option shall be required to repay the
13 Secretary (on such terms as the Secretary may
14 require) for any payments made under para-
15 graph (1)(B) by the date that is not later than
16 10 years after the date on which the payment
17 is made. The Secretary may require the pay-
18 ment of interest with respect to such repay-
19 ments at rates that do not exceed the market
20 interest rate (as determined by the Secretary).

21 “(B) SANCTIONS IN CASE OF FOR-PROFIT
22 CONVERSION.—In any case in which the Sec-
23 retary enters into a contract with a qualified
24 entity for the offering of a community health
25 insurance option and such entity is determined

1 to be a for-profit entity by the Secretary, such
2 entity shall be—

3 “(i) immediately liable to the Sec-
4 retary for any payments received by such
5 entity from the Start-Up Fund; and

6 “(ii) permanently ineligible to offer a
7 qualified health plan.

8 “(d) STATE ADVISORY COUNCIL.—

9 “(1) ESTABLISHMENT.—The State shall estab-
10 lish or designate a public or non-profit private entity
11 to serve as the State Advisory Council to provide
12 recommendations to the Secretary on the operations
13 and policies of the community health insurance op-
14 tion in the State. Such Council shall provide rec-
15 ommendations on at least the following:

16 “(A) policies and procedures to integrate
17 quality improvement and cost containment
18 mechanisms into the health care delivery sys-
19 tem;

20 “(B) mechanisms to facilitate public
21 awareness of the availability of the community
22 health insurance option; and

23 “(C) alternative payment structures under
24 the community health insurance option for

1 health care providers that encourage quality im-
2 provement and cost control.

3 “(2) MEMBERS.—The members of the State
4 Advisory Council shall be representatives of the pub-
5 lic and shall include health care consumers and pro-
6 viders.

7 “(3) APPLICABILITY OF RECOMMENDATIONS.—
8 The Secretary may apply the recommendations of a
9 State Advisory Council to the community health in-
10 surance option that state, or in any other State, or
11 in all States.

12 “(e) AUTHORITY TO CONTRACT; TERMS OF CON-
13 TRACT.—

14 “(1) AUTHORITY.—

15 “(A) IN GENERAL.—The Secretary may
16 enter into a contract with a qualified entity for
17 the purpose of performing administrative func-
18 tions (including functions described in sub-
19 section (a)(4) of section 1874A of the Social
20 Security Act) with respect to the community
21 health insurance option in the same manner as
22 the Secretary may enter into contracts under
23 subsection (a)(1) of such section. The Secretary
24 shall have the same authority with respect to
25 the community health insurance option under

1 this section as the Secretary has under sub-
2 sections (a)(1) and (b) of section 1874A of the
3 Social Security Act with respect to title XVIII
4 of such Act.

5 “(B) REQUIREMENTS APPLY.—If the Sec-
6 retary enters into a contract with a qualified
7 entity to offer a community health insurance
8 option, under such contract such entity—

9 “(i) shall meet the criteria established
10 under paragraph (2); and

11 “(ii) shall receive an administrative
12 fee under paragraph (7).

13 “(C) LIMITATION.—Contracts under this
14 subsection shall not involve the transfer of in-
15 surance risk to the contracting administrator.

16 “(D) REFERENCE.—An entity with which
17 the Secretary has entered into a contract under
18 this paragraph shall be referred to as a ‘con-
19 tracting administrator’.

20 “(2) QUALIFIED ENTITY.—To be qualified to be
21 selected by the Secretary to offer a community
22 health insurance option, an entity shall—

23 “(A) meet the criteria established under
24 section 1874A(a)(2) of the Social Security Act;

1 “(B) be a nonprofit entity for purposes of
2 offering such option;

3 “(C) meet the solvency standards applica-
4 ble under subsection (b)(7);

5 “(D) be eligible to offer health insurance
6 or health benefits coverage;

7 “(E) meet quality standards specified by
8 the Secretary;

9 “(F) have in place effective procedures to
10 control fraud, abuse, and waste; and

11 “(G) meet such other requirements as the
12 Secretary may impose.

13 “(3) TERM.—A contract provided for under
14 paragraph (1) shall be for a term of at least 5 years
15 but not more than 10 years, as determined by the
16 Secretary. At the end of each such term, the Sec-
17 retary shall conduct a competitive bidding process
18 for the purposes of renewing existing contracts or
19 selecting new qualified entities with which to enter
20 into contracts under such paragraph.

21 “(4) LIMITATION.—A contract may not be re-
22 newed under this subsection unless the Secretary de-
23 termines that the contracting administrator has met
24 performance requirements established by the Sec-
25 retary in the areas described in paragraph (7)(B).

1 “(5) AUDITS.—The Inspector General shall
2 conduct periodic audits with respect to contracting
3 administrators under this subsection to ensure that
4 the administrator involved is in compliance with this
5 section.

6 “(6) REVOCATION.—A contract awarded under
7 this subsection may be revoked by the Secretary only
8 after notice to the contracting administrator involved
9 and an opportunity for a hearing. The Secretary
10 may revoke such contract if the Secretary deter-
11 mines that such administrator has engaged in fraud,
12 deception, or gross mismanagement. An entity that
13 has had a contract revoked under this paragraph
14 shall not be qualified to enter into a subsequent con-
15 tract under this subsection.

16 “(7) FEE FOR ADMINISTRATION.—

17 “(A) IN GENERAL.—The Secretary shall
18 pay the contracting administrator a fee for the
19 management, administration, and delivery of
20 the benefits under this section.

21 “(B) REQUIREMENT FOR HIGH QUALITY
22 ADMINISTRATION.—The Secretary may increase
23 the fee described in subparagraph (A) by not
24 more than 10 percent, or reduce the fee de-
25 scribed in subparagraph (A) by not more than

1 50 percent, based on the extent to which the
2 contracting administrator, in the determination
3 of the Secretary, meets performance require-
4 ments established by the Secretary, in at least
5 the following areas:

6 “(i) Reducing administrative costs
7 and promoting administrative simplifica-
8 tion for beneficiaries.

9 “(ii) Promoting high quality clinical
10 care.

11 “(iii) Providing high quality customer
12 service to beneficiaries.

13 “(C) NON-RENEWAL.—The Secretary may
14 not renew a contract to offer a community
15 health insurance option under this section with
16 any contracting entity that has been assessed
17 more than one reduction under subparagraph
18 (B) during the contract period.

19 “(8) LIMITATION.—Notwithstanding the terms
20 of a contract under this subsection, the Secretary
21 shall negotiate the reimbursement rates for purposes
22 of subsection (b)(6).

23 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated, such sums as may be
25 necessary to carry out this section.”.

1 **Subtitle C—Affordable Coverage**
2 **for All Americans**

3 **SEC. 151. SUPPORT FOR AFFORDABLE HEALTH COVERAGE.**

4 (a) IN GENERAL.—Title XXXI of the Public Health
5 Service Act, as added by section 142(a), is amended by
6 inserting after subtitle A the following:

7 **“Subtitle B—Making Coverage**
8 **Affordable**

9 **“SEC. 3111. SUPPORT FOR AFFORDABLE HEALTH COV-**
10 **ERAGE.**

11 “(a) COST SHARING FOR A BASIC PLAN.—

12 “(1) BASIC PLAN.—The Secretary shall estab-
13 lish at least the following tiers of cost sharing for el-
14 igible individuals:

15 “(A) A tier for a basic plan in which—

16 “(i) a qualified health plan shall pro-
17 vide coverage for not less than 76 percent
18 of the total allowed costs of the benefit
19 provided; and

20 “(ii) the out of pocket limitation for
21 the plan shall not be greater than the out
22 of pocket limitation applicable under sec-
23 tion 223(d)(2) of the Internal Revenue
24 Code of 1986.

25 “(B) A tier in which—

1 “(i) the coverage percentage is equal
2 to the coverage percentage of the basic
3 plan increased by 8 percentage points; and

4 “(ii) the dollar value of the out of
5 pocket limitation is 50 percent of the dol-
6 lar value of the out of pocket limitation of
7 the basic plan.

8 “(C) A tier in which—

9 “(i) the coverage percentage is equal
10 to the coverage percentage of the basic
11 plan increased by 17 percentage points;
12 and

13 “(ii) the dollar value of the out of
14 pocket limitation that is 20 percent of the
15 dollar value of the out of pocket limitation
16 of the basic plan.

17 “(2) OUT OF POCKET.—For purposes of this
18 section, the term ‘out of pocket’ shall include all ex-
19 penditures for covered qualified medical expenses (as
20 provided for with respect to high deductible health
21 plans under section 223(d)(2) of the Internal Rev-
22 enue Code of 1986).

23 “(b) PAYMENT OF CREDITS.—

24 “(1) IN GENERAL.—The Secretary shall, with
25 respect to an eligible individual (as defined in sub-

1 section (i)) and on behalf of such individual, pay an
2 annual premium credit to the Gateway through
3 which the individual is enrolled in the qualified
4 health plan involved. Such Gateway shall remit an
5 amount equal to such credit to the qualified health
6 plan in which such individual is enrolled.

7 “(2) AMOUNT.—

8 “(A) IN GENERAL.—Subject to the index-
9 ing provision described in paragraph (6), and
10 the limitation described in paragraph (4), the
11 amount of an annual credit with respect to an
12 eligible individual under subparagraph (A) shall
13 be an amount determined by the Secretary so
14 that the eligible individual involved is not re-
15 quired to pay in the case of an individual with
16 an adjusted gross income that does not exceed
17 400 percent of the poverty line for a family of
18 the size involved, an amount that exceeds 12.5
19 percent of such individual’s income for the year
20 involved.

21 “(B) REDUCTIONS BASED ON INCOME.—

22 The amount that an eligible individual is re-
23 quired to pay under subparagraph (A) shall be
24 ratably reduced to 1 percent of income in the
25 case of an eligible individual with an adjusted

1 “(II) are offered in the commu-
2 nity rating area in which the indi-
3 vidual resides;

4 “(ii) with respect to an individual en-
5 rolling in coverage whose income exceeds
6 200, but does not exceed 300, percent of
7 the poverty line for a family of the size in-
8 volved for the year, the weighted average
9 annual premium of the 3 lowest cost quali-
10 fied health plans that—

11 “(I) meet the criteria for cost
12 sharing and out of pocket limits de-
13 scribed in subsection (a)(1)(B); and

14 “(II) are offered in the commu-
15 nity rating area in which the indi-
16 vidual resides; and

17 “(iii) with respect to an individual en-
18 rolling in coverage whose income exceeds
19 300, but does not exceed 400, percent of
20 the poverty line for a family of the size in-
21 volved for the year, the weighted average
22 annual premium of the 3 lowest cost quali-
23 fied health plans that—

1 “(I) meet the criteria for cost
2 sharing and out of pocket limits de-
3 scribed in subsection (a)(1)(A); and

4 “(II) are offered in the commu-
5 nity rating area in which the indi-
6 vidual resides.

7 “(C) INDIVIDUALS ALLOWED TO ENROLL
8 IN ANY PLAN.—Nothing in this section shall be
9 construed to prohibit a qualified individual from
10 enrolling in any qualified health plan.

11 “(D) LIMITATION.—In determining the 3
12 lowest cost health plans for purposes of this
13 paragraph, the community health insurance op-
14 tion shall not be considered.

15 “(5) METHOD OF CALCULATION.—

16 “(A) CALCULATION OF CREDIT BASED ON
17 ESSENTIAL HEALTH CARE BENEFITS.—In the
18 case of a qualified health plan that provides re-
19 imbursement for benefits that are not included
20 in the essential health benefits established by
21 the Secretary under section 3103(a)(1)(A), the
22 reference premium shall be determined for pur-
23 poses of paragraph (2) without regard to such
24 reimbursement.

1 “(B) RISK ADJUSTMENT.—The reference
2 premium shall be determined for a standard
3 population.

4 “(C) RULE IN CASE OF FEWER PLANS.—
5 In any case in which there are less than 3
6 qualified health plans offered in the community
7 rating area in which the individual resides, the
8 determinations made under paragraph (2) shall
9 be based on the number of such qualified plans
10 that are actually offered in the area.

11 “(6) INDEXING.—Beginning with calendar
12 years after 2013, the percentages described in para-
13 graph (2) that specify the portion of the reference
14 premium that an individual or family is responsible
15 for paying shall be annually adjusted by a percent-
16 age that is equal to the percentage increase or de-
17 crease in the medical care component of the Con-
18 sumer Price Index for all urban consumers (U.S.
19 city average) during the preceding calendar year.

20 “(c) STATE FLEXIBILITY.—A State may make pay-
21 ments to or on behalf of an eligible individual that are
22 greater than the amounts required under this section.

23 “(d) ELIGIBILITY DETERMINATIONS.—

1 “(2) CALCULATION OF ELIGIBILITY.—For pur-
2 poses of paragraph (1), the Secretary shall establish
3 rules that permit eligibility to be calculated based
4 on—

5 “(A) the applicant’s adjusted gross income
6 for the second preceding taxable year; or

7 “(B) in the case of an individual who is
8 seeking payment under this section based on
9 claiming a significant decrease in adjusted
10 gross income—

11 “(i) the applicant’s adjusted gross in-
12 come for the most recent period otherwise
13 practicable; or

14 “(ii) the applicant’s declaration of es-
15 timated annual adjusted gross income for
16 the year involved.

17 “(3) DETERMINING ELIGIBILITY.—

18 “(A) AUTHORITY OF THE SECRETARY.—

19 “(i) IN GENERAL.—The Secretary
20 shall have the authority to make deter-
21 minations (including redeterminations)
22 with respect to the eligibility of individuals
23 submitting applications for credits under
24 this section. The Secretary shall verify,
25 through the Internal Revenue Service, the

1 income data received from individuals sub-
2 mitting applications for credits under this
3 section.

4 “(ii) AUTHORITY TO USE TAX RE-
5 TURNS.—To be eligible to receive a credit
6 under this section, an individual shall au-
7 thorize the disclosure of the tax return in-
8 formation of the individual as provided for
9 in section 6103(l)(21) of the Internal Rev-
10 enue Code.

11 “(B) DELEGATION OF AUTHORITY.—Ex-
12 cept under the conditions described in subpara-
13 graph (D), the Secretary shall delegate to a
14 Gateway (and, upon request from such State or
15 States, to the State or States in which such
16 Gateway operates) the authority to carry out
17 the activities described in subparagraph (A).
18 The Gateway may consult with the Internal
19 Revenue Service to verify income data received
20 from individuals submitting applications for
21 credits under this section.

22 “(C) REQUIREMENT FOR CONSISTENCY.—
23 A Gateway (and, as applicable, the State or
24 States in which such Gateway operates) shall
25 carry out the activities described in subpara-

1 graph (B) in a manner that is consistent with
2 the regulations promulgated under paragraph
3 (1).

4 “(D) REVOCATION OF AUTHORITY.—If the
5 Secretary determines that a Gateway (or the
6 State or States in which such Gateway oper-
7 ates) is carrying out the activities described in
8 subparagraph (A) in a manner that is substan-
9 tially inconsistent with the regulations promul-
10 gated under paragraph (1), the Secretary may,
11 after notice and opportunity for a hearing, re-
12 voke the delegation of authority under subpara-
13 graph (A). If the Secretary revokes the delega-
14 tion of authority, the references to a Gateway
15 in subparagraph (E) and (F) shall be deemed
16 to be references to the Secretary.

17 “(E) REQUIREMENT TO REPORT CHANGE
18 IN STATUS.—

19 “(i) IN GENERAL.—An individual that
20 has been determined to be eligible for sub-
21 sidies shall notify the Gateway of any
22 changes that may affect such eligibility in
23 a manner specified by the Secretary.

24 “(ii) REDETERMINATION.—If the
25 Gateway receives a notice from an indi-

1 Gateway, or to a State agency for a determina-
2 tion under this section.

3 “(D) ASSISTANCE.—A Gateway, or a State
4 agency under this section, shall assist individ-
5 uals in the filing of applications under para-
6 graph (1)(A).

7 “(5) RECONCILIATION.—

8 “(A) FILING OF STATEMENT.—In the case
9 of an individual who has received payments
10 under this section for a year and who is claim-
11 ing a significant decrease (as determined by the
12 Secretary) in adjusted gross income from such
13 year, such individual shall file with the Sec-
14 retary an income reconciliation statement, at
15 such time, in such manner, and containing such
16 information as the Secretary may require.

17 “(B) RECONCILIATION.—

18 “(i) IN GENERAL.—Based on and
19 using the adjusted gross income reported
20 in the statement filed by an individual
21 under subparagraph (A), the Secretary
22 shall compute the amount of payments
23 that should have been provided to the indi-
24 vidual for the year involved.

25 “(ii) OVERPAYMENT OF PAYMENTS.—

1 “(I) IN GENERAL.—Subject to
2 the limitation in subclause (II), if the
3 amount of payments provided to an
4 individual for a year under this sec-
5 tion was significantly greater (as de-
6 termined by the Secretary) than the
7 amount computed under clause (i),
8 the individual shall be liable to the
9 Secretary for such excess amount.
10 The Secretary may establish methods
11 under which such liability may be as-
12 sessed through a reduction in the
13 amount of any credit otherwise appli-
14 cable under section 3111 with respect
15 to such individual.

16 “(II) LIMITATION.—With respect
17 to any individual described in sub-
18 clause (I) who had a verified adjusted
19 gross income that did not exceed 400
20 percent of the poverty line for a fam-
21 ily of the size involved for such year,
22 the amount of any repayment under
23 such subclause (I) shall not exceed—

1 dures to enable the Internal Revenue Serv-
2 ice to administer this subparagraph with
3 respect to the collection of overpayments.

4 “(C) FAILURE TO FILE.—In the case of an
5 individual who fails to file a statement for a
6 year as required under subparagraph (A), the
7 individual shall not be eligible for further pay-
8 ments until such statement is filed. The Sec-
9 retary shall waive the application of this sub-
10 paragraph if the individual establishes, to the
11 satisfaction of the Secretary, good cause for the
12 failure to file the statement on a timely basis.

13 “(D) DETERMINATIONS.—The Secretary
14 shall make determinations with respect to state-
15 ments submitted under this paragraph based on
16 income data from the most recent tax return
17 filed by the individual.

18 “(6) DETERMINATIONS MADE WITH RESPECT
19 TO SAME TAXABLE YEARS.—In making determina-
20 tions under this section with respect to adjusted
21 gross income as compared to the poverty line, the
22 Secretary shall ensure that the poverty line data
23 used relates to the same taxable year for which the
24 adjusted gross income is determined.

1 “(7) OUTREACH.—The Gateway shall conduct
2 outreach activities to provide information to individ-
3 uals that may potentially be eligible for payments
4 under this section. Such activities shall include infor-
5 mation on the application process with respect to
6 such payments.

7 “(e) EXCLUSION FROM INCOME.—Amounts received
8 by an individual under this section shall not be considered
9 as income, and shall not be taken into account in deter-
10 mining assets or resources, for the month of receipt and
11 the following 8 months, for purposes of determining the
12 eligibility of such individual, or any other individual, for
13 benefits or assistance, or the amount or extent of benefits
14 or assistance, under any Federal program or under any
15 State or local program financed in whole or in part with
16 Federal funds.

17 “(f) CONFLICT.—A Gateway may not establish rules
18 that conflict with or prevent the application of regulations
19 promulgated by the Secretary under this title.

20 “(g) NO FEDERAL FUNDING.—Nothing in this Act
21 shall allow Federal payments for individuals who are not
22 lawfully present in the United States.

23 “(h) APPROPRIATION.—Out of any funds in the
24 Treasury of the United States not otherwise appropriated,

1 there are appropriated such sums as may be necessary to
2 carry out this section for each fiscal year.

3 **“SEC. 3112. SMALL BUSINESS HEALTH OPTIONS PROGRAM**

4 **CREDIT.**

5 “(a) **CALCULATION OF CREDIT.**—For each calendar
6 year beginning in calendar year 2010, in the case of an
7 employer that is a qualified small employer, the Secretary
8 shall make a payment to such qualified small employer
9 in the amount described in subsection (b).

10 “(b) **GENERAL CREDIT AMOUNT.**—For purposes of
11 this section:

12 “(1) **IN GENERAL.**—The credit amount de-
13 scribed in this subsection shall be the product of—

14 “(A) the applicable amount specified in
15 paragraph (2);

16 “(B) the employer size factor specified in
17 paragraph (3); and

18 “(C) the percentage of year factor specified
19 in paragraph (4).

20 “(2) **APPLICABLE AMOUNT.**—For purposes of
21 paragraph (1):

22 “(A) **IN GENERAL.**—The applicable
23 amount shall be equal to—

1 “(i) \$1,000 for each employee of the
2 employer who receives self-only health in-
3 surance coverage through the employer;

4 “(ii) \$2,000 for each employee of the
5 employer who receives family health insur-
6 ance coverage through the employer; and

7 “(iii) \$1,500 for each employee of the
8 employer who receives health insurance
9 coverage for two adults or one adult and
10 one or more children through the employer.

11 “(B) BONUS FOR PAYMENT OF GREATER
12 PERCENTAGE OF PREMIUMS.—The applicable
13 amount specified in subparagraph (A) shall be
14 increased by \$200 in the case of subparagraph
15 (A)(i), \$400 in the case of subparagraph
16 (A)(ii), and \$300 in the case of subparagraph
17 (A)(iii), for each additional 10 percent of the
18 qualified employee health insurance expenses
19 exceeding 60 percent which are paid by the
20 qualified small employer.

21 “(3) EMPLOYER SIZE FACTOR.—For purposes
22 of paragraph (1), the employer size factor shall be
23 the percentage determined in accordance with the
24 following:

1 “(A) With respect to an employer with
2 more than 10, but not more than 20, full-time
3 employees, the percentage shall be 80 percent.

4 “(B) With respect to an employer with
5 more than 20, but not more than 30, full-time
6 employees, the percentage shall be 50 percent.

7 “(C) With respect to an employer with
8 more than 30, but not more than 40, full-time
9 employees, the percentage shall be 40 percent.

10 “(D) With respect to an employer with
11 more than 40, but not more than 50, full-time
12 employees, the percentage shall be 20 percent.

13 “(E) With respect to an employer with
14 more than 50 full-time employees, the percent-
15 age shall be 0 percent.

16 “(4) PERCENTAGE OF YEAR FACTOR.—For pur-
17 poses of paragraph (1), the percentage of year factor
18 shall be equal to the ratio of—

19 “(A) the number of months during the tax-
20 able year for which the employer paid or in-
21 curred qualified employee health insurance ex-
22 penses; and

23 “(B) 12.

24 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
25 poses of this section:

1 ings from self-employment in the
2 preceding taxable year;

3 “(bb) had not greater than
4 \$50,000 in net earnings or not
5 greater than \$150,000 in gross
6 earnings from self-employment in
7 the preceding taxable year; and

8 “(cc) has elected not to re-
9 ceive a credit under section 3111.

10 “(B) LIMITATION.—An employer may not
11 receive a credit under this section for more than
12 three consecutive years.

13 “(2) QUALIFIED EMPLOYEE HEALTH INSUR-
14 ANCE EXPENSES.—

15 “(A) IN GENERAL.—The term ‘qualified
16 employee health insurance expenses’ means any
17 amount paid by an employer or an employee of
18 such employer for health insurance coverage
19 under this Act to the extent such amount is for
20 coverage—

21 “(i) provided to any employee (as de-
22 fined in subsection 3001(a)(3) of such
23 Act), or

24 “(ii) for the employer, in the case of
25 a self-employed individual.

1 “(B) EXCEPTION FOR AMOUNTS PAID
2 UNDER SALARY REDUCTION ARRANGEMENTS.—
3 No amount paid or incurred for health insur-
4 ance coverage pursuant to a salary reduction
5 arrangement shall be taken into account for
6 purposes of subparagraph (A).

7 “(3) FULL-TIME EMPLOYEE.—The term ‘full
8 time employee’ means, with respect to any period, an
9 employee (as defined in section 3001(a)(3)) of an
10 employer if the average number of hours worked by
11 such employee in the preceding taxable year for such
12 employer was at least 35 hours per week.

13 “(d) INFLATION ADJUSTMENT.—

14 “(1) IN GENERAL.—For each calendar year
15 after 2009, the dollar amounts specified in sub-
16 sections (b)(2)(A), (b)(2)(B), and (c)(1)(A)(iii)
17 (after the application of this paragraph) shall be the
18 amounts in effect in the preceding calendar year or,
19 if greater, the product of—

20 “(A) the corresponding dollar amount
21 specified in such subsection; and

22 “(B) the ratio of the index of wage infla-
23 tion (as determined by the Bureau of Labor
24 Statistics) for August of the preceding calendar

1 year to such index of wage inflation for August
2 of 2008.

3 “(2) ROUNDING.—If any amount determined
4 under paragraph (1) is not a multiple of \$100, such
5 amount shall be rounded to the next lowest multiple
6 of \$100.

7 “(e) APPLICATION OF CERTAIN RULES IN DETER-
8 MINATION OF EMPLOYER SIZE.—For purposes of this sec-
9 tion:

10 “(1) APPLICATION OF AGGREGATION RULE FOR
11 EMPLOYERS.—All persons treated as a single em-
12 ployer under subsection (b), (c), (m), or (o) of sec-
13 tion 414 of the Internal Revenue Code of 1986 shall
14 be treated as 1 employer.

15 “(2) EMPLOYERS NOT IN EXISTENCE IN PRE-
16 CEDING YEAR.—In the case of an employer which
17 was not in existence for the full preceding taxable
18 year, the determination of whether such employer
19 meets the requirements of this section shall be based
20 on the average number of full-time employees that it
21 is reasonably expected such employer will employ on
22 business days in the employer’s first full taxable
23 year.

1 “(3) PREDECESSORS.—Any reference in this
2 subsection to an employer shall include a reference
3 to any predecessor of such employer.”.

4 **SEC. 152. PROGRAM INTEGRITY.**

5 (a) IN GENERAL.—Subsection (l) of section 6103 of
6 the Internal Revenue Code of 1986 is amended by adding
7 at the end the following new paragraph:

8 “(21) VOLUNTARY AUTHORIZATION FOR IN-
9 COME VERIFICATION.—

10 “(A) VOLUNTARY AUTHORIZATION.—The
11 Secretary shall provide a mechanism for each
12 taxpayer to indicate whether such taxpayer au-
13 thorizes the Secretary to disclose to the Sec-
14 retary of Health and Human Services (or, pur-
15 suant to a delegation described in subsection
16 (d)(4)(B), to a State or a Gateway (as defined
17 in section 3101 of the Public Health Service
18 Act) return information of a taxpayer who may
19 be eligible for credits under section 3111 of the
20 Public Health Service Act.

21 “(B) PROVISION OF INFORMATION.—If a
22 taxpayer authorizes the disclosure described in
23 subparagraph (A), the Secretary shall disclose
24 to the Secretary of Health and Human Services
25 (or, pursuant to a delegation described in sub-

1 section (d)(4)(B), to a State or a Gateway) the
2 minimum necessary amount of information nec-
3 essary to establish whether such individual is el-
4 igible for credits under section 3111 of the
5 Public Health Service Act.

6 “(C) RESTRICTION ON USE OF DISCLOSED
7 INFORMATION.—Return information disclosed
8 under subparagraph (A) may be used by the
9 Secretary (or, pursuant to a delegation de-
10 scribed in subsection (d)(4)(B), a State or a
11 Gateway) only for the purposes of, and to the
12 extent necessary in, establishing the appropriate
13 amount of any payments under section 3111 of
14 the Public Health Service Act.”.

15 (b) COLLECTION OF AMOUNTS.—Section 6305(a) of
16 the Internal Revenue Code of 1986 is amended by insert-
17 ing “or under section 3111 of the Public Health Service
18 Act” after “Social Security Act”.

19 (c) CONFORMING AMENDMENTS.—

20 (1) Paragraph (3) of section 6103(a) of such
21 Code is amended by striking “or (20)” and inserting
22 “(20), or (21)”.

23 (2) Paragraph (4) of section 6103(p) of such
24 Code is amended by striking “(l)(10), (16), (18),

1 (19), or (20)” each place it appears and inserting
2 “(1)(10), (16), (18), (19), (20), or (21)”.

3 (3) Paragraph (2) of section 7213(a) of such
4 Code is amended by striking “or (20)” and inserting
5 “(20), or (21)”.

6 **Subtitle D—Shared Responsibility**
7 **for Health Care**

8 **SEC. 161. INDIVIDUAL RESPONSIBILITY.**

9 (a) PAYMENTS.—

10 (1) IN GENERAL.—Subchapter A of chapter 1
11 of the Internal Revenue Code of 1986 (relating to
12 determination of tax liability) is amended by adding
13 at the end the following new part:

14 **“PART VIII—SHARED RESPONSIBILITY**
15 **PAYMENTS**

“Sec. 59B. Shared responsibility payments.

16 **“SEC. 59B. SHARED RESPONSIBILITY PAYMENTS.**

17 “(a) REQUIREMENT.—Every individual shall ensure
18 that such individual, and each dependent of such indi-
19 vidual, is covered under qualifying coverage at all times
20 during the taxable year.

21 “(b) PAYMENT.—

22 “(1) IN GENERAL.—In the case of any indi-
23 vidual who did not have in effect qualifying coverage
24 (as defined in section 3116 of the Public Health

1 Service Act) for any month during the taxable year,
2 there is hereby imposed for the taxable year, in addi-
3 tion to any other amount imposed by this subtitle,
4 an amount equal to the amount established under
5 paragraph (2). Any amount to be imposed under
6 this subsection with respect to a child that does not
7 have in effect qualifying coverage shall be imposed
8 upon the custodial parent or guardian of such child.

9 “(2) AMOUNT ESTABLISHED.—

10 “(A) REQUIREMENT TO ESTABLISH.—Not
11 later than June 30 of each calendar year, the
12 Secretary, in consultation with the Secretary of
13 Health and Human Services and with the
14 States, shall establish an amount for purposes
15 of paragraph (1).

16 “(B) EFFECTIVE DATE.—The amount es-
17 tablished under subparagraph (A) shall be ef-
18 fective with respect to the taxable year following
19 the date on which the amount under subpara-
20 graph (A) is established.

21 “(C) REQUIRED CONSIDERATION.—Subject
22 to the limitation described in subparagraph (D),
23 in establishing the amount under subparagraph
24 (A), the Secretary shall seek to establish the
25 minimum practicable amount that can accom-

1 plish the goal of enhancing participation in
2 qualifying coverage (as so defined).

3 “(D) LIMITATION.—In no case may the
4 Secretary establish an amount that is less than
5 50 percent of the average annual premium
6 (family coverage in the case of a failure with re-
7 spect to more than one individual) under the
8 basic plan described in section 3111(a)(1)(A) of
9 the Public Health Service Act, as determined by
10 the Secretary of Health and Human Services
11 for the calendar year preceding the calendar
12 year in which the taxable year begins.

13 “(c) EXEMPTIONS.—Subsection (b) shall not apply to
14 any individual—

15 “(1) with respect to any month if such month
16 occurs during any period in which such individual
17 did not have qualifying coverage (as so defined) for
18 a period of less than 90 days,

19 “(2) who is a resident of a State that is not a
20 participating State or an establishing State (as such
21 terms are defined in section 3104 of the Public
22 Health Service Act),

23 “(3) who is an Indian as defined in section 4
24 of the Indian Health Care Improvement Act,

1 “(4) for whom affordable health care coverage
2 is not available (as such terms are defined by the
3 Secretary of Health and Human Services under sec-
4 tion 3103 of the Public Health Service Act), or

5 “(5) described in section 3116(a)(5)(C) of the
6 Public Health Service Act.

7 “(d) COORDINATION WITH OTHER PROVISIONS.—

8 “(1) NOT TREATED AS TAX FOR CERTAIN PUR-
9 POSES.—The amount imposed by this section shall
10 not be treated as a tax imposed by this chapter for
11 purposes of determining—

12 “(A) the amount of any credit allowable
13 under this chapter, or

14 “(B) the amount of the minimum tax im-
15 posed by section 55.

16 “(2) TREATMENT UNDER SUBTITLE F.—For
17 purposes of subtitle F, the amount imposed by this
18 section shall be treated as if it were a tax imposed
19 by section 1.

20 “(3) SECTION 15 NOT TO APPLY.—Section 15
21 shall not apply to the amount imposed by this sec-
22 tion.

23 “(4) SECTION NOT TO AFFECT LIABILITY OF
24 POSSESSIONS, ETC.—This section shall not apply for
25 purposes of determining liability to any possession of

1 the United States. For purposes of section 932 and
2 7654, the amount imposed under this section shall
3 not be treated as a tax imposed by this chapter.

4 “(e) REGULATIONS.—The Secretary may prescribe
5 such regulations as may be appropriate to carry out the
6 purposes of this section.”.

7 (2) CLERICAL AMENDMENT.—The table of
8 parts for subchapter A of chapter 1 of such Code is
9 amended by adding at the end the following new
10 item:

“PART VIII—SHARED RESPONSIBILITY PAYMENTS”.

11 (3) EFFECTIVE DATE.—The amendments made
12 by this section shall apply to taxable years beginning
13 after December 31, 2010.

14 (b) REPORTING OF HEALTH INSURANCE COV-
15 ERAGE.—

16 (1) IN GENERAL.—Part III of subchapter A of
17 chapter 61 of the Internal Revenue Code of 1986 is
18 amended by inserting after subpart B the following
19 new subpart:

20 **“Subpart D—Information Regarding Health**
21 **Insurance Coverage**

“Sec. 6055. Reporting of health insurance coverage.

1 **“SEC. 6055. REPORTING OF HEALTH INSURANCE COV-**
2 **ERAGE.**

3 “(a) IN GENERAL.—Every person who provides
4 health insurance that is qualifying coverage shall make a
5 return described in subsection (b).

6 “(b) FORM AND MANNER OF RETURN.—A return is
7 described in this subsection if such return—

8 “(1) is in such form as the Secretary pre-
9 scribes,

10 “(2) contains—

11 “(A) the name, address, and taxpayer
12 identification number of each individual who is
13 covered under health insurance that is quali-
14 fying coverage provided by such person, and

15 “(B) the number of months during the cal-
16 endar year during which each such individual
17 was covered under such health insurance, and

18 “(3) such other information as the Secretary
19 may prescribe.

20 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
21 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
22 PORTED.—

23 “(1) IN GENERAL.—Every person required to
24 make a return under subsection (a) shall furnish to
25 each individual whose name is required to be set
26 forth in such return a written statement showing—

1 “(A) the name, address, and phone num-
2 ber of the information contact of the person re-
3 quired to make such return, and

4 “(B) the number of months during the cal-
5 endar year during which such individual was
6 covered under health insurance that is quali-
7 fying coverage provided by such person.

8 “(2) TIME FOR FURNISHING STATEMENTS.—
9 The written statement required under paragraph (1)
10 shall be furnished on or before January 31 of the
11 year following the calendar year for which the return
12 under subsection (a) was required to be made.

13 “(d) QUALIFYING COVERAGE.—For purposes of this
14 section, the term ‘qualifying coverage’ has the meaning
15 given such term under section 3116 of the Public Health
16 Service Act.”.

17 (2) CONFORMING AMENDMENTS.—The table of
18 subparts for part III of subchapter A of chapter 61
19 of such Code is amended by inserting after the item
20 relating to subpart C the following new item:

 “SUBPART D—HEALTH INSURANCE COVERAGE”.

21 (3) EFFECTIVE DATE.—The amendments made
22 by this section shall apply to taxable years beginning
23 after December 31, 2010.

24 (c) NOTIFICATION OF NONENROLLMENT.—Not later
25 than June 30 of each year, the Secretary of the Treasury,

1 acting through the Internal Revenue Service and in con-
2 sultation with the Secretary of Health and Human Serv-
3 ices, shall send a notification each individual who files an
4 individual income tax return and who is not enrolled in
5 qualifying coverage (as defined in section 3116 of the Pub-
6 lic Health Service Act). Such notification shall contain in-
7 formation on the services available through the Gateway
8 operating in the State in which such individual resides.

9 **SEC. 162. NOTIFICATION ON THE AVAILABILITY OF AF-**
10 **FORDABLE HEALTH CHOICES.**

11 The Fair Labor Standards Act of 1938 is amended
12 by inserting after section 18 (29 U.S.C. 218) the fol-
13 lowing:

14 **“SEC. 18A. NOTICE TO EMPLOYEES.**

15 “(a) IN GENERAL.—In accordance with regulations
16 promulgated by the Secretary, an employer to which this
17 Act applies, shall provide to each employee at the time
18 of hiring (or with respect to current employees, within 90
19 days of the date on which a State becomes an establishing
20 or participating State under section 3104 of the Public
21 Health Service Act), written notice informing the em-
22 ployee of the existence of the American Health Benefits
23 Gateway, including a description of the services provided
24 by such Gateway and the manner in which the employee
25 may contact the Gateway to request assistance.

1 “(b) EFFECTIVE DATE.—Subsection (a) shall take
2 effect with respect to employers in a State beginning 90
3 days after the date on which the State becomes an estab-
4 lishing or participating State under section 3104 of the
5 Public Health Service Act.”.

6 **SEC. 163. SHARED RESPONSIBILITY OF EMPLOYERS.**

7 Subtitle B of title XXXI of the Public Health Service
8 Act, as amended by section 153, is further amended by
9 adding at the end the following:

10 **“SEC. 3115. SHARED RESPONSIBILITY OF EMPLOYERS.**

11 “(a) EMPLOYEES NOT OFFERED COVERAGE.—An
12 employer shall make a payment to the Secretary in the
13 amount described in subsection (b) with respect to each
14 employee—

15 “(1) who is not offered qualifying coverage by
16 such employer during each month where such em-
17 ployee is not offered qualifying coverage; or

18 “(2) on behalf of whom such employer is not
19 contributing at least 60 percent of the monthly pre-
20 miums for such coverage for each such month.

21 “(b) AMOUNT.—

22 “(1) IN GENERAL.—The annual amount de-
23 scribed in this subsection shall be equal to \$750 for
24 each full-time employee described in subsection (a).

25 Such amount shall be pro-rated with respect to each

1 month in which subsection (a) applies with respect
2 to an employee.

3 “(2) PRO RATA APPLICATION FOR PART-TIME
4 EMPLOYEES.—The provisions of paragraph (1) shall
5 apply with respect to part-time employees employed
6 by the employer, except that the annual payment
7 amount described in such paragraph shall be re-
8 duced to \$375 for each part-time employee.

9 “(c) PROCEDURES.—The Secretary shall develop pro-
10 cedures for making determinations with respect to quali-
11 fying coverage and for making the payments required
12 under subsection (a). Such procedures shall provide for
13 the making of payments on a quarterly basis.

14 “(d) USE OF FUNDS.—Amounts shall be collected
15 under subsection (a) and be available for obligation only
16 to the extent and in the amount provided in advance in
17 appropriations Acts. Such amounts are authorized to re-
18 main available until expended.

19 “(e) INFLATION ADJUSTMENT.—Beginning with cal-
20 endar years after 2013, the amounts described in sub-
21 section (b) shall be adjusted by the Secretary by notice,
22 published in the Federal Register, for each fiscal year to
23 reflect the total percentage change that occurred in the
24 medical care component of the Consumer Price Index for

1 all urban consumers (all items; U.S. city average) during
2 the preceding calendar year.

3 “(f) EXEMPTION FOR SMALL EMPLOYERS.—

4 “(1) IN GENERAL.—For purposes of this sec-
5 tion, the term ‘employer’ means an employer that
6 employs more than 25 employees on business days
7 during the preceding calendar year.

8 “(2) APPLICATION OF AGGREGATION RULE FOR
9 EMPLOYERS.—All persons treated as a single em-
10 ployer under subsection (b), (c), (m), or (o) of sec-
11 tion 414 of the Internal Revenue Code of 1986 shall
12 be treated as 1 employer.

13 “(3) EMPLOYERS NOT IN EXISTENCE IN PRE-
14 CEDING YEAR.—In the case of an employer which
15 was not in existence throughout the preceding cal-
16 endar year, the determination of whether such em-
17 ployer is a small or large employer shall be based on
18 the average number of employees that it is reason-
19 ably expected such employer will employ on business
20 days in the current calendar year.

21 “(4) PREDECESSORS.—Any reference in this
22 subsection to an employer shall include a reference
23 to any predecessor of such employer.

24 “(g) AUTHORITY TO CERTIFY.—The Secretary, in
25 collaboration with the Secretary of the Treasury and the

1 Secretary of Labor, shall establish procedures for deter-
2 mining the number of employees of employers who are not
3 offered qualifying coverage.

4 “(h) REGULATIONS.—The Secretary, in consultation
5 with the Secretary of Labor, shall promulgate such regula-
6 tions as may be appropriate to carry out activities under
7 this section.

8 **“SEC. 3116. DEFINITIONS.**

9 “(a) IN GENERAL.—In this title:

10 “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible
11 individual’ means an individual who is—

12 “(A) a citizen or national of the United
13 States or an alien lawfully admitted to the
14 United States for permanent residence or an
15 alien lawfully present in the United States;

16 “(B) a qualified individual;

17 “(C) enrolled in a qualified health plan;

18 and

19 “(D) not receiving full benefits coverage
20 under a State child health plan under title XXI
21 of the Social Security Act (42 U.S.C. 1397aa et
22 seq.) (or full benefits coverage under a dem-
23 onstration project funded through such title
24 XXI).

25 “(2) QUALIFIED EMPLOYER.—

1 “(A) IN GENERAL.—The term ‘qualified
2 employer’ means an employer that—

3 “(i) elects to make all full-time em-
4 ployees of such employer eligible for a
5 qualified health plan; and

6 “(ii)(I) in the case of an employer
7 that elects to enroll in a qualified health
8 plan made available through a Gateway in
9 an establishing State, meets criteria (in-
10 cluding criteria regarding the size of a
11 qualified employer) established by such
12 State; or

13 “(II) in the case of an employer that
14 elects to enroll in a qualified health plan
15 made available through a Gateway in a
16 participating State—

17 “(aa) employs fewer than the
18 number of employees specified in sub-
19 paragraph (B); and

20 “(bb) meets criteria established
21 by the Secretary.

22 “(B) NUMBER OF EMPLOYEES.—

23 “(i) ESTABLISHMENT.—The Secretary
24 may by regulation establish the number of

1 employees described in subparagraph
2 (A)(ii)(II)(aa).

3 “(ii) DEFAULT.—If the Secretary
4 does not establish the number described in
5 subparagraph (A)(ii)(II)(aa), such number
6 shall be deemed to be 10.

7 “(3) QUALIFIED HEALTH PLAN.—

8 “(A) IN GENERAL.—The term ‘qualified
9 health plan’ means health plan that—

10 “(i) has in effect a certification (which
11 may include a seal or other indication of
12 approval) that such plan meets the criteria
13 for certification described in section
14 3101(l) issued or recognized by each Gate-
15 way through which such plan is offered;
16 and

17 “(ii) is offered by a health insurance
18 issuer that—

19 “(I) is licensed and in good
20 standing to offer health insurance cov-
21 erage in each State in which such
22 issuer offers health insurance coverage
23 under this title;

24 “(II) agrees to offer at least one
25 qualified health plan in the tier de-

1 scribed in section 3111(a)(1)(A) and
2 at least one plan in the tier described
3 in section 3111(a)(1)(B);

4 “(III) complies with the regula-
5 tions developed by the Secretary
6 under section 3101(l) and such other
7 requirements as an applicable Gate-
8 way may establish; and

9 “(IV) agrees to pay any sur-
10 charge assessed under section
11 3101(d)(5).

12 “(B) INCLUSION OF COMMUNITY HEALTH
13 INSURANCE OPTION.—Any reference in this title
14 to a qualified health plan shall be deemed to in-
15 clude a community health insurance option, un-
16 less specifically provided for otherwise.

17 “(4) QUALIFIED INDIVIDUAL.—

18 “(A) IN GENERAL.—The term ‘qualified
19 individual’ means an individual who is—

20 “(i) residing in a participating State
21 or an establishing State (as defined in sec-
22 tion 3104);

23 “(ii) not incarcerated, except individ-
24 uals in custody pending the disposition of
25 charges;

1 “(iii) not entitled to coverage under
2 the Medicare program under part A of title
3 XVIII of the Social Security Act;

4 “(iv) not enrolled in coverage under
5 the Medicare program under part B of title
6 XVIII of the Social Security Act or under
7 part C of such title; and

8 “(v) not eligible for coverage under—

9 “(I) the Medicaid program under
10 a State plan under title XIX of the
11 Social Security Act (42 U.S.C. 1396
12 et seq.), or under a waiver under sec-
13 tion 1115 of such Act;

14 “(II) the TRICARE program
15 under chapter 55 of title 10, United
16 States Code (as defined in section
17 1072(7) of such title);

18 “(III) the Federal employees
19 health benefits program under chapter
20 89 of title 5, United States Code; or

21 “(IV) employer-sponsored cov-
22 erage (except as provided under sub-
23 paragraph (B)).

24 “(B) EMPLOYEE.—An individual who is el-
25 igible for employer-sponsored coverage shall be

1 deemed to be a qualified individual under sub-
2 paragraph (A) only if such coverage—

3 “(i) does not meet the criteria estab-
4 lished under section 3103 for minimum
5 qualifying coverage; or

6 “(ii) is not affordable (as such term is
7 defined by the Secretary under section
8 3103) for such employee.

9 “(C) INDIVIDUALS AT LESS THAN 150 PER-
10 CENT OF POVERTY.—An individual with an ad-
11 justed gross income that does not exceed 150
12 percent of the poverty line for a family of the
13 size involved shall not be considered a qualified
14 individual for purposes of this title.

15 “(5) QUALIFYING COVERAGE.—The term ‘quali-
16 fying coverage’ means—

17 “(A) a group health plan or health insur-
18 ance coverage—

19 “(i) that an individual is enrolled in
20 on the date of enactment of this title; or

21 “(ii) that is described in clause (i) and
22 that is renewed by an enrollee;

23 “(B) a group health plan or health insur-
24 ance coverage that—

1 “(i) is not described in subparagraph
2 (A); and

3 “(ii) meets or exceeds the criteria for
4 minimum qualifying coverage (as defined
5 in subsection (d));

6 “(C) Medicare coverage under parts A and
7 B of title XVIII of the Social Security Act or
8 under part C of such title;

9 “(D) Medicaid coverage under a State plan
10 under title XIX of the Social Security Act (or
11 under a waiver under section 1115 of such
12 Act), other than coverage consisting solely of
13 benefits under section 1928 of such Act;

14 “(E) coverage under title XXI of the So-
15 cial Security Act;

16 “(F) coverage under the TRICARE pro-
17 gram under chapter 55 of title 10, United
18 States Code;

19 “(G) coverage under the veteran’s health
20 care program under chapter 17 of title 38,
21 United States Code, but only if the coverage for
22 the individual involved is determined by the
23 Secretary to be not less than the coverage pro-
24 vided under a qualified health plan, based on

1 the individual's priority for services as provided
2 under section 1705(a) of such title;

3 “(H) coverage under the Federal employ-
4 ees health benefits program under chapter 89 of
5 title 5, United States Code;

6 “(I) a State health benefits high risk pool;

7 “(J) a health benefit plan under section
8 2504(e) of title 22, United States Code; or

9 “(K) coverage under a qualified health
10 plan.

11 For purposes of this paragraph, an individual shall
12 be deemed to have qualifying coverage if such indi-
13 vidual is an individual described in section 1402(e)
14 and (g) of the Internal Revenue Code of 1986.

15 “(6) ADJUSTED GROSS INCOME.—The term ‘ad-
16 justed gross income’ with respect to an individual
17 has the meaning given such term for purposes of
18 section 62(a) of the Internal Revenue Code of 1986.

19 “(b) INCORPORATION OF ADDITIONAL DEFINI-
20 TIONS.—Unless specifically provided for otherwise, the
21 definitions contained in section 2791 shall apply with re-
22 spect to this title.”.

1 **Subtitle E—Improving Access to**
2 **Health Care Services**

3 **SEC. 171. SPENDING FOR FEDERALLY QUALIFIED HEALTH**
4 **CENTERS (FQHCS).**

5 Section 330(r) of the Public Health Service Act (42
6 U.S.C. 254b(r)) is amended by striking paragraph (1) and
7 inserting the following:

8 “(1) GENERAL AMOUNTS FOR GRANTS.—For
9 the purpose of carrying out this section, in addition
10 to the amounts authorized to be appropriated under
11 subsection (d), there is authorized to be appro-
12 priated the following:

13 “(A) For fiscal year 2010,
14 \$2,988,821,592.

15 “(B) For fiscal year 2011,
16 \$3,862,107,440.

17 “(C) For fiscal year 2012, \$4,990,553,440.

18 “(D) For fiscal year 2013,
19 \$6,448,713,307.

20 “(E) For fiscal year 2014,
21 \$7,332,924,155.

22 “(F) For fiscal year 2015,
23 \$8,332,924,155.

24 “(G) For fiscal year 2016, and each subse-
25 quent fiscal year, the amount appropriated for

1 the preceding fiscal year adjusted by the prod-
2 uct of—

3 “(i) one plus the average percentage
4 increase in costs incurred per patient
5 served; and

6 “(ii) one plus the average percentage
7 increase in the total number of patients
8 served.”.

9 **SEC. 172. OTHER PROVISIONS.**

10 (a) **SETTINGS FOR SERVICE DELIVERY.**—Section
11 330(a)(1) of the Public Health Service Act (42 U.S.C.
12 254b(a)(1)) is amended by adding at the end the fol-
13 lowing: “Required primary health services and additional
14 health services may be provided either at facilities directly
15 operated by the center or at any other inpatient or out-
16 patient settings determined appropriate by the center to
17 meet the needs of its patents.”.

18 (b) **LOCATION OF SERVICE DELIVERY SITES.**—Sec-
19 tion 330(a) of the Public Health Service Act (42 U.S.C.
20 254b(a)) is amended by adding at the end the following:

21 “(3) **CONSIDERATIONS.**—

22 “(A) **LOCATION OF SITES.**—Subject to
23 subparagraph (B), a center shall not be re-
24 quired to locate its service facility or facilities
25 within a designated medically underserved area

1 in order to serve either the residents of its
2 catchment area or a special medically under-
3 served population comprised of migratory and
4 seasonal agricultural workers, the homeless, or
5 residents of public housing, if that location is
6 determined by the center to be reasonably ac-
7 cessible to and appropriate to meet the needs of
8 the medically underserved residents of the cen-
9 ter's catchment area or the special medically
10 underserved population, in accordance with sub-
11 paragraphs (A) and (J) of subsection (k)(3).

12 “(B) LOCATION WITHIN ANOTHER CEN-
13 TER'S AREA.—The Secretary may permit appli-
14 cants for grants under this section to propose
15 the location of a service delivery site within an-
16 other center's catchment area if the applicant
17 demonstrates sufficient unmet need in such
18 area and can otherwise justify the need for ad-
19 ditional Federal resources in the catchment
20 area. In determining whether to approve such a
21 proposal, the Secretary shall take into consider-
22 ation whether collaboration between the two
23 centers exists, or whether the applicant has
24 made reasonable attempts to establish such col-
25 laboration, and shall consider any comments

1 timely submitted by the affected center con-
2 cerning the potential impact of the proposal on
3 the availability or accessibility of services the
4 affected center currently provides or the finan-
5 cial viability of the affected center.”.

6 (c) AFFILIATION AGREEMENTS.—Section
7 330(k)(3)(B) of the Public Health Service Act (42 U.S.C.
8 254b(k)(3)(B)) is amended by inserting before the semi-
9 colon the following: “, including contractual arrangements
10 as appropriate, while maintaining full compliance with the
11 requirements of this section, including the requirements
12 of subparagraph (H) concerning the composition and au-
13 thorities of the center’s governing board, and, except as
14 otherwise provided in clause (ii) of such subparagraph, en-
15 suring full autonomy of the center over policies, direction,
16 and operations related to health care delivery, personnel,
17 finances, and quality assurance”.

18 (d) GOVERNANCE REQUIREMENTS.—Section
19 330(k)(3) of the Public Health Service Act (42 U.S.C.
20 254b(k)(3)) is amended—

21 (1) in subparagraph (H)—

22 (A) in clause (ii), strike “; and” and in-
23 serting “, except that in the case of a public
24 center (as defined in the second sentence of this
25 paragraph), the public entity may retain au-

1 thority to establish financial and personnel poli-
2 cies for the center; and”;

3 (B) in clause (iii), by adding “and” at the
4 end; and

5 (C) by inserting after clause (iii) the fol-
6 lowing:

7 “(iv) in the case of a co-applicant with
8 a public entity, meets the requirements of
9 clauses (i) and (ii);” and

10 (2) in the second sentence, by inserting before
11 the period the following: “that is governed by a
12 board that satisfies the requirements of subpara-
13 graph (H) or that jointly applies (or has applied) for
14 funding with a co-applicant board that meets such
15 requirements”.

16 (e) ADJUSTMENT IN CENTER’S OPERATING PLAN
17 AND BUDGET.—Section 330(k)(3)(I)(i) of the Public
18 Health Service Act (42 U.S.C. 254b(k)(3)(I)(i)) is amend-
19 ed by adding before the semicolon the following: “, which
20 may be modified by the center at any time during the fis-
21 cal year involved if such modifications do not require addi-
22 tional grant funds, do not compromise the availability or
23 accessibility of services currently provided by the center,
24 and otherwise meet the conditions of subsection (a)(3)(B),
25 except that any such modifications that do not comply

1 with this clause, as determined by the health center, shall
2 be submitted to the Secretary for approval”.

3 (f) JOINT PURCHASING ARRANGEMENTS FOR RE-
4 DUCED COST.—Section 330(l) of the Public Health Serv-
5 ice Act (42 U.S.C. 254b(l)) is amended—

6 (1) by striking “The Secretary” and inserting
7 the following:

8 “(1) IN GENERAL.—The Secretary”; and

9 (2) by adding at the end the following:

10 “(2) ASSISTANCE WITH SUPPLIES AND SERV-
11 ICES COSTS.—The Secretary, directly or through
12 grants or contracts, may carry out projects to estab-
13 lish and administer arrangements under which the
14 costs of providing the supplies and services needed
15 for the operation of federally qualified health centers
16 are reduced through collaborative efforts of the cen-
17 ters, through making purchases that apply to mul-
18 tiple centers, or through such other methods as the
19 Secretary determines to be appropriate.”.

20 (g) OPPORTUNITY TO CORRECT MATERIAL FAILURE
21 REGARDING GRANT CONDITIONS.—Section 330(e) of the
22 Public Health Service Act (42 U.S.C. 254b(e)) is amended
23 by adding at the end the following:

24 “(6) OPPORTUNITY TO CORRECT MATERIAL
25 FAILURE REGARDING GRANT CONDITIONS.—If the

1 Secretary finds that a center materially fails to meet
2 any requirement (except for any requirements
3 waived by the Secretary) necessary to qualify for its
4 grant under this subsection, the Secretary shall pro-
5 vide the center with an opportunity to achieve com-
6 pliance (over a period of up to 1 year from making
7 such finding) before terminating the center’s grant.
8 A center may appeal and obtain an impartial review
9 of any Secretarial determination made with respect
10 to a grant under this subsection, or may appeal and
11 receive a fair hearing on any Secretarial determina-
12 tion involving termination of the center’s grant enti-
13 tlement, modification of the center’s service area,
14 termination of a medically underserved population
15 designation within the center’s service area, disallow-
16 ance of any grant expenditures, or a significant re-
17 duction in a center’s grant amount.”.

18 **SEC. 173. FUNDING FOR NATIONAL HEALTH SERVICE**

19 **CORPS.**

20 Section 338H(a) of the Public Health Service Act (42
21 U.S.C. 254q(a)) is amended to read as follows:

22 “(a) **AUTHORIZATION OF APPROPRIATIONS.**—For the
23 purpose of carrying out this section, there is authorized
24 to be appropriated, out of any funds in the Treasury not
25 otherwise appropriated, the following:

1 “(1) For fiscal year 2010, \$320,461,632.

2 “(2) For fiscal year 2011, \$414,095,394.

3 “(3) For fiscal year 2012, \$535,087,442.

4 “(4) For fiscal year 2013, \$691,431,432.

5 “(5) For fiscal year 2014, \$893,456,433.

6 “(6) For fiscal year 2015, \$1,154,510,336.

7 “(7) For fiscal year 2016, and each subsequent
8 fiscal year, the amount appropriated for the pre-
9 ceding fiscal year adjusted by the product of—

10 “(A) one plus the average percentage in-
11 crease in the costs of health professions edu-
12 cation during the prior fiscal year; and

13 “(B) one plus the average percentage
14 change in the number of individuals residing in
15 health professions shortage areas designated
16 under section 333 during the prior fiscal year,
17 relative to the number of individuals residing in
18 such areas during the previous fiscal year.”.

19 **SEC. 174. NEGOTIATED RULEMAKING FOR DEVELOPMENT**
20 **OF METHODOLOGY AND CRITERIA FOR DES-**
21 **IGNATING MEDICALLY UNDERSERVED POPU-**
22 **LATIONS AND HEALTH PROFESSIONS SHORT-**
23 **AGE AREAS.**

24 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (in this section referred to as the
3 “Secretary”) shall establish, through a negotiated
4 rulemaking process under subchapter 3 of chapter 5
5 of title 5, United States Code, a comprehensive
6 methodology and criteria for designation of—

7 (A) medically underserved populations in
8 accordance with section 330(b)(3) of the Public
9 Health Service Act (42 U.S.C. 254b(b)(3));

10 (B) health professions shortage areas
11 under section 332 of the Public Health Service
12 Act (42 U.S.C. 254e).

13 (2) FACTORS TO CONSIDER.—In establishing
14 the methodology and criteria under paragraph (1),
15 the Secretary—

16 (A) shall consult with relevant stakeholders
17 who will be significantly affected by a rule
18 (such as national, State and regional organiza-
19 tions representing affected entities), State
20 health offices, community organizations, health
21 centers and other affected entities, and other
22 interested parties; and

23 (B) shall take into account—

24 (i) the timely availability and appro-
25 priateness of data used to determine a des-

1 ignation to potential applicants for such
2 designations;

3 (ii) the impact of the methodology and
4 criteria on communities of various types
5 and on health centers and other safety net
6 providers;

7 (iii) the degree of ease or difficulty
8 that will face potential applicants for such
9 designations in securing the necessary
10 data; and

11 (iv) the extent to which the method-
12 ology accurately measures various barriers
13 that confront individuals and population
14 groups in seeking health care services.

15 (b) PUBLICATION OF NOTICE.—In carrying out the
16 rulemaking process under this subsection, the Secretary
17 shall publish the notice provided for under section 564(a)
18 of title 5, United States Code, by not later than 45 days
19 after the date of the enactment of this Act.

20 (c) TARGET DATE FOR PUBLICATION OF RULE.—As
21 part of the notice under subsection (b), and for purposes
22 of this subsection, the “target date for publication”, as
23 referred to in section 564(a)(5) of title 5, United States
24 Code, shall be July 1, 2010.

1 (d) APPOINTMENT OF NEGOTIATED RULEMAKING
2 COMMITTEE AND FACILITATOR.—The Secretary shall pro-
3 vide for—

4 (1) the appointment of a negotiated rulemaking
5 committee under section 565(a) of title 5, United
6 States Code, by not later than 30 days after the end
7 of the comment period provided for under section
8 564(c) of such title; and

9 (2) the nomination of a facilitator under section
10 566(c) of such title 5 by not later than 10 days after
11 the date of appointment of the committee.

12 (e) PRELIMINARY COMMITTEE REPORT.—The nego-
13 tiated rulemaking committee appointed under subsection
14 (d) shall report to the Secretary, by not later than April
15 1, 2010, regarding the committee's progress on achieving
16 a consensus with regard to the rulemaking proceeding and
17 whether such consensus is likely to occur before one month
18 before the target date for publication of the rule. If the
19 committee reports that the committee has failed to make
20 significant progress toward such consensus or is unlikely
21 to reach such consensus by the target date, the Secretary
22 may terminate such process and provide for the publica-
23 tion of a rule under this section through such other meth-
24 ods as the Secretary may provide.

1 (f) FINAL COMMITTEE REPORT.—If the committee
2 is not terminated under subsection (e), the rulemaking
3 committee shall submit a report containing a proposed
4 rule by not later than one month before the target publica-
5 tion date.

6 (g) INTERIM FINAL EFFECT.—The Secretary shall
7 publish a rule under this section in the Federal Register
8 by not later than the target publication date. Such rule
9 shall be effective and final immediately on an interim
10 basis, but is subject to change and revision after public
11 notice and opportunity for a period (of not less than 90
12 days) for public comment. In connection with such rule,
13 the Secretary shall specify the process for the timely re-
14 view and approval of applications for such designations
15 pursuant to such rules and consistent with this section.

16 (h) PUBLICATION OF RULE AFTER PUBLIC COM-
17 MENT.—The Secretary shall provide for consideration of
18 such comments and republication of such rule by not later
19 than 1 year after the target publication date.

20 **SEC. 175. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.**

21 (a) REBUTTABLE PRESUMPTION.—Section 411(c)(4)
22 of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is
23 amended by striking the last sentence.

24 (b) CONTINUATION OF BENEFITS.—Section 422(l) of
25 the Black Lung Benefits Act (30 U.S.C. 932(l)) is amend-

1 ed by striking “, except with respect to a claim filed under
2 this part on or after the effective date of the Black Lung
3 Benefits Amendments of 1981”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply with respect to claims filed under
6 part B or part C of the Black Lung Benefits Act (30
7 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005,
8 that are pending on or after the date of enactment of this
9 Act.

10 **SEC. 176. REAUTHORIZATION OF THE WAKEFIELD EMER-**
11 **GENCY MEDICAL SERVICES FOR CHILDREN**
12 **PROGRAM.**

13 Section 1910 of the Public Health Service Act (42
14 U.S.C. 300w–9) is amended—

15 (1) in subsection (a), by striking “3-year period
16 (with an optional 4th year” and inserting “4-year
17 period (with an optional 5th year”;

18 (2) in subsection (d)—

19 (A) by striking “and such sums” and in-
20 serting “such sums”; and

21 (B) by inserting before the period the fol-
22 lowing: “, \$25,000,000 for fiscal year 2010,
23 \$26,250,000 for fiscal year 2011, \$27,562,500
24 for fiscal year 2012, \$28,940,625 for fiscal year
25 2013, and \$30,387,656 for fiscal year 2014”.

1 **Subtitle F—Making Health Care**
2 **More Affordable for Retirees**

3 **SEC. 181. REINSURANCE FOR RETIREES.**

4 (a) ADMINISTRATION.—

5 (1) IN GENERAL.—Not later than 90 days after
6 the date of enactment of this section, the Secretary
7 shall establish a temporary reinsurance program to
8 provide reimbursement to participating employment-
9 based plans for the cost of providing health benefits
10 to retirees whose primary residence is located in any
11 State that is not a participating State or an estab-
12 lishing State (as described in section 3104) for the
13 cost of providing health insurance coverage to retir-
14 ees (and to the eligible spouses, surviving spouses,
15 and dependents of such retirees) during the period
16 beginning on the date on which such program is es-
17 tablished and ending on the date on which such
18 State becomes a participating State or an estab-
19 lishing State.

20 (2) REFERENCE.—In this section:

21 (A) HEALTH BENEFITS.—The term
22 “health benefits” means medical, surgical, hos-
23 pital, prescription drug, and such other benefits
24 as shall be determined by the Secretary, wheth-

1 er self-funded, or delivered through the pur-
2 chase of insurance or otherwise.

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

6 (i) is—

7 (I) maintained by one or more
8 current or former employers (includ-
9 ing without limitation any State or
10 local government or political subdivi-
11 sion thereof), employee organization, a
12 voluntary employees’ beneficiary asso-
13 ciation, or a committee or board of in-
14 dividuals appointed to administer such
15 plan; or

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

20 (ii) provides health benefits to retir-
21 ees.

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

1 tive employees of an employer maintaining , or
2 currently contributing to, the employment-based
3 plan or of any employer that has made substan-
4 tial contributions to fund such plan.

5 (b) PARTICIPATION.—

6 (1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—

7 To be eligible to participate in the program estab-
8 lished under this section, an employment-based plan
9 (as defined in subsection (a)(2) and referred to in
10 this section as a “participating employment-based
11 plan” shall—

12 (A) provide employment-based health plan
13 benefits; and

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

18 (2) APPROPRIATE EMPLOYMENT-BASED
19 HEALTH BENEFITS.—Appropriate employment-based
20 health benefits described in this paragraph shall—

21 (A) meet the requirements established
22 under section 3103(a)(1)(B);

23 (B) implement programs and procedures to
24 generate cost-savings with respect to partici-
25 pants with chronic and high-cost conditions;

1 (C) provide documentation of the actual
2 cost of medical claims involved; and

3 (D) be certified as appropriate by the Sec-
4 retary.

5 (c) PAYMENTS.—

6 (1) SUBMISSION OF CLAIMS.—

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

13 (B) BASIS FOR CLAIMS.—Claims submitted
14 under paragraph (1) shall be based on the ac-
15 tual amount expended by the participating em-
16 ployment-based plan involved within the plan
17 year for the appropriate employment-based
18 health benefits provided to a retiree or the
19 spouse, surviving spouse, or dependent of such
20 retiree. In determining the amount of a claim
21 for purposes of this subsection, the partici-
22 pating employment-based plan shall take into
23 account any negotiated price concessions (such
24 as discounts, direct or indirect subsidies, re-
25 bates, and direct or indirect remunerations) ob-

1 tained by such plan with respect to such health
2 benefit. For purposes of determining the
3 amount of any such claim, the costs paid by the
4 retiree or the retiree's spouse, surviving spouse,
5 or dependent in the form of deductibles, co-pay-
6 ments, or co-insurance shall be included in the
7 amounts paid by the participating employment-
8 based plan.

9 (2) PROGRAM PAYMENTS.—If the Secretary de-
10 termines that a participating employment-based plan
11 has submitted a valid claim under paragraph (1),
12 the Secretary shall reimburse such plan for 80 per-
13 cent of that portion of the costs attributable to such
14 claim that exceed \$15,000, subject to the limits con-
15 tained in paragraph (3).

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

1 (4) USE OF PAYMENTS.—Amounts paid to a
2 participating employment-based plan under this sub-
3 section shall be used to lower costs for participants
4 for health benefits under such plan, in the form of
5 premiums, co-payments, deductibles, co-insurance, or
6 other out-of-pocket costs. Such payments shall not
7 be used to reduce the costs of an employer maintain-
8 ing the participating employment-based plan. The
9 Secretary shall develop a mechanism to monitor the
10 appropriate use of such payments by such employ-
11 ers.

12 (5) PAYMENTS NOT TREATED AS INCOME.—
13 Payments received under this subsection shall not be
14 included in determining the gross income of an enti-
15 ty described in subsection (a)(2)(B)(i) that is main-
16 taining or currently contributing to a participating
17 employment-based plan.

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

19 (A) an appeals process to permit partici-
20 pating employment-based plans to appeal a de-
21 termination of the Secretary with respect to
22 claims submitted under this section; and

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

1 (d) AUDITS.—The Secretary shall conduct annual au-
2 dits of claims data submitted by participating employ-
3 ment-based plans under this section to ensure that such
4 plans are in compliance with the requirements of this sec-
5 tion.

6 (e) RETIREE RESERVE TRUST FUND.—

7 (1) ESTABLISHMENT OF TRUST FUND.—

8 (A) IN GENERAL.—There is established in
9 the Treasury of the United States a trust fund
10 to be known as the “Retiree Reserve Trust
11 Fund” (referred to in this section as the “Trust
12 Fund”), that shall consist of such amounts as
13 may be appropriated or credited to the Trust
14 Fund as provided for in this subsection to en-
15 able the Secretary to carry out the program
16 under this section. Such amounts shall remain
17 available until expended.

18 (B) FUNDING.—There are hereby appro-
19 priated to the Trust Fund, out of any moneys
20 in the Treasury not otherwise appropriated an
21 amount requested by the Secretary of Health
22 and Human Services as necessary to carry out
23 this section, except that the total of all such
24 amounts requested shall not exceed
25 \$10,000,000,000.

1 (C) APPROPRIATIONS FROM THE TRUST
2 FUND.—Amounts in the Trust Fund may be
3 appropriated to provide funding to carry out
4 this program under this section

5 (2) USE OF TRUST FUND.—The Secretary shall
6 use amounts contained in the Trust Fund to carry
7 out the program under this section.

8 (3) LIMITATIONS.—The Secretary has the au-
9 thority to stop taking applications for participation
10 in the program to comply with the funding limit pro-
11 vided for in paragraph (1)(B).

12 **Subtitle G—Improving the Use of**
13 **Health Information Technology**
14 **for Enrollment; Miscellaneous**
15 **Provisions**

16 **SEC. 185. HEALTH INFORMATION TECHNOLOGY ENROLL-**
17 **MENT STANDARDS AND PROTOCOLS.**

18 Title XXX of the Public Health Service Act (42
19 U.S.C. 300jj et seq.) is amended by adding at the end
20 the following:

21 **“Subtitle C—Other Provisions**

22 **“SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLL-**
23 **MENT STANDARDS AND PROTOCOLS.**

24 **“(a) IN GENERAL.—**

1 “(1) STANDARDS AND PROTOCOLS.—Not later
2 than 180 days after the date of enactment of this
3 title, the Secretary, in consultation with the HIT
4 Policy Committee and the HIT Standards Com-
5 mittee, shall develop interoperable and secure stand-
6 ards and protocols that facilitate enrollment of indi-
7 viduals in Federal and State health and human serv-
8 ices programs, as determined by the Secretary.

9 “(2) METHODS.—The Secretary shall facilitate
10 enrollment in such programs through methods deter-
11 mined appropriate by the Secretary, which shall in-
12 clude providing individuals and third parties author-
13 ized by such individuals and their designees notifica-
14 tion of eligibility and verification of eligibility re-
15 quired under such programs.

16 “(b) CONTENT.—The standards and protocols for
17 electronic enrollment in the Federal and State programs
18 described in subsection (a) shall allow for the following:

19 “(1) Electronic matching against existing Fed-
20 eral and State data, including vital records, employ-
21 ment history, enrollment systems, tax records, and
22 other data determined appropriate by the Secretary
23 to serve as evidence of eligibility and in lieu of
24 paper-based documentation.

1 “(2) Simplification and submission of electronic
2 documentation, digitization of documents, and sys-
3 tems verification of eligibility.

4 “(3) Reuse of stored eligibility information (in-
5 cluding documentation) to assist with retention of el-
6 igible individuals.

7 “(4) Capability for individuals to apply, recer-
8 tify and manage their eligibility information online,
9 including at home, at points of service, and other
10 community-based locations.

11 “(5) Ability to expand the enrollment system to
12 integrate new programs, rules, and functionalities, to
13 operate at increased volume, and to apply stream-
14 lined verification and eligibility processes to other
15 Federal and State programs, as appropriate.

16 “(6) Notification of eligibility, recertification,
17 and other needed communication regarding eligi-
18 bility, which may include communication via email
19 and cellular phones.

20 “(7) Other functionalities necessary to provide
21 eligibles with streamlined enrollment process.

22 “(c) APPROVAL AND NOTIFICATION.—With respect
23 to any standard or protocol developed under subsection (a)
24 that has been approved by the HIT Policy Committee and
25 the HIT Standards Committee, the Secretary—

1 “(1) shall notify States of such standards or
2 protocols; and

3 “(2) may require, as a condition of receiving
4 Federal funds for the health information technology
5 investments, that States or other entities incorporate
6 such standards and protocols into such investments.

7 “(d) GRANTS FOR IMPLEMENTATION OF APPRO-
8 PRIATE ENROLLMENT HIT.—

9 “(1) IN GENERAL.—The Secretary shall award
10 grant to eligible entities to develop new, and adapt
11 existing, technology systems to implement the HIT
12 enrollment standards and protocols developed under
13 subsection (a) (referred to in this subsection as ‘ap-
14 propriate HIT technology’).

15 “(2) ELIGIBLE ENTITIES.—To be eligible for a
16 grant under this subsection, an entity shall—

17 “(A) be a State, political subdivision of a
18 State, or a local governmental entity; and

19 “(B) submit to the Secretary an applica-
20 tion at such time, in such manner, and con-
21 taining—

22 “(i) a plan to adopt and implement
23 appropriate enrollment technology that in-
24 cludes—

1 “(I) proposed reduction in main-
2 tenance costs of technology systems;

3 “(II) elimination or updating of
4 legacy systems; and

5 “(III) demonstrated collaboration
6 with other entities that may receive a
7 grant under this section that are lo-
8 cated in the same State, political sub-
9 division, or locality;

10 “(ii) an assurance that the entity will
11 share such appropriate enrollment tech-
12 nology in accordance with paragraph (4);
13 and

14 “(iii) such other information as the
15 Secretary may require.

16 “(3) SHARING.—

17 “(A) IN GENERAL.—The Secretary shall
18 ensure that appropriate enrollment HIT adopt-
19 ed under grants under this subsection is made
20 available to other qualified State, qualified po-
21 litical subdivisions of a State, or other appro-
22 priate qualified entities (as described in sub-
23 paragraph (B)) at no cost.

24 “(B) QUALIFIED ENTITIES.—The Sec-
25 retary shall determine what entities are quali-

1 fied to receive enrollment HIT under subpara-
2 graph (A), taking into consideration the rec-
3 ommendations of the HIT Policy Committee
4 and the HIT Standards Committee.”.

5 **SEC. 186. RULE OF CONSTRUCTION REGARDING HAWAII'S**
6 **PREPAID HEALTH CARE ACT.**

7 Nothing in this title (or an amendment made by this
8 title) shall be construed to modify or limit the application
9 of the exemption for Hawaii's Prepaid Health Care Act
10 (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under
11 section 514(b)(5) of the Employee Retirement Income Se-
12 curity Act of 1974 (29 U.S.C. 1144(b)(5)).

13 **SEC. 187. KEY NATIONAL INDICATORS.**

14 (a) DEFINITIONS.—In this section:

15 (1) ACADEMY.—The term “Academy” means
16 the National Academy of Sciences.

17 (2) COMMISSION.—The term “Commission”
18 means the Commission on Key National Indicators
19 established under subsection (b).

20 (3) INSTITUTE.—The term “Institute” means a
21 Key National Indicators Institute as designated
22 under subsection (c)(3).

23 (b) COMMISSION ON KEY NATIONAL INDICATORS.—

24 (1) ESTABLISHMENT.—There is established a
25 “Commission on Key National Indicators”.

1 (2) MEMBERSHIP.—

2 (A) NUMBER AND APPOINTMENT.—The
3 Commission shall be composed of 8 members, to
4 be appointed equally by the majority and mi-
5 nority leaders of the Senate and the Speaker
6 and minority leader of the House of Represent-
7 atives.

8 (B) PROHIBITED APPOINTMENTS.—Mem-
9 bers of the Commission shall not include Mem-
10 bers of Congress or other elected Federal,
11 State, or local government officials.

12 (C) QUALIFICATIONS.—In making appoint-
13 ments under subparagraph (A), the majority
14 and minority leaders of the Senate and the
15 Speaker and minority leader of the House of
16 Representatives shall appoint individuals who
17 have shown a dedication to improving civic dia-
18 logue and decision-making through the wide use
19 of scientific evidence and factual information.

20 (D) PERIOD OF APPOINTMENT.—Each
21 member of the Commission shall be appointed
22 for a 2-year term, except that 1 initial appoint-
23 ment shall be for 3 years. Any vacancies shall
24 not affect the power and duties of the Commis-
25 sion but shall be filled in the same manner as

1 the original appointment and shall last only for
2 the remainder of that term.

3 (E) DATE.—Members of the Commission
4 shall be appointed by not later than 30 days
5 after the date of enactment of this Act.

6 (F) INITIAL ORGANIZING PERIOD.—Not
7 later than 60 days after the date of enactment
8 of this Act, the Commission shall develop and
9 implement a schedule for completion of the re-
10 view and reports required under subsection (d).

11 (G) CO-CHAIRPERSONS.—The Commission
12 shall select 2 Co-Chairpersons from among its
13 members.

14 (c) DUTIES OF THE COMMISSION.—

15 (1) IN GENERAL.—The Commission shall—

16 (A) conduct comprehensive oversight of a
17 newly established key national indicators system
18 consistent with the purpose described in this
19 subsection;

20 (B) make recommendations on how to im-
21 prove the key national indicators system;

22 (C) coordinate with Federal Government
23 users and information providers to assure ac-
24 cess to relevant and quality data; and

25 (D) enter into contracts with the Academy.

1 (2) REPORTS.—

2 (A) ANNUAL REPORT TO CONGRESS.—Not
3 later than 1 year after the selection of the 2
4 Co-Chairpersons of the Commission, and each
5 subsequent year thereafter, the Commission
6 shall prepare and submit to the appropriate
7 Committees of Congress and the President a re-
8 port that contains a detailed statement of the
9 recommendations, findings, and conclusions of
10 the Commission on the activities of the Acad-
11 emy and a designated Institute related to the
12 establishment of a Key National Indicator Sys-
13 tem.

14 (B) ANNUAL REPORT TO THE ACADEMY.—

15 (i) IN GENERAL.—Not later than 6
16 months after the selection of the 2 Co-
17 Chairpersons of the Commission, and each
18 subsequent year thereafter, the Commis-
19 sion shall prepare and submit to the Acad-
20 emy and a designated Institute a report
21 making recommendations concerning po-
22 tential issue areas and key indicators to be
23 included in the Key National Indicators.

24 (ii) LIMITATION.—The Commission
25 shall not have the authority to direct the

1 Academy or, if established, the Institute,
2 to adopt, modify, or delete any key indica-
3 tors.

4 (3) CONTRACT WITH THE NATIONAL ACADEMY
5 OF SCIENCES.—

6 (A) IN GENERAL.—As soon as practicable
7 after the selection of the 2 Co-Chairpersons of
8 the Commission, the Co-Chairpersons shall
9 enter into an arrangement with the National
10 Academy of Sciences under which the Academy
11 shall—

12 (i) review available public and private
13 sector research on the selection of a set of
14 key national indicators;

15 (ii) determine how best to establish a
16 key national indicator system for the
17 United States, by either creating its own
18 institutional capability or designating an
19 independent private nonprofit organization
20 as an Institute to implement a key national
21 indicator system;

22 (iii) if the Academy designates an
23 independent Institute under clause (ii),
24 provide scientific and technical advice to
25 the Institute and create an appropriate

1 governance mechanism that balances Acad-
2 emy involvement and the independence of
3 the Institute; and

4 (iv) provide an annual report to the
5 Commission addressing scientific and tech-
6 nical issues related to the key national in-
7 dicator system and, if established, the In-
8 stitute, and governance of the Institute's
9 budget and operations.

10 (B) PARTICIPATION.—In executing the ar-
11 rangement under subparagraph (A), the Na-
12 tional Academy of Sciences shall convene a
13 multi-sector, multi-disciplinary process to define
14 major scientific and technical issues associated
15 with developing, maintaining, and evolving a
16 Key National Indicator System and, if an Insti-
17 tute is established, to provide it with scientific
18 and technical advice.

19 (C) ESTABLISHMENT OF A KEY NATIONAL
20 INDICATOR SYSTEM.—

21 (i) IN GENERAL.—In executing the ar-
22 rangement under subparagraph (A), the
23 National Academy of Sciences shall enable
24 the establishment of a key national indi-
25 cator system by—

1 (I) creating its own institutional
2 capability; or

3 (II) partnering with an inde-
4 pendent private nonprofit organization
5 as an Institute to implement a key na-
6 tional indicator system.

7 (ii) INSTITUTE.—If the Academy des-
8 ignates an Institute under clause (i)(II),
9 such Institute shall be a non-profit entity
10 (as defined for purposes of section
11 501(c)(3) of the Internal Revenue Code of
12 1986) with an educational mission, a gov-
13 ernance structure that emphasizes inde-
14 pendence, and characteristics that make
15 such entity appropriate for establishing a
16 key national indicator system.

17 (iii) RESPONSIBILITIES.—Either the
18 Academy or the Institute designated under
19 clause (i)(II) shall be responsible for the
20 following:

21 (I) Identifying and selecting issue
22 areas to be represented by the key na-
23 tional indicators.

24 (II) Identifying and selecting the
25 measures used for key national indica-

1 progress toward establishing a web-ac-
2 cessible database.

3 (VIII) Responding directly to the
4 Commission in response to any Com-
5 mission recommendations and to the
6 Academy regarding any inquiries by
7 the Academy.

8 (iv) GOVERNANCE.—Upon the estab-
9 lishment of a key national indicator sys-
10 tem, the Academy shall create an appro-
11 priate governance mechanism that incor-
12 porates advisory and control functions. If
13 an Institute is designated under clause
14 (i)(II), the governance mechanism shall
15 balance appropriate Academy involvement
16 and the independence of the Institute.

17 (v) MODIFICATION AND CHANGES.—
18 The Academy shall retain the sole discre-
19 tion, at any time, to alter its approach to
20 the establishment of a key national indi-
21 cator system or, if an Institute is des-
22 ignated under clause (i)(II), to alter any
23 aspect of its relationship with the Institute
24 or to designate a different non-profit entity
25 to serve as the Institute.

1 (vi) CONSTRUCTION.—Nothing in this
2 section shall be construed to limit the abil-
3 ity of the Academy or the Institute des-
4 ignated under clause (i)(II) to receive pri-
5 vate funding for activities related to the es-
6 tablishment of a key national indicator sys-
7 tem.

8 (D) ANNUAL REPORT.—As part of the ar-
9 rangement under subparagraph (A), the Na-
10 tional Academy of Sciences shall, not later than
11 270 days after the date of enactment of this
12 Act, and annually thereafter, submit to the Co-
13 Chairpersons of the Commission a report that
14 contains the findings and recommendations of
15 the Academy.

16 (d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY
17 AND REPORT.—

18 (1) GAO STUDY.—The Comptroller General of
19 the United States shall conduct a study of previous
20 work conducted by all public agencies, private orga-
21 nizations, or foreign countries with respect to best
22 practices for a key national indicator system. The
23 study shall be submitted to the appropriate author-
24 izing committees of Congress.

1 (2) GAO FINANCIAL AUDIT.—If an Institute is
2 established under this section, the Comptroller Gen-
3 eral shall conduct an annual audit of the financial
4 statements of the Institute, in accordance with gen-
5 erally accepted government auditing standards and
6 submit a report on such audit to the Commission
7 and the appropriate authorizing committees of Con-
8 gress.

9 (3) GAO PROGRAMMATIC REVIEW.—The Comp-
10 troller General of the United States shall conduct
11 programmatic assessments of the Institute estab-
12 lished under this section as determined necessary by
13 the Comptroller General and report the findings to
14 the Commission and to the appropriate authorizing
15 committees of Congress.

16 (e) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—There are authorized to be
18 appropriated to carry out the purposes of this sec-
19 tion, \$10,000,000 for fiscal year 2010, and
20 \$7,500,000 for each of fiscal year 2011 through
21 2018.

22 (2) AVAILABILITY.—Amounts appropriated
23 under paragraph (1) shall remain available until ex-
24 pended.

1 On page 598, line 4, insert “(2),” after “para-
2 graphs”.

3 On page 598, strike lines 8 through 10, and insert
4 the following:

5 (A) by striking “OTHER DEFINITION” and
6 all that follows through “In this section” and
7 inserting the following: “OTHER DEFINI-
8 TIONS.—

9 “(1) IN GENERAL.—In this section”.

10 On page 601, between lines 4 and 5, insert the fol-
11 lowing:

12 “(iv) PURCHASING ARRANGEMENTS
13 FOR INPATIENT DRUGS.—The Secretary
14 shall ensure that a hospital described in
15 subparagraph (L), (M), (N), or (O) of sub-
16 section (a)(4) that is enrolled to partici-
17 pate in the drug discount program under
18 this section shall have multiple options for
19 purchasing covered drugs for inpatients,
20 including by utilizing a group purchasing
21 organization or other group purchasing ar-
22 rangement, establishing and utilizing its
23 own group purchasing program, pur-

1 chasing directly from a manufacturer, and
2 any other purchasing arrangements that
3 the Secretary determines is appropriate to
4 ensure access to drug discount pricing
5 under this section for inpatient drugs tak-
6 ing into account the particular needs of
7 small and rural hospitals.”.

8 On page 601, strike lines 5 through 7 and insert the
9 following:

10 (d) MEDICAID CREDITS ON INPATIENT DRUGS.—
11 Section 340B(a)(5) of the Public Health Service Act (42
12 U.S.C. 256b(a)(5)) is amended by adding at the end the
13 following
14 :

15 On page 601, line 9, strike “hospitals” and insert
16 “hospital’s”.

17 On page 601, line 16, insert “and section 612” after
18 “this section”.

19 On page 601, line 20, insert “and section 612” after
20 “this section”.

1 Beginning on page 601, line 24, strike “and of” and
2 all that follows through “(5)” on line 1 on page 602.

3 On page 602, strike line 3 and all that follows
4 through line 20 on page 603.