# *TITLE IX—REVENUE PROVISIONS*

## *Subtitle A—Revenue Offset Provisions*

***SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.***

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

***"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.***

*"(a) IMPOSITION OF TAX.—If—*

*"(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and*

*"(2) there is any excess benefit with respect to the coverage,*

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

*"(b) EXCESS BENEFIT.—For purposes of this section—*

*"(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the*

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

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

*"(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over*

*"(B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.*

*"(3) ANNUAL LIMITATION.—For purposes of this subsection—*

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

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

*"(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—*

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

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

*"(II) in the case of an employee with coverage other than self-only coverage, $23,000.*

*"(ii) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—*

*"(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,350, and*

*"(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.*

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

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

*"(I) such amount as so in effect, multiplied by*

*"(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point.*

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

*"(D) TRANSITION RULE FOR STATES WITH HIGHEST COVERAGE COSTS.—*

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

*the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).*

*"(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.*

*"(iii) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined using the most recent data available as of August 31, 2012.*

*"(c) LIABILITY TO PAY TAX.—*

*"(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.*

*"(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:*

*"(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.*

*"(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.*

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

*"(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—*

*"(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to*

*"(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.*

*"(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—*

*"(A) IN GENERAL.—Each employer shall—*

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

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

*"(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).*

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

*"(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—*

*"(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).*

*"(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—*

*"(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or*

*"(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.*

*"(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard*

*to whether the employer or employee pays for the coverage.*

*"(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.*

*"(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.*

*"(2) DETERMINATION OF COST.—*

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

*this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.*

*"(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—*

*"(i) the amount of employer contributions under any salary reduction election under the arrangement, plus*

*"(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).*

*"(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions de-*

*scribed in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.*

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

*"(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—*

*"(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—*

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

*"(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate de-*

*termined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.*

*"(2) LIMITATIONS ON PENALTY.—*

*"(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.*

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

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

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

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

*"(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.*

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

*"(1) COVERAGE DETERMINATIONS.—*

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

*"(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided*

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

*"(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—*

*"(A) is receiving coverage by reason of being a retiree,*

*"(B) has attained age 55, and*

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

*"(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an em-*

*ployee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.*

*"(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).*

*"(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—*

*"(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).*

*"(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).*

*"(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.*

*"(7) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B)*

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

*"(8) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.*

*"(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.*

*"(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).*

*"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.".*

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

*"Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.".*

*(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.*

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

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

*"(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—*

*"(A) coverage to which paragraphs (11) and (12) apply, or*

*"(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).".*

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

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

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

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

*(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: "Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.".*

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

*"(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.".*

*(d) EFFECTIVE DATES.—*

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

*(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.*

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

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

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

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

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

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

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

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

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

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

***SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.***

*(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:*

*"(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation*

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

*''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.*

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

*(1) by inserting ''amounts in consideration for property,'' after ''wages,'',*

*(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and*

*(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.*

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

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

*(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is*

*amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:*

*"(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—*

*"(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—*

*"(A) meets the community health needs assessment requirements described in paragraph (3),*

*"(B) meets the financial assistance policy requirements described in paragraph (4),*

*"(C) meets the requirements on charges described in paragraph (5), and*

*"(D) meets the billing and collection requirement described in paragraph (6).*

*"(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—*

*"(A) IN GENERAL.—This subsection shall apply to—*

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

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

*"(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).*

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

*"(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and*

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

*"(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—*

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

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

*ments of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and*

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

*"(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—*

*"(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and*

*"(ii) is made widely available to the public.*

*"(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:*

*"(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—*

*"(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,*

*"(ii) the basis for calculating amounts charged to patients,*

*"(iii) the method for applying for financial assistance,*

*"(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and*

*"(v) measures to widely publicize the policy within the community to be served by the organization.*

*"(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).*

*"(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—*

*"(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and*

*"(B) prohibits the use of gross charges.*

*"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).*

*"(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility*

*of a patient under a financial assistance policy for purposes of paragraph (6).".*

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

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

***"SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.***

*"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.".*

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

*"Sec. 4959. Taxes on failures by hospital organizations.".*

*(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.*

*(d) ADDITIONAL REPORTING REQUIREMENTS.—*

*(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:*

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

*"(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and*

*"(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).".*

*(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking "and" at the end of subparagraph (B), by inserting "and" at the end of subparagraph (C), and by adding at the end the following new subparagraph:*

*"(D) section 4959 (relating to taxes on failures by hospital organizations),".*

*(e) REPORTS.—*

*(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:*

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

*(i) levels of charity care provided,*

*(ii) bad debt expenses,*

*(iii) unreimbursed costs for services provided with respect to means-tested government programs, and*

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

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

*(2) REPORT ON TRENDS.—*

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

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

*(f) EFFECTIVE DATES.—*

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

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

*(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.*

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

***SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.***

*(a) IMPOSITION OF FEE.—*

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

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

*by the Secretary, but in no event later than September 30 of such calendar year.*

*(b) DETERMINATION OF FEE AMOUNT.—*

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

*(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to*

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

*(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:*

| *With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:* | *The percentage of such sales taken into account is:* |
|---|---|
| *Not more than $5,000,000* | *0 percent* |
| *More than $5,000,000 but not more than $125,000,000.* | *10 percent* |
| *More than $125,000,000 but not more than $225,000,000.* | *40 percent* |
| *More than $225,000,000 but not more than $400,000,000.* | *75 percent* |
| *More than $400,000,000* | *100 percent.* |

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

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

*(d) COVERED ENTITY.—*

*(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any manufacturer or importer with gross receipts from branded prescription drug sales.*

*(2) CONTROLLED GROUPS.—*

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

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

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

*(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—*

*(1) IN GENERAL.—The term "branded prescription drug sales" means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.*

*(2) BRANDED PRESCRIPTION DRUGS.—*

*(A) IN GENERAL.—The term "branded prescription drug" means—*

*(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or*

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

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

*(3) EXCLUSION OF ORPHAN DRUG SALES.—The term "branded prescription drug sales" shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.*

*(4) SPECIFIED GOVERNMENT PROGRAM.—The term "specified government program" means—*

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

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

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

*(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,*

*(E) any program under which branded prescription drugs are procured by the Department of Defense, or*

*(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.*

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

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

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

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

*covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:*

*(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—*

*(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and*

*(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.*

*(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medi-*

*care Part B program under section 1862(a) of the Social Security Act, the product of—*

*(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and*

*(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.*

*The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.*

*(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—*

*(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered*

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

*(B) the number of units of the branded prescription drug paid for under the Medicaid program.*

*(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.*

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

*(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and*

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

*(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and*

*(ii) the number of units of the branded prescription drug dispensed under such program.*

*(h) SECRETARY.—For purposes of this section, the term "Secretary" includes the Secretary's delegate.*

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

*(j) APPLICATION OF SECTION.—This section shall apply to any branded prescription drug sales after December 31, 2008.*

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

***SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.***

*(a) IMPOSITION OF FEE.—*

*(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).*

*(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.*

*(b) DETERMINATION OF FEE AMOUNT.—*

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

*(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to*

*(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.*

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

| *With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:* | *The percentage of gross receipts taken into account is:* |
|---|---|
| *Not more than $5,000,000* | *0 percent* |
| *More than $5,000,000 but not more than $25,000,000.* | *50 percent* |

| *With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:* | *The percentage of gross receipts taken into account is:* |
|---|---|
| *More than $25,000,000* | *100 percent.* |

*(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.*

*(c) COVERED ENTITY.—*

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

*(2) CONTROLLED GROUPS.—*

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

*(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in*

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

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

*(1) IN GENERAL.—The term "medical device sales" means sales for use in the United States of any medical device, other than the sales of a medical device that—*

*(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or*

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

*(2) UNITED STATES.—For purposes of paragraph (1), the term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.*

*(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term "medical device" means any device (as defined in section 201(h) of the Federal Food,*

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

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

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

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

*(f) REPORTING REQUIREMENT.—*

*(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.*

*(2) PENALTY FOR FAILURE TO REPORT.—*

*(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there*

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

*(i) $10,000, plus*

*(ii) the lesser of—*

*(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or*

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

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

*(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,*

*(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and*

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

*(g) SECRETARY.—For purposes of this section, the term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.*

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

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

***SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.***

*(a) IMPOSITION OF FEE.—*

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

*(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.*

*(b) DETERMINATION OF FEE AMOUNT.—*

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

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

*(A) the sum of—*

*(i) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus*

*(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to*

*(B) the sum of—*

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

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

*(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—*

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

*ance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:*

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

*(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:*

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

*(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third*

*party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.*

*(c) COVERED ENTITY.—*

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

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

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

*(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).*

*(3) CONTROLLED GROUPS.—*

*(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).*

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

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

*(1) a United States citizen,*

*(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or*

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

*(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—For purposes of this section, the term "third party administration agreement fees" means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits under an arrangement under which such employer self-insures the United States health risk of its employees.*

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

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

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

*(g) REPORTING REQUIREMENT.—*

*(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk and third party administration agreement fees for such calendar year.*

*(2) PENALTY FOR FAILURE TO REPORT.—*

*(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—*

*(i) $10,000, plus*

*(ii) the lesser of—*

*(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or*

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

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

*(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,*

*(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and*

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

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

*(1) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.*

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

*(3) HEALTH INSURANCE.—The term "health insurance" shall not include insurance for long-term care or disability.*

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

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

***SEC. 9011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.***

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

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

*(2) veterans' access to medical devices and branded prescription drugs.*

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

*Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.*

***SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.***

*(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.*

*(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.*

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

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

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

*"(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer*

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

*(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "by substituting '10 percent' for '7.5 percent'" and inserting "without regard to subsection (f) of such section".*

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

***SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.***

*(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:*

*"(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—*

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

*"(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the ex-*

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

*"(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—*

*"(I) the applicable individual remuneration for such disqualified taxable year, plus*

*"(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).*

*"(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.*

*"(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—*

*"(i) IN GENERAL.—The term 'covered health insurance provider' means—*

*"(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and*

*"(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing*

*health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).*

*"(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.*

*"(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration*

*with respect to services performed during the disqualified taxable year.*

*"(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term 'deferred deduction remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.*

*"(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—*

*"(i) who is an officer, director, or employee in such taxable year, or*

*"(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.*

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

*"(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.".*

*(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.*

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

*(a) FICA.—*

*(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—*

*(A) by striking "In addition" and inserting the following:*

*"(1) IN GENERAL.—In addition",*

*(B) by striking "the following percentages of the" and inserting "1.45 percent of the",*

*(C) by striking "(as defined in section 3121(b))—" and all that follows and inserting "(as defined in section 3121(b)).", and*

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

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

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

*"(A) in the case of a joint return, $250,000, and*

*"(B) in any other case, $200,000.".*

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

*"(f) SPECIAL RULES FOR ADDITIONAL TAX.—*

*"(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.*

*"(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.*

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

*hold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.".*

*(b) SECA.—*

*(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—*

*(A) by striking "In addition" and inserting the following:*

*"(1) IN GENERAL.—In addition", and*

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

*"(2) ADDITIONAL TAX.—*

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

*"(i) in the case of a joint return, $250,000, and*

*"(ii) in any other case, $200,000.*

*"(B) COORDINATION WITH FICA.—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.".*

*(2) NO DEDUCTION FOR ADDITIONAL TAX.—*

*(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting "(other than the taxes imposed by section 1401(b)(2))" after "section 1401)".*

*(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(determined without regard to the rate imposed under paragraph (2) of section 1401(b))" after "for such year".*

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

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

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

*"(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.".*

*(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.*

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

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

## *"CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES*

***"SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.***

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

*"(b) COSMETIC SURGERY AND MEDICAL PROCEDURE.—For purposes of this section, the term 'cosmetic surgery and medical procedure' means any cosmetic surgery (as defined in section 213(d)(9)(B)) or other similar procedure which—*

*"(1) is performed by a licensed medical professional, and*

*"(2) is not necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.*

*"(c) PAYMENT OF TAX.—*

*"(1) IN GENERAL.—The tax imposed by this section shall be paid by the individual on whom the procedure is performed.*

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

*performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.*

*"(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for cosmetic surgery and medical procedures are made, then to the extent that such tax is not collected, such tax shall be paid by the person who performs the procedure.".*

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

*"CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES".*

*(c) EFFECTIVE DATE.—The amendments made by this section shall apply to procedures performed on or after January 1, 2010.*

## *Subtitle B—Other Provisions*

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

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

***"SEC. 139D. INDIAN HEALTH CARE BENEFITS.***

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

*"(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—*

*"(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,*

*"(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,*

*"(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and*

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

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

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

*"(1) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term by section 45A(c)(6).*

*"(2) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.*

*"(3) MEDICAL CARE.—The term 'medical care' has the same meaning as when used in section 213.*

*"(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in section 105.*

*"(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.*

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

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

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

*"Sec. 139D. Indian health care benefits.".*

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

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

*(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and*

*(2) benefits provided prior to the date of the enactment of this Act.*

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

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

*"(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—*

*"(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.*

*"(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—*

*"(A) which is established and maintained by an eligible employer, and*

*"(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.*

*"(3) CONTRIBUTION REQUIREMENTS.—*

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

*"(i) a uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or*

*"(ii) an amount which is not less than the lesser of—*

*"(I) 6 percent of the employee's compensation for the plan year, or*

*"(II) twice the amount of the salary reduction contributions of each qualified employee.*

*"(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.*

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

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

*"(D) DEFINITIONS.—For purposes of this paragraph—*

*"(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.*

*"(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.*

*"(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).*

*"(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416(i).*

*"(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—*

*"(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—*

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

*"(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.*

*"(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—*

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

*"(ii) who have less than 1 year of service with the employer as of any day during the plan year,*

*"(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under*

*the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or*

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

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

*"(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—*

*"(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.*

*"(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.*

*"(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—*

*"(i) IN GENERAL.—If—*

*"(I) an employer was an eligible employer for any year (a 'qualified year'), and*

*"(II) such employer establishes a simple cafeteria plan for its employees for such year,*

*then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.*

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

*"(D) SPECIAL RULES.—*

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

*"(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.*

*"(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).*

*"(7) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).".*

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

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

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

*amended by inserting after section 48C the following new section:*

***"SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.***

*"(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.*

*"(b) QUALIFIED INVESTMENT.—*

*"(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project.*

*"(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.*

*"(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—*

*"(A) for remuneration for an employee described in section 162(m)(3),*

*"(B) for interest expenses,*

*"(C) for facility maintenance expenses,*

*"(D) which is identified as a service cost under section 1.263A–1(e)(4) of title 26, Code of Federal Regulations, or*

*"(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.*

*"(4) CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.*

*"(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.*

*"(c) DEFINITIONS.—*

*"(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—*

*"(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,*

*"(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or*

*"(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.*

*"(2) ELIGIBLE TAXPAYER.—*

*"(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).*

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

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

*"(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—*

*"(A) mortgage or rent payments,*

*"(B) insurance payments,*

*"(C) utility and maintenance costs, and*

*"(D) costs of employment of maintenance personnel.*

*"(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—*

*"(1) ESTABLISHMENT.—*

*"(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.*

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

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

*"(2) CERTIFICATION.—*

*"(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).*

*"(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.*

*"(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).*

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

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

*"(i) to result in new therapies—*

*"(I) to treat areas of unmet medical need, or*

*"(II) to prevent, detect, or treat chronic or acute diseases and conditions,*

*"(ii) to reduce long-term health care costs in the United States, or*

*"(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and*

*"(B) shall take into consideration which projects have the greatest potential—*

*"(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and*

*"(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.*

*"(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the appli-*

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

*"(e) SPECIAL RULES.—*

*"(1) BASIS ADJUSTMENT.—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.*

*"(2) DENIAL OF DOUBLE BENEFIT.—*

*"(A) BONUS DEPRECIATION.—A credit shall not be allowed under this section for any investment for which bonus depreciation is allowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).*

*"(B) DEDUCTIONS.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for deprecia-*

*tion the basis of which is reduced under paragraph (1), or which are described in section 280C(g).*

*"(C) CREDIT FOR RESEARCH ACTIVITIES.—*

*"(i) IN GENERAL.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.*

*"(ii) EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.—Any expenses for any taxable year which are qualified research expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.*

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

*"(1) DENIAL OF CREDIT.—No credit shall be determined under this section with respect to such in-*

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

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

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

*"(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and*

*"(C) the amount of such grant shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.*

*"(3) TREATMENT OF GRANTS.—Any such grant shall not be includible in the gross income of the taxpayer.".*

*(b) INCLUSION AS PART OF INVESTMENT CREDIT.—Section 46 of the Internal Revenue Code of 1986 is amended—*

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

*(2) by striking the period at the end of paragraph (5) and inserting ", and", and*

*(3) by adding at the end the following new paragraph:*

*"(6) the qualifying therapeutic discovery project credit.".*

*(c) CONFORMING AMENDMENTS.—*

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

*(A) by striking "and" at the end of clause (iv),*

*(B) by striking the period at the end of clause (v) and inserting ", and", and*

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

*"(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.".*

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

*"(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—*

*"(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—*

*"(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or section 45C were allowed with respect to such expenses for such taxable year, and*

*"(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—*

*"(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and*

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

*"(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—In the case of expenses described in paragraph (1)(A) taken*

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

*"(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds*

*"(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),*

*the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.*

*"(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.".*

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

*"Sec. 48D. Qualifying therapeutic discovery project credit.".*

*(e) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—*

*(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying*

*therapeutic discovery project in the amount of 50 percent of such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.*

*(2) APPLICATION.—*

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

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

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

*(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.*

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

*shall include such information and be in such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year for the qualified investment with respect to which such application is made.*

*(3) TIME FOR PAYMENT OF GRANT.—*

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

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

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

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

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

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

*(5) APPLICATION OF CERTAIN RULES.—*

*(A) IN GENERAL.—In making grants under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in tax under chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the grant was made.*

*(B) SPECIAL RULES.—*

*(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable as a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.*

*(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under*

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

*(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—*

*(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),*

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

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

*(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).*

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

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

*(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.*

*(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.*

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

*(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.*

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

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

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

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

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

## *Subtitle A—Provisions Relating to Title I*

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

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

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

*"(a) PROHIBITION.—*

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

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

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

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

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

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

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

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

***"SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(B) REBATE AMOUNT.—*

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

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

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

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

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

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

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

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

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

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

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

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

*"(a) INTERNAL CLAIMS APPEALS.—*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***"SEC. 2719A. PATIENT PROTECTIONS.***

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

*"(b) COVERAGE OF EMERGENCY SERVICES.—*

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

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

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

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

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

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

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

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

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

*"(2) DEFINITIONS.—In this subsection:*

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

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

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

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

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

*"(c) ACCESS TO PEDIATRIC CARE.—*

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

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

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

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

*"(1) GENERAL RIGHTS.—*

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

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

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

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

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

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

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

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

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

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

*(1) in subsection (c)(1)—*

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

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

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

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

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

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

*"(d) MEDICAL REIMBURSEMENT DATA CENTERS.—*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(a) COVERAGE.—*

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

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

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

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

*"(2) ROUTINE PATIENT COSTS.—*

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

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

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

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

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

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

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

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

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

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

*"(2) Either—*

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

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

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

*"(d) APPROVED CLINICAL TRIAL DEFINED.—*

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

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

*"(i) The National Institutes of Health.*

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

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

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

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

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

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

*"(I) The Department of Veterans Affairs.*

*"(II) The Department of Defense.*

*"(III) The Department of Energy.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***"SEC. 1254. STUDY OF LARGE GROUP MARKET.***

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

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

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

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

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

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

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

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

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

***SEC. 10104. AMENDMENTS TO SUBTITLE D.***

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

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

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

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

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

*(b) Section 1302 of this Act is amended—*

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(B) ABORTION SERVICES.—*

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

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

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

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

*following for purposes of paying for such services:*

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

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

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

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

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

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

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

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

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

*"(C) SEGREGATION OF FUNDS.—*

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

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

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

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

*"(D) ACTUARIAL VALUE.—*

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

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

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

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

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

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

*"(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—*

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

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

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

*"(3) RULES RELATING TO NOTICE.—*

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

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

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

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

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

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

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

*"(i) conscience protection;*

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

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

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

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

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

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

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

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

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

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

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

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

*the qualified health plan in which such individual is enrolled;*

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

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

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

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

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

*''(3) TRANSPARENCY IN COVERAGE.—*

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

*''(i) Claims payment policies and practices.*

*''(ii) Periodic financial disclosures.*

*''(iii) Data on enrollment.*

*''(iv) Data on disenrollment.*

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

*''(vi) Data on rating practices.*

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

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

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

*"(B) USE OF PLAIN LANGUAGE.—The information required to be submitted under subparagraph (A) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.*

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

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

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

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

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

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

*(3) by adding at the end the following:*

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

*nity outreach, and cultural competency trainings.".*

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

*(i) Section 1312 of this Act is amended—*

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

*(2) in subsection (e)—*

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

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

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

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

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

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

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

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

*"(iii) from the news media,*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*(o) Section 1331 of this Act is amended—*

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

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

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

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

***"SEC. 1334. MULTI-STATE PLANS.***

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

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

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

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

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

*"(A) a medical loss ratio;*

*"(B) a profit margin;*

*"(C) the premiums to be charged; and*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(3) CREDITS.—*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(g) CONTINUED SUPPORT FOR FEHBP.—*

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

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

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

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

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

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

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

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

*(r) Section 1341 of this Act is amended—*

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

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

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

***SEC. 10105. AMENDMENTS TO SUBTITLE E.***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*"(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and implication of adjusting the application of the Federal poverty level under this subtitle (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. Not later than January 1, 2013, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.*

*"(b) INCLUSION OF TERRITORIES.—*

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

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

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

***SEC. 10106. AMENDMENTS TO SUBTITLE F.***

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

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

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

*creases financial risks to households and medical providers.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***SEC. 10107. AMENDMENTS TO SUBTITLE G.***

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

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

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

*(2) by inserting after section 1561 the following:*

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

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

*"(b) DATA.—*

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

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

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

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

*"(ii) the reasons such applications are denied.*

*"(2) SCOPE OF DATA.—*

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

*insurance issuer later approves such coverage or application.*

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

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

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

***"SEC. 1563. SMALL BUSINESS PROCUREMENT.***

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

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

***SEC. 10108. FREE CHOICE VOUCHERS.***

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

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

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

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

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

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

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

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

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

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

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

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

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

*(d) FREE CHOICE VOUCHER.—*

*(1) AMOUNT.—*

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

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

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

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

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

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

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

*(f) EXCLUSION FROM INCOME FOR EMPLOYEE.—*

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

***"SEC. 139D. FREE CHOICE VOUCHERS.***

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

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

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

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

*(g) DEDUCTION ALLOWED TO EMPLOYER.—*

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

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

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

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

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

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

*(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—*

*(1) SHARED RESPONSIBILITY PENALTY.—*

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

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

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

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

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

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

*(j) EMPLOYER REPORTING.—*

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

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

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

*"(1) OFFERING EMPLOYER.—*

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

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

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

*(3) CONFORMING AMENDMENTS.—*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*(c) ICD CODING CROSSWALKS.—*

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

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

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

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

# *Subtitle B—Provisions Relating to Title II*

## *PART I—MEDICAID AND CHIP*

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

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

*"(IX) who—*

*"(aa) are under 26 years of age;*

*"(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;*

*"(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and*

*"(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;".*

*(2) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G), by*

*striking "and (XV)" and inserting "(XV)", and by inserting "and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)" before the semicolon.*

*(3) Section 2004(d) of this Act is amended by striking "2019" and inserting "2014".*

*(b) Section 1902(k)(2) of the Social Security Act (42 U.S.C. 1396a(k)(2)), as added by section 2001(a)(4)(A), is amended by striking "January 1, 2011" and inserting "April 1, 2010".*

*(c) Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2001(a)(5)(C), 2006, and 4107(a)(2), is amended—*

*(1) in subsection (a), in the matter preceding paragraph (1), by inserting in clause (xiv), "or 1902(a)(10)(A)(i)(IX)" before the comma;*

*(2) in subsection (b), in the first sentence, by inserting ", (z)," before "and (aa)";*

*(3) in subsection (y)—*

*(A) in paragraph (1)(B)(ii)(II), in the first sentence, by inserting "includes inpatient hos-*

*pital services," after "100 percent of the poverty line, that"; and*

*(B) in paragraph (2)(A), by striking "on the date of enactment of the Patient Protection and Affordable Care Act" and inserting "as of December 1, 2009";*

*(4) by inserting after subsection (y) the following:*

*"(z) EQUITABLE SUPPORT FOR CERTAIN STATES.—*

*"(1)(A) During the period that begins on January 1, 2014, and ends on September 30, 2019, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to a fiscal year occurring during that period shall be increased by 2.2 percentage points for any State described in subparagraph (B) for amounts expended for medical assistance for individuals who are not newly eligible (as defined in subsection (y)(2)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).*

*"(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—*

*"(i) is an expansion State described in subsection (y)(1)(B)(ii)(II);*

*"(ii) the Secretary determines will not receive any payments under this title on the basis of an increased Federal medical assistance percentage under subsection (y) for expenditures for medical assistance for newly eligible individuals (as so defined); and*

*"(iii) has not been approved by the Secretary to divert a portion of the DSH allotment for a State to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.*

*"(2)(A) During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year occurring during that period shall be increased by .5 percentage point for a State described in subparagraph (B) for amounts expended for medical assistance under the State plan under this title or under a waiver of that plan during that period.*

*"(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that—*

*"(i) is described in clauses (i) and (ii) of paragraph (1)(B); and*

*"(ii) is the State with the highest percentage of its population insured during 2008, based on the Current Population Survey.*

*"(3) Notwithstanding subsection (b) and paragraphs (1) and (2) of this subsection, the Federal medical assistance percentage otherwise determined under subsection (b) with respect to all or any portion of a fiscal year that begins on or after January 1, 2017, for the State of Nebraska, with respect to amounts expended for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be determined as provided for under subsection (y)(1)(A) (notwithstanding the period provided for in such paragraph).*

*"(4) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to—*

*"(A) disproportionate share hospital payments described in section 1923;*

*"(B) payments under title IV;*

*"(C) payments under title XXI; and*

*"(D) payments under this title that are based on the enhanced FMAP described in section 2105(b).";*

*(5) in subsection (aa), is amended by striking "without regard to this subsection and subsection (y)"*

*and inserting "without regard to this subsection, subsection (y), subsection (z), and section 10202 of the Patient Protection and Affordable Care Act" each place it appears;*

*(6) by adding after subsection (bb), the following:*

*"(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), in the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under the State plan under section 1902(a)(2), the State shall not be eligible for an increase in its Federal medical assistance percentage under such subsections if it requires that political subdivisions pay a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentages that would have been required by the State under the State plan under this title, State law, or both, as in effect on December 31, 2009, and without regard to any such increase. Voluntary contributions by a political subdivision to the non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under section 1923, shall not be considered to be required contributions for purposes of this subsection. The treatment of voluntary contributions, and the treatment of contributions required by*

*a State under the State plan under this title, or State law, as provided by this subsection, shall also apply to the increases in the Federal medical assistance percentage under section 5001 of the American Recovery and Reinvestment Act of 2009.".*

*(d) Section 1108(g)(4)(B) of the Social Security Act (42 U.S.C. 1308(g)(4)(B)), as added by section 2005(b), is amended by striking "income eligibility level in effect for that population under title XIX or under a waiver" and inserting "the highest income eligibility level in effect for parents under the commonwealth's or territory's State plan under title XIX or under a waiver of the plan".*

*(e)(1) Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), as amended by section 2551, is amended—*

*(A) in paragraph (6)—*

*(i) by striking the paragraph heading and inserting the following: "ALLOTMENT ADJUSTMENTS"; and*

*(ii) in subparagraph (B), by adding at the end the following:*

*"(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL*

*YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):*

*"(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.*

*"(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).*

*"(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive pay-*

*ments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project."; and*

*(B) in paragraph (7)—*

*(i) in subparagraph (A), in the matter preceding clause (i), by striking "subparagraph (E)" and inserting "subparagraphs (E) and (G)";*

*(ii) in subparagraph (B)—*

*(I) in clause (i), by striking subclauses (I) and (II), and inserting the following:*

*"(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90*

*percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;*

*"(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 17.5 percent;*

*"(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and*

*"(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the*

*State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 35 percent.";*

*(II) in clause (ii), by striking subclauses (I) and (II), and inserting the following:*

*"(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;*

*"(II) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is*

*equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 20 percent;*

*"(III) if the State is not a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 55 percent; and*

*"(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered in-*

*dividuals for the fiscal year from the preceding fiscal year and 40 percent.";*

*(III) in subparagraph (E), by striking "35 percent" and inserting "50 percent"; and*

*(IV) by adding at the end the following:*

*"(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).".*

*(f) Section 2551 of this Act is amended by striking subsection (b).*

*(g) Section 2105(d)(3)(B) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(B)), as added by section 2101(b)(1), is amended by adding at the end the following: "For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.".*

*(h) Clause (i) of subparagraph (C) of section 513(b)(2) of the Social Security Act, as added by section 2953 of this Act, is amended to read as follows:*

*"(i) Healthy relationships, including marriage and family interactions.".*

*(i) Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:*

*"(d)(1) An application or renewal of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXI (in this subsection referred to as a 'demonstration project') shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).*

*"(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall promulgate regulations relating to applications for, and renewals of, a demonstration project that provide for—*

*"(A) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;*

*"(B) requirements relating to—*

*"(i) the goals of the program to be implemented or renewed under the demonstration project;*

*"(ii) the expected State and Federal costs and coverage projections of the demonstration project; and*

*"(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with title XIX or XXI;*

*"(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;*

*"(D) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the demonstration project; and*

*"(E) a process for the periodic evaluation by the Secretary of the demonstration project.*

*"(3) The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for demonstration projects under this section.".*

*(j) Subtitle F of title III of this Act is amended by adding at the end the following:*

***"SEC. 3512. GAO STUDY AND REPORT ON CAUSES OF ACTION.***

*"(a) STUDY.—*

*"(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether the development, recognition, or implementation of any guideline or other standards under a provision described in paragraph (2) would result in the establishment of a new cause of action or claim.*

*"(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph include the following:*

*"(A) Section 2701 (adult health quality measures).*

*"(B) Section 2702 (payment adjustments for health care acquired conditions).*

*"(C) Section 3001 (Hospital Value-Based Purchase Program).*

*"(D) Section 3002 (improvements to the Physician Quality Reporting Initiative).*

*"(E) Section 3003 (improvements to the Physician Feedback Program).*

*"(F) Section 3007 (value based payment modifier under physician fee schedule).*

*"(G) Section 3008 (payment adjustment for conditions acquired in hospitals).*

*"(H) Section 3013 (quality measure development).*

*"(I) Section 3014 (quality measurement).*

*"(J) Section 3021 (Establishment of Center for Medicare and Medicaid Innovation).*

*"(K) Section 3025 (hospital readmission reduction program).*

*"(L) Section 3501 (health care delivery system research, quality improvement).*

*"(M) Section 4003 (Task Force on Clinical and Preventive Services).*

*"(N) Section 4301 (research to optimize deliver of public health services).*

*"(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the appropriate committees of Congress, a report containing the findings made by the Comptroller General under the study under subsection (a).".*

***SEC. 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.***

*(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing*

*incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (z) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).*

*(b) BALANCING INCENTIVE PAYMENT STATE.—A balancing incentive payment State is a State—*

*(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined by the Secretary under subsection (f))(1)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);*

*(2) that submits an application and meets the conditions described in subsection (c); and*

*(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.*

*(c) CONDITIONS.—The conditions described in this subsection are the following:*

*(1) APPLICATION.—The State submits an application to the Secretary that includes, in addition to such other information as the Secretary shall require—*

*(A) a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a "no wrong door—single entry point system", optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services; and*

*(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section*

*1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish for such purpose, not to exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (42 U.S.C. 1382(b)(1)).*

*(2) TARGET SPENDING PERCENTAGES.—*

*(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.*

*(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total*

*expenditures for long-term services and supports under the State Medicaid program are for home and community-based services.*

*(3) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—The State does not apply eligibility standards, methodologies, or procedures for determining eligibility for medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes on December 31, 2010.*

*(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program.*

*(5) STRUCTURAL CHANGES.—The State agrees to make, not later than the end of the 6-month period that begins on the date the State submits an application under this section, the following changes:*

*(A) "NO WRONG DOOR—SINGLE ENTRY POINT SYSTEM".—Development of a statewide*

*system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional eligibility for such services and supports, or assistance with assessment processes for financial and functional eligibility.*

*(B) CONFLICT-FREE CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.*

*(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligi-*

*bility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.*

*(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:*

*(A) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in subsection (f)(1)(B) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.*

*(B) QUALITY DATA.—Quality data on a selected set of core quality measures agreed upon by the Secretary and the State that are linked to population-specific outcomes measures and accessible to providers.*

*(C) OUTCOMES MEASURES.—Outcomes measures data on a selected set of core population-specific outcomes measures agreed upon by the Secretary and the State that are accessible to providers and include—*

*(i) measures of beneficiary and family caregiver experience with providers;*

*(ii) measures of beneficiary and family caregiver satisfaction with services; and*

*(iii) measures for achieving desired outcomes appropriate to a specific beneficiary, including employment, participation in community life, health stability, and prevention of loss in function.*

*(d) APPLICABLE PERCENTAGE POINTS INCREASE IN FMAP.—The applicable percentage points increase is—*

*(1) in the case of a balancing incentive payment State subject to the target spending percentage described in subsection (c)(2)(A), 5 percentage points; and*

*(2) in the case of any other balancing incentive payment State, 2 percentage points.*

*(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—*

*(1) IN GENERAL.—Subject to paragraph (2), medical assistance described in this subsection is medical assistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) that is provided by a balancing incentive payment State under its State Medicaid program during the balancing incentive payment period.*

*(2) LIMITATION ON PAYMENTS.—In no case may the aggregate amount of payments made by the Secretary to balancing incentive payment States under this section during the balancing incentive period exceed $3,000,000,000.*

*(f) DEFINITIONS.—In this section:*

*(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term "long-term services and supports" has the meaning given that term by Secretary and may include any of the following (as defined for purposes of State Medicaid programs):*

*(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:*

*(i) Nursing facility services.*

*(ii) Services in an intermediate care facility for the mentally retarded described*

*in subsection (a)(15) of section 1905 of such Act.*

*(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not provided in an institution, including the following:*

*(i) Home and community-based services provided under subsection (c), (d), or (i) of section 1915 of such Act or under a waiver under section 1115 of such Act.*

*(ii) Home health care services.*

*(iii) Personal care services.*

*(iv) Services described in subsection (a)(26) of section 1905 of such Act (relating to PACE program services).*

*(v) Self-directed personal assistance services described in section 1915(j) of such Act.*

*(2) BALANCING INCENTIVE PERIOD.—The term "balancing incentive period" means the period that begins on October 1, 2011, and ends on September 30, 2015.*

*(3) POVERTY LINE.—The term "poverty line" has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).*

*(4) STATE MEDICAID PROGRAM.—The term "State Medicaid program" means the State program for medical assistance provided under a State plan under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.*

***SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEAR 2015 AND OTHER CHIP-RELATED PROVISIONS.***

*(a) Section 1311(c)(1) of this Act is amended by striking "and" at the end of subparagraph (G), by striking the period at the end of subparagraph (H) and inserting "; and", and by adding at the end the following:*

*"(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act.".*

*(b) Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3):*

*(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking "means" and all that follows through the period and*

*inserting "has the meaning given that term in section 2105(c)(3)(A).".*

*(2)(A) Section 1906A(a) of the Social Security Act (42 U.S.C. 1396e–1(a)), is amended by inserting before the period the following: "and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)".*

*(B) This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and that subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.*

*(3) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1397ee(c)(10)) is amended—*

*(A) in subparagraph (A), in the first sentence, by inserting before the period the following: "if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A)";*

*(B) by striking subparagraph (M); and*

*(C) by redesignating subparagraph (N) as subparagraph (M).*

*(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)) is amended—*

*(A) in the matter preceding clause (i), by striking "to" and inserting "to—"; and*

*(B) in clause (ii), by striking the period and inserting a semicolon.*

*(c) Section 2105 of the Social Security Act (42 U.S.C. 1397ee), as amended by section 2101, is amended—*

*(1) in subsection (b), in the second sentence, by striking "2013" and inserting "2015"; and*

*(2) in subsection (d)(3)—*

*(A) in subparagraph (A)—*

*(i) in the first sentence, by inserting "as a condition of receiving payments under section 1903(a)," after "2019,";*

*(ii) in clause (i), by striking "or" at the end;*

*(iii) by redesignating clause (ii) as clause (iii); and*

*(iv) by inserting after clause (i), the following:*

*"(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or";*

*(B) in subparagraph (B), by striking "provided coverage" and inserting "screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered"; and*

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

*"(C) CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing*

*with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.".*

*(d)(1) Section 2104(a) of such Act (42 U.S.C. 1397dd(a)) is amended—*

*(A) in paragraph (15), by striking "and" at the end; and*

*(B) by striking paragraph (16) and inserting the following:*

*"(16) for fiscal year 2013, $17,406,000,000;*

*"(17) for fiscal year 2014, $19,147,000,000; and*

*"(18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—*

*"(A) $2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and*

*"(B) $2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015.".*

*(2)(A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2102(a)(1), is amended—*

*(i) in the subsection heading, by striking "2013" and inserting "2015";*

*(ii) in paragraph (2)—*

*(I) in the paragraph heading, by striking "2012" and inserting "2014"; and*

*(II) by adding at the end the following:*

*"(B) FISCAL YEARS 2013 AND 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and 2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:*

*"(i) REBASING IN FISCAL YEAR 2013.—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013.*

*"(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014.—For fiscal year 2014, the allotment of the State is equal to the sum of—*

*"(I) the amount of the State allotment under clause (i) for fiscal year 2013; and*

*"(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013,*

*multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.";*

*(iii) in paragraph (3)—*

*(I) in the paragraph heading, by striking "2013" and inserting "2015";*

*(II) in subparagraphs (A) and (B), by striking "paragraph (16)" each place it appears and inserting "paragraph (18)";*

*(III) in subparagraph (C)—*

*(aa) by striking "2012" each place it appears and inserting "2014"; and*

*(bb) by striking "2013" and inserting "2015"; and*

*(IV) in subparagraph (D)—*

*(aa) in clause (i)(I), by striking "subsection (a)(16)(A)" and inserting "subsection (a)(18)(A)"; and*

*(bb) in clause (ii)(II), by striking "subsection (a)(16)(B)" and inserting "subsection (a)(18)(B)";*

*(iv) in paragraph (4), by striking "2013" and inserting "2015";*

*(v) in paragraph (6)—*

*(I) in subparagraph (A), by striking "2013" and inserting "2015"; and*

*(II) in the flush language after and below subparagraph (B)(ii), by striking "or fiscal year 2012" and inserting ", fiscal year 2012, or fiscal year 2014"; and*

*(vi) in paragraph (8)—*

*(I) in the paragraph heading, by striking "2013" and inserting "2015"; and*

*(II) by striking "2013" and inserting "2015".*

*(B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended—*

*(i) in paragraph (2)—*

*(I) in subparagraph (A)(ii)—*

*(aa) by striking "2012" and inserting "2014"; and*

*(bb) by striking "2013" and inserting "2015";*

*(II) in subparagraph (B)—*

*(aa) by striking "2012" and inserting "2014"; and*

*(bb) by striking "2013" and inserting "2015"; and*

*(ii) in paragraph (3)(A), by striking "or a semi-annual allotment period for fiscal year 2013" and inserting "fiscal year 2013, fiscal year 2014, or a semi-annual allotment period for fiscal year 2015".*

*(C) Section 2105(g)(4) of such Act (42 U.S.C. 1397ee(g)(4)) is amended—*

*(i) in the paragraph heading, by striking "2013" and inserting "2015"; and*

*(ii) in subparagraph (A), by striking "2013" and inserting "2015".*

*(D) Section 2110(b) of such Act (42 U.S.C. 1397jj(b)) is amended—*

*(i) in paragraph (2)(B), by inserting "except as provided in paragraph (6)," before "a child"; and*

*(ii) by adding at the end the following new paragraph:*

*"(6) EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.—*

*"(A) IN GENERAL.—A child shall not be considered to be described in paragraph (2)(B) if—*

*"(i) the public agency that employs a member of the child's family to which such paragraph applies satisfies subparagraph (B); or*

*"(ii) subparagraph (C) applies to such child.*

*"(B) MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.—For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban*

*Consumers (all items: U.S. City Average) for such preceding fiscal year.*

*"(C) HARDSHIP EXCEPTION.—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.".*

*(E) Section 2113 of such Act (42 U.S.C. 1397mm) is amended—*

*(i) in subsection (a)(1), by striking "2013" and inserting "2015"; and*

*(ii) in subsection (g), by striking "$100,000,000 for the period of fiscal years 2009 through 2013" and inserting "$140,000,000 for the period of fiscal years 2009 through 2015".*

*(F) Section 108 of Public Law 111–3 is amended by striking "$11,706,000,000" and all that follows through the second sentence and inserting "$15,361,000,000 to accompany the allotment made for the period beginning on October 1, 2014, and ending on March 31, 2015, under section 2104(a)(18)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(18)(A)), to remain available until expended.*

*Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2015 in the same manner as allotments are provided under subsection (a)(18)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(18)(A).".*

## *PART II—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN*

### *SEC. 10211. DEFINITIONS.*

*In this part:*

*(1) ACCOMPANIMENT.—The term "accompaniment" means assisting, representing, and accompanying a woman in seeking judicial relief for child support, child custody, restraining orders, and restitution for harm to persons and property, and in filing criminal charges, and may include the payment of court costs and reasonable attorney and witness fees associated therewith.*

*(2) ELIGIBLE INSTITUTION OF HIGHER EDUCATION.—The term "eligible institution of higher education" means an institution of higher education (as such term is defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) that has established and operates, or agrees to establish and op-*

*erate upon the receipt of a grant under this part, a pregnant and parenting student services office.*

*(3) COMMUNITY SERVICE CENTER.—The term "community service center" means a non-profit organization that provides social services to residents of a specific geographical area via direct service or by contract with a local governmental agency.*

*(4) HIGH SCHOOL.—The term "high school" means any public or private school that operates grades 10 through 12, inclusive, grades 9 through 12, inclusive or grades 7 through 12, inclusive.*

*(5) INTERVENTION SERVICES.—The term "intervention services" means, with respect to domestic violence, sexual violence, sexual assault, or stalking, 24-hour telephone hotline services for police protection and referral to shelters.*

*(6) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.*

*(7) STATE.—The term "State" includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.*

*(8) SUPPORTIVE SOCIAL SERVICES.—The term "supportive social services" means transitional and permanent housing, vocational counseling, and indi-*

*vidual and group counseling aimed at preventing domestic violence, sexual violence, sexual assault, or stalking.*

*(9) VIOLENCE.—The term "violence" means actual violence and the risk or threat of violence.*

***SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.***

*(a) IN GENERAL.—The Secretary, in collaboration and coordination with the Secretary of Education (as appropriate), shall establish a Pregnancy Assistance Fund to be administered by the Secretary, for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women.*

*(b) USE OF FUND.—A State may apply for a grant under subsection (a) to carry out any activities provided for in section 10213.*

*(c) APPLICATIONS.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the purposes for which the grant is being requested and the designation of a State agency for receipt and administration of funding received under this part.*

***SEC. 10213. PERMISSIBLE USES OF FUND.***

*(a) IN GENERAL.—A State shall use amounts received under a grant under section 10212 for the purposes described in this section to assist pregnant and parenting teens and women.*

*(b) INSTITUTIONS OF HIGHER EDUCATION.—*

*(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available to eligible institutions of higher education to enable the eligible institutions to establish, maintain, or operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services.*

*(2) APPLICATION.—An eligible institution of higher education that desires to receive funding under this subsection shall submit an application to the designated State agency at such time, in such manner, and containing such information as the State agency may require.*

*(3) MATCHING REQUIREMENT.—An eligible institution of higher education that receives funding under this subsection shall contribute to the conduct of the pregnant and parenting student services office supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of the funding provided. The non-Federal share may be in cash*

*or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.*

*(4) USE OF FUNDS FOR ASSISTING PREGNANT AND PARENTING COLLEGE STUDENTS.—An eligible institution of higher education that receives funding under this subsection shall use such funds to establish, maintain or operate pregnant and parenting student services and may use such funding for the following programs and activities:*

*(A) Conduct a needs assessment on campus and within the local community—*

*(i) to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the needs described in subparagraph (B); and*

*(ii) to set goals for—*

*(I) improving such resources for pregnant, parenting, and prospective parenting students; and*

*(II) improving access to such resources.*

*(B) Annually assess the performance of the eligible institution in meeting the following needs*

*of students enrolled in the eligible institution who are pregnant or are parents:*

*(i) The inclusion of maternity coverage and the availability of riders for additional family members in student health care.*

*(ii) Family housing.*

*(iii) Child care.*

*(iv) Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school.*

*(v) Education to improve parenting skills for mothers and fathers and to strengthen marriages.*

*(vi) Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children.*

*(vii) Post-partum counseling.*

*(C) Identify public and private service providers, located on the campus of the eligible institution or within the local community, that are qualified to meet the needs described in subpara-*

*graph (B), and establishes programs with qualified providers to meet such needs.*

*(D) Assist pregnant and parenting students, fathers or spouses in locating and obtaining services that meet the needs described in subparagraph (B).*

*(E) If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals only to service providers that serve the following types of individuals:*

*(i) Parents.*

*(ii) Prospective parents awaiting adoption.*

*(iii) Women who are pregnant and plan on parenting or placing the child for adoption.*

*(iv) Parenting or prospective parenting couples.*

*(5) REPORTING.—*

*(A) ANNUAL REPORT BY INSTITUTIONS.—*

*(i) IN GENERAL.—For each fiscal year that an eligible institution of higher education receives funds under this subsection,*

*the eligible institution shall prepare and submit to the State, by the date determined by the State, a report that—*

*(I) itemizes the pregnant and parenting student services office's expenditures for the fiscal year;*

*(II) contains a review and evaluation of the performance of the office in fulfilling the requirements of this section, using the specific performance criteria or standards established under subparagraph (B)(i); and*

*(III) describes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students.*

*(ii) PERFORMANCE CRITERIA.—Not later than 180 days before the date the annual report described in clause (i) is submitted, the State—*

*(I) shall identify the specific performance criteria or standards that shall be used to prepare the report; and*

*(II) may establish the form or format of the report.*

*(B) REPORT BY STATE.—The State shall annually prepare and submit a report on the findings under this subsection, including the number of eligible institutions of higher education that were awarded funds and the number of students served by each pregnant and parenting student services office receiving funds under this section, to the Secretary.*

*(c) SUPPORT FOR PREGNANT AND PARENTING TEENS.—A State may use amounts received under a grant under section 10212 to make funding available to eligible high schools and community service centers to establish, maintain or operate pregnant and parenting services in the same general manner and in accordance with all conditions and requirements described in subsection (b), except that paragraph (3) of such subsection shall not apply for purposes of this subsection.*

*(d) IMPROVING SERVICES FOR PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.—*

*(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make*

*funding available tp its State Attorney General to assist Statewide offices in providing—*

*(A) intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking.*

*(B) technical assistance and training (as described in subsection (c)) relating to violence against eligible pregnant women to be made available to the following:*

*(i) Federal, State, tribal, territorial, and local governments, law enforcement agencies, and courts.*

*(ii) Professionals working in legal, social service, and health care settings.*

*(iii) Nonprofit organizations.*

*(iv) Faith-based organizations.*

*(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.*

*(3) TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.—For purposes of paragraph (1)(B), technical assistance and training is—*

*(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;*

*(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;*

*(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and*

*(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.*

*(4) ELIGIBLE PREGNANT WOMAN.—In this subsection, the term "eligible pregnant woman" means*

*any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence, sexual assault, or stalking or who was pregnant during the one-year period before such date.*

*(e) PUBLIC AWARENESS AND EDUCATION.—A State may use amounts received under a grant under section 10212 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this part. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.*

***SEC. 10214. APPROPRIATIONS.***

*There is authorized to be appropriated, and there are appropriated, $25,000,000 for each of fiscal years 2010 through 2019, to carry out this part.*

## *PART III—INDIAN HEALTH CARE IMPROVEMENT*

***SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.***

*(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.", as reported by the Committee on In-*