AMENDMENT NO._____ Calendar No._____

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

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

S._____

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

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

Strike section 1 and all that follows through subtitle G of title I and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Affordable Health Choices Act''.

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

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Effective Coverage for All Americans

PART I—PROVISIONS APPLICABLE TO THE INDIVIDUAL AND GROUP MARKETS

SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

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

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

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS

"Subpart 1—General Reform";

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

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

''SEC. 2705. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.''; and

(B) by transferring the remainder of section so as to appear after the section 2704 as added by paragraph (5);

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

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

(B) in subsection (b)—

(i) by striking ''health insurance issuer offering health insurance coverage in connection with a group health plan'' each place that such appears and inserting ''health insurance issuer offering group or individual health insurance coverage'';

(ii) in paragraph (2)(A)—

(I) by inserting ''or individual'' after ''employer''; and

(II) by inserting ''or individual health coverage, as the case may be'' before the semicolon; and

(iii) by transferring the remainder of such section to appear at the end of section 2706 (as added by paragraph (5));

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

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

"SEC. 2701. FAIR INSURANCE COVERAGE.

''(a) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or group market—

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

''(A) family structure;

''(B) community rating area;

''(C) the actuarial value of the benefit;

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

''(2) such rate shall not vary with respect to the particular plan or coverage involved by health status-related factors, gender, class of business, claims experience, or any other factor not described in paragraph (1).

''(b) COMMUNITY RATING AREA.—Taking into account the applicable recommendations of the National Association of Insurance Commissioners, the Secretary shall by regulation establish a minimum size for community rating areas for purposes of this section.

''SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

''(a) ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

''(b) ENROLLMENT.—

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

''(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

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

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

"SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

"Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

"SEC. 2704. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall publicly report (in a manner to be established by the Secretary through regulation) the percentage of total premium revenue that such coverage expends—

"(1) on reimbursement for clinical services provided to enrollees under such plan or 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.

"(b) DEFINITION.—In this section, the term 'activities to improve health care quality' means activities described in section 2707.

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

''(d) PROCESSES AND METHODS.—The Secretary shall develop a methodology for calculating the percentage described in subsection (a)(3). Such methodology may provide for a requirement that a report described in subsection (a)(1) include an actuarial certification of the information included in such report.

''SEC. 2706. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(1) Health status.

''(2) Medical condition (including both physical and mental illnesses).

''(3) Claims experience.

''(4) Receipt of health care.

''(5) Medical history.

''(6) Genetic information.

''(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(8) Disability.

''(9) Any other health status-related factor determined appropriate by the Secretary.

''SEC. 2707. ENSURING THE QUALITY OF CARE.

''(a) IN GENERAL.—Except as provided in subsection (b), a group health plan and a health insurance issuer offering group or individual health insurance coverage shall develop and implement a reimbursement structure for making payments to health care providers that provides incentives for—

''(1) the provision of high quality health care under the plan or coverage in a manner that includes—

''(A) the implementation of case management, care coordination, chronic disease management, and medication and care compliance activities that includes the use of the medical home model as defined in section 212 of the Affordable Health Choices Act for treatment or services under the plan or coverage;

"(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional;

"(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

"(D) the implementation of wellness and health promotion activities;

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

"(F) culturally and linguistically appropriate care, as defined by the Secretary; and

"(2) payment policies that substantially reflects the payment policy of the Medicare program under title XVIII of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to any generally implemented incentive policy to promote high quality health care.

''(b) EXCEPTIONS.—In promulgating regulations under subsection (c), the Secretary may provide for exceptions to the requirements of subsection (a) for insurers that substantially meet the goals of this section.

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

''(1) that define the term 'generally implemented' for purposes of subsection (a)(2);

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

''(3) that provide criteria for determining whether a payment policy is described in subsection (a).

"SEC. 2708. COVERAGE OF PREVENTIVE HEALTH SERVICES.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements (other than minimal cost sharing in accordance with guidelines developed by the Secretary) for—

''(1) items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

''(3) with respect to infants, children and adolescents, preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

''(b) INTERVAL.—

''(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

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

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

''SEC. 2709. EXTENSION OF DEPENDENT COVERAGE.

''(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependant coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.

''(b) REGULATIONS.—The Secretary shall promulgate regulations to define the scope of the dependants to which coverage shall be made available under subsection (a).

''SEC. 2710. NO LIFETIME OR ANNUAL LIMITS.

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

''SEC. 2711. NOTIFICATION BY PLANS NOT PROVIDING MINIMUM QUALIFYING COVERAGE.

''(a) IN GENERAL.—Not later than 1 year after the date on which the Secretary establishes criteria with respect to minimum qualifying coverage under section 3103,

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

''(b) MODIFICATIONS.—If the Secretary modifies the criteria with respect to minimum qualifying coverage under section 3103, a group health plan or health insurance issuer that fails to provide such modified minimum qualifying coverage shall provide the notice required under subsection (a) within 60 days of the date of such modification.''.

PART II—PROVISION APPLICABLE TO THE GROUP MARKET

SEC. 121. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

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

''SEC. 2719. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

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

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

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a group health plan or health insurance issuer from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of a similarly situated employees with a higher hourly or annual compensation.''.

PART III—OTHER PROVISIONS

SEC. 131. NO CHANGES TO EXISTING COVERAGE.

(a) OPTION TO RETAIN CURRENT INSURANCE COVERAGE.—

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

(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled prior to the date of enactment of this title, this subtitle (and

the amendments made by this subtitle) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

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

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

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

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

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

(f) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this title, the provisions of this subtitle (and the amendments made by this subtitle) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this subtitle (or amendments) shall not be treated as a termination of such collective bargaining agreement.

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

SEC. 132. APPLICABILITY.

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

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking ''1 through 3'' and inserting ''1 and 2''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ''subparagraph (D)'' and inserting ''subparagraph (D) or (E)'';

(ii) by striking ''1 through 3'' and inserting ''1 and 2''; and

(iii) by adding at the end the following:

''(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subpart 1.'';

(3) in subsection (c), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(4) in subsection (d)—

(A) in paragraph (1), by striking ''1 through 3 shall not apply to any group'' and in-

serting ''1 and 2 shall not apply to any individual coverage or any group'';

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ''1 through 3 shall not apply to any group'' and inserting ''1 and 2 shall not apply to any individual coverage or any group''; and

(ii) in subparagraph (C), by inserting ''or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer''; and

(C) in paragraph (3), by striking ''any group'' and inserting ''any individual coverage or any group''.

SEC. 133. CONFORMING AMENDMENTS.

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

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

(A) in subsection (c)—

(i) in paragraph (2), by striking ''group health plan'' each place that such

appears and inserting ''group or individual health plan''; and

(ii) in paragraph (3)—

(I) by striking ''group health insurance'' each place that such appears and inserting ''group or individual health insurance''; and

(II) in subparagraph (D), by striking ''small or large'' and inserting ''individual or group'';

(B) in subsection (d), by striking ''group health insurance'' each place that such appears and inserting ''group or individual health insurance''; and

(C) in subsection (e)(1)(A), by striking ''group health insurance'' and inserting ''group or individual health insurance'';

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

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

(A) in subsection (a), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance

issuer offering group or individual health insurance coverage'';

(B) in subsection (b)—

(i) by striking ''health insurance issuer offering group health insurance coverage in connection with a group health plan'' in the matter preceding paragraph (1) and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (1), by striking ''plan'' and inserting ''plan or coverage'';

(C) in subsection (c)—

(i) in paragraph (2), by striking ''group health insurance coverage offered by a health insurance issuer'' and inserting ''health insurance issuer offering group or individual health insurance coverage''; and

(ii) in paragraph (3), by striking ''issuer'' and inserting ''health insurance issuer''; and

(D) in subsection (e), by striking ''health insurance issuer offering group health insurance coverage'' and inserting ''health insurance

issuer offering group or individual health insurance coverage'';

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

(A) in subsection (a), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

(B) in subsection (b), by striking ''(or health insurance coverage offered in connection with such a plan)'' each place that such appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage''; and

(C) in subsection (c)—

(i) in paragraph (1), by striking ''(and group health insurance coverage offered in connection with a group health plan)'' and inserting ''and a health insurance issuer offering group or individual health insurance coverage'';

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

nection with such a plan)'' each place that such appears and inserting ''or a health insurance issuer offering group or individual health insurance coverage'';

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

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

(A) in subsection (a), by striking ''health insurance coverage offered in connection with such plan'' and inserting ''individual health insurance coverage'';

(B) in subsection (b)—

(i) in paragraph (1), by striking ''or a health insurance issuer that provides health insurance coverage in connection with a group health plan'' and inserting ''or a health insurance issuer that offers group or individual health insurance coverage'';

(ii) in paragraph (2), by striking ''health insurance coverage offered in connection with the plan'' and inserting ''individual health insurance coverage''; and

(iii) in paragraph (3), by striking ''health insurance coverage offered by an issuer in connection with such plan'' and inserting ''individual health insurance coverage'';

(C) in subsection (c), by striking ''health insurance issuer providing health insurance coverage in connection with a group health plan'' and inserting ''health insurance issuer that offers group or individual health insurance coverage''; and

(D) in subsection (e)(1), by striking ''health insurance coverage offered in connection with such a plan'' and inserting ''individual health insurance coverage'';

(7) by striking the heading for subpart 3;

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

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

(B) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small group'' and inserting ''group and individual''; and

(II) in subparagraph (B)—

(aa) in the matter preceding clause (i), by inserting ''and individuals'' after ''employers'';

(bb) in clause (i), by inserting ''or any additional individuals'' after ''additional groups''; and

(cc) in clause (ii), by striking ''without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such'' and inserting ''and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health

status-related factor relating to such individuals''; and

(ii) in paragraph (2), by striking ''small group'' and inserting ''group or individual'';

(C) in subsection (d)—

(i) by striking ''small group'' each place that such appears and inserting ''group or individual''; and

(ii) in paragraph (1)(B)—

(I) by striking ''all employers'' and inserting ''all employers and individuals'';

(II) by striking ''those employers'' and inserting ''those individuals, employers''; and

(III) by striking ''such employees'' and inserting ''such individuals, employees'';

(D) by striking subsection (e);

(E) by redesignating subsection (f) as subsection (e); and

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

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

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

(B) in subsection (b)—

(i) in the matter preceding paragraph (1), by striking ''group health plan in the small or large group market'' and inserting ''health insurance coverage offered in the group or individual market'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''plan sponsor'';

(iii) in paragraph (2), by inserting '', or individual, as applicable,'' after ''plan sponsor''; and

(iv) by striking paragraph (3) and inserting the following:

''(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RATES.—In the case of a group health plan, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable State law.'';

(C) in subsection (c)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''group health insurance coverage offered in the small or large group market'' and inserting ''group or individual health insurance coverage'';

(II) in subparagraph (A), by inserting ''or individual, as applicable,'' after ''plan sponsor'';

(III) in subparagraph (B)—

(aa) by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

(bb) by inserting ''or individual health insurance coverage''; and

(IV) in subparagraph (C), by inserting ''or individuals, as applicable,'' after ''those sponsors''; and

(ii) in paragraph (2)(A)—

(I) in the matter preceding clause (i), by striking ''small group market or the large group market, or both

markets,'' and inserting ''individual or group market, or all markets,''; and

(II) in clause (i), by inserting ''or individual, as applicable,'' after ''plan sponsor''; and

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

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

(A) in subsection (a)—

(i) in the matter preceding paragraph (1), by striking ''small employer'' and inserting ''small employer or an individual'';

(ii) in paragraph (1), by inserting '', or individual, as applicable,'' after ''employer'' each place that such appears; and

(iii) in paragraph (2), by striking ''small employer'' and inserting ''employer, or individual, as applicable,'';

(B) in subsection (b)—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''small em-

ployer'' and inserting ''employer, or individual, as applicable,'';

(II) in subparagraph (A), by adding ''and'' at the end;

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

(IV) in subparagraph (D)—

(aa) by inserting '', or individual, as applicable,'' after ''employer''; and

(bb) by redesignating such subparagraph as subparagraph (B);

(ii) in paragraph (2)—

(I) by striking ''small employers'' each place that such appears and inserting ''employers, or individuals, as applicable,''; and

(II) by striking ''small employer'' and inserting ''employer, or individual, as applicable,''; and

(C) by redesignating such section as section 2712 and transferring such section to appear after section 2711 (as added by section 101(5));

(11) by redesignating subpart 4 as subpart 2;

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

(A) by striking subsection (a);

(B) by striking ''subparts 1 through 3'' each place that such appears and inserting ''subpart 1''; and

(C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively;

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

(A) in subsection (a)—

(i) in paragraph (1), by striking ''small or large group markets'' and inserting ''individual or group market''; and

(ii) in paragraph (2), by inserting ''or individual health insurance coverage'' after ''group health plans''; and

(B) in subsection (b)(1)(B), by inserting ''individual health insurance coverage or'' after ''respect to''; and

(14) in section 2723(a)(1) (42 U.S.C. 300gg-23), by inserting ''individual or'' before ''group health insurance''.

(b) TECHNICAL AMENDMENT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart

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

"SEC. 715. ADDITIONAL MARKET REFORMS.

"(a) GENERAL RULE.—Except as provided in subsection (b)—

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

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

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

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

(c) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9815. ADDITIONAL MARKET REFORMS.

''(a) GENERAL RULE.—Except as provided in subsection (b)—

''(1) the provisions of subpart 1 of part A of title XXVII of the Public Health Service Act (as amended by the Affordable Health Choices Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

''(2) to the extent that any provision of this subchapter conflicts with a provision of such subpart 1 with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such subpart 1 shall apply.

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

the Affordable Health Choices Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.''.

SEC. 134. EFFECTIVE DATES.

(a) IMMEDIATE APPLICABILITY.—Except as otherwise provided in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective on the date of enactment of this Act.

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

Subtitle B—Available Coverage for All Americans

SEC. 141. BUILDING ON THE SUCCESS OF THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM SO ALL AMERICANS HAVE AFFORDABLE HEALTH BENEFIT CHOICES.

(a) FINDINGS.—The Senate finds that—

(1) the Federal employees health benefits program under chapter 89 of title 5, United States Code, allows Members of Congress to have affordable choices among competing health benefit plans;

(2) the Federal employees health benefits program ensures that the health benefit plans available to Members of Congress meet minimum standards of quality and effectiveness;

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

(4) all Americans should have the same kinds of meaningful choices of health benefit plans that Members of Congress, as Federal employees, enjoy through the Federal employees health benefits program.

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

SEC. 142. AFFORDABLE HEALTH CHOICES FOR ALL AMERICANS.

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

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

"TITLE XXXI—AFFORDABLE HEALTH CHOICES FOR ALL AMERICANS

"Subtitle A—Affordable Choices

"SEC. 3101. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

"(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT GATEWAYS.—

"(1) PLANNING AND ESTABLISHMENT GRANTS.—Not later than 60 days after the date of enactment of this section, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

"(2) AMOUNT SPECIFIED.—

"(A) TOTAL DETERMINED.—For each fiscal year, the Secretary shall determine the total

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

''(B) STATE AMOUNT.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula established by the Secretary under which each State shall receive an award in an amount that is based on the following two components:

''(i) A minimum amount for each State.

''(ii) An additional amount based on population.

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

''(4) RENEWABILITY OF GRANT.—

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

''(i) is making progress, as determined by the Secretary, toward—

''(I) establishing a Gateway; and

''(II) implementing the reforms described subtitle A of title I of the Affordable Health Choices Act; and

''(ii) is meeting such other benchmarks as the Secretary may establish.

''(B) LIMITATION.—If a State is an establishing State or a participating State (as defined in section 3104), such State shall not be eligible for a grant renewal under subparagraph (A) as of the second fiscal year following the date on which such State was deemed to be an establishing State or a participating State.

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

''(b) AMERICAN HEALTH BENEFIT GATEWAYS.—An American Health Benefit Gateway (referred to in this section as a 'Gateway') means a mechanism that—

''(1) facilitates the purchase of health insurance coverage and related insurance products through the Gateway at an affordable price by qualified individuals and qualified employer groups; and

''(2) meets the requirements of subsection (c).

''(c) REQUIREMENTS.—

''(1) VOLUNTARY NATURE OF GATEWAY.—

''(A) CHOICE TO ENROLL OR NOT TO ENROLL.—A qualified individual shall have the choice to enroll or not to enroll in a qualified health plan or to participate in a Gateway.

''(B) PROHIBITION ON COMPELLED ENROLLMENT.—No individual shall be compelled to enroll in a qualified health plan or to participate in a Gateway.

''(2) ESTABLISHMENT.—A Gateway shall be a governmental agency or nonprofit entity that is established by—

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

''(B) the Secretary, in the case of a participating State (as described in section 3104).

''(3) OFFERING OF COVERAGE.—

''(A) IN GENERAL.—A Gateway shall make available qualified health plans to qualified individuals and qualified employers.

''(B) INCLUSION.—In making available coverage pursuant to subparagraph (A), a Gateway shall include a community health insurance option (as described in section 3106).

"(C) LIMITATION.—A Gateway may not make available any health plan or other health insurance coverage that is not a qualified health plan.

"(D) ALLOWANCE TO OFFER.—A Gateway may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 3103(a).

"(E) STATES MAY REQUIRE ADDITIONAL BENEFITS.—Subject to the requirements of subparagraph (F), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits described in section 3103(a).

"(F) ADDITIONAL BENEFITS.—

"(i) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (E) that a qualified health plan cover benefits in addition to the essential health benefits required shall not affect the amount of a credit provided under section 3111 with respect to such plan.

''(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (E).

''(4) FUNCTIONS.—A Gateway shall, at a minimum—

''(A) establish procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (l), of health plans as qualified health plans;

''(B) develop and make available tools to allow consumers to receive accurate information on—

''(i) expected premiums and out of pocket expenses (taking into account any credits for which such individual is eligible under section 3111);

''(ii) the availability of in-network and out-of-network providers;

''(iii) the costs of any surcharge assessed under paragraph (5);

''(iv) data, by plan, that reflects the frequency with which preventive services

rated 'A' or 'B' by the U.S. Preventive Services Task Force are utilized by enrollees, a comparison of such data to the average frequency of preventive services utilized by enrollees across all qualified health plans, and whether 'A' and 'B' rated preventive services are utilized by enrollees as frequently as recommended by the U.S. Preventive Services Task Force; and

''(v) such other matters relating to consumer costs and expected experience under the plan as a Gateway may determine necessary;

''(C) utilize the administrative simplification measures and standards developed under section 222 of the Affordable Health Choices Act;

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

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

''(F) collect, analyze, and respond to complaints and concerns from enrollees regarding coverage provided through the Gateway.

''(5) SURCHARGES.—

''(A) IN GENERAL.—A Gateway may assess a surcharge on all health insurance issuers offering qualified health plans through the Gateway to pay for the administrative and operational expenses of the Gateway.

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

''(6) RISK ADJUSTMENT PAYMENT.—

''(A) ESTABLISHING AND PARTICIPATING STATES.—

''(i) LOW ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in section 3104) shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subparagraph (C) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that

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

''(ii) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subparagraph (B), each establishing State or participating State (as defined in section 3104) shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subparagraph (C) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

''(B) CRITERIA AND METHODS.—The Secretary, in consultation with States shall establish criteria and methods to be used in carrying out the risk adjustment activities under this paragraph. The Secretary may utilize criteria

and methods similar to the criteria and methods utilized under parts C and D of title XVIII of the Social Security Act.

''(C) SCOPE.—A health plan or a health insurance issuer is described in this subparagraph if such health plan or health insurance issuer provides coverage for an individual or for an employer group the size of which does not exceed—

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

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

''(7) FACILITATING ENROLLMENT.—

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

information technology) implement policies and procedures to—

"(i) facilitate the identification of individuals who lack qualifying coverage; and

"(ii) assist such individuals in enrolling in—

"(I) a qualified health plan that is affordable and available to such individual, if such individual is a qualified individual;

"(II) the medicaid program under title XIX of the Social Security Act, if such individual is eligible for such program;

"(III) the CHIP program under title XXI of the Social Security Act, if such individual is eligible for such program; or

"(IV) other Federal programs in which such individual is eligible to participate.

"(B) CHOICE FOR INDIVIDUALS ELIGIBLE FOR CHIP.—A qualified individual who is eligible for the Children's Health Insurance Program under title XXI of the Social Security Act

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

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

''(D) ACCESSIBILITY OF MATERIALS.—Any materials used by a Gateway to carry out this paragraph shall be provided in a form and manner calculated to be understood by individuals who may apply to be enrollees in a qualified health plan, taking into account potential language barriers and disabilities of individuals.

''(8) CONSULTATION.—A Gateway shall consult with stakeholders relevant to carrying out the activities under this subsection, including—

''(A) consumers who are enrollees in qualified health plans;

''(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

''(C) State Medicaid offices; and

"(D) advocates for enrolling hard to reach populations.

"(9) STANDARDS AND PROTOCOLS.—

"(A) IN GENERAL.—The Secretary, in consultation with the Office of the National Coordinator for Health Information Technology, shall develop interoperable, secure, scalable, and reusable standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs.

"(B) COORDINATION.—The Secretary shall facilitate enrollment of individuals in programs described in subparagraph (A) through methods which shall include—

"(i) electronic matching against existing Federal and State data to serve as evidence of eligibility and digital documentation in lieu of paper-based documentation;

"(ii) capability for individuals to apply, recertify, and manage eligibility information online, including conducting real-time queries against databases for existing eligibility prior to submitting applications; and

"(iii) other functionalities necessary to provide eligible individuals with a streamlined enrollment process.

"(C) ASSISTANCE.—The Secretary shall award grants to enhance community-based enrollment to—

"(i) States to assist such States in—

"(I) contracting with qualified technology vendors to develop or acquire electronic enrollment software systems;

"(II) contracting with community and consumer focused nonprofit organizations with experience working with consumers, including the uninsured and the underinsured, to establish Statewide helplines for enrollment assistance and referrals; and

"(III) establishing public education campaigns through grants to qualifying organizations for the design and implementation of public education campaigns targeting uninsured and traditionally underserved communities; and

"(ii) community-based organizations for infrastructure and training to establish electronic assistance programs.

"(10) NOTIFICATION.—With respect to the standards and protocols developed under subsection (9), the Secretary—

"(A) shall notify States of such standards and protocols; and

"(B) may require, as a condition of receiving Federal funds, that States or other entities incorporate such standards and protocols into such investments.

"(d) CERTIFICATION.—A Gateway may certify a health plan if—

"(1) such health plan meets the requirements of subsection (l); and

"(2) the Gateway determines that making available such health plan through such Gateway is in the interests of qualified individuals and qualified employers in the States or States in which such Gateway operates.

"(e) GUIDANCE.—The Secretary shall develop guidance that may be used by a Gateway to carry out the activities described in subsection (c).

"(f) FLEXIBILITY.—

''(1) REGIONAL OR OTHER INTERSTATE GATEWAYS.—A Gateway may operate in more than one State, provided that each State in which such Gateway operates permits such operation.

''(2) SUBSIDIARY GATEWAYS.—A State may establish one or more subsidiary Gateway, provided that—

''(A) each such Gateway serves a geographically distinct area; and

''(B) the area served by each such Gateway is at least as large as a community rating area described in section 2701.

''(g) PORTALS TO STATE GATEWAY.—The Secretary shall establish a mechanism, including an Internet website, through which a resident of any State may identify any Gateway operating in such State.

''(h) CHOICE.—

''(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual.

''(2) QUALIFIED EMPLOYERS.—

''(A) EMPLOYER MAY SPECIFY TIER.—A qualified employer may select to provide support for coverage of employees under a qualified

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

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

''(3) SELF-EMPLOYED INDIVIDUALS.—

''(A) DEEMING.—An individual who is self-employed (as defined in section 401(c)(1) of the Internal Revenue Code of 1986) shall be deemed to be a qualified employer unless such individual notifies the applicable Gateway that such individual elects to be considered a qualified individual.

''(B) ELIGIBILITY.—In the case of a self-employed individual making the election described in subparagraph (A)—

''(i) the income of such individual for purposes of section 3111 shall be deemed to be the total business income of such individual;

''(ii) premium payments made by such individual to a qualified health plan shall

not be treated as employer-provided coverage under section 106(a) of the Internal Revenue Code of 1986; and

''(iii) the individual shall not be eligible for a credit under section 3112.

''(i) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

''(j) SINGLE RISK POOL.—

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

''(2) GROUP HEALTH INSURANCE POLICIES.—A health insurance issuer shall consider all enrollees in a group health plan, other than a self-insured group health plan, including individuals who do not purchase such a plan through the Gateway, to be a member of a single risk pool.

''(k) EMPOWERING CONSUMER CHOICE.—

''(1) CONTINUED OPERATION OF MARKET OUTSIDE GATEWAYS.—Nothing in this title shall be con-

strued to prohibit a health insurance issuer from offering a health insurance policy or providing coverage under such policy to a qualified individual where such policy is not a qualified health plan. Nothing in this title shall be construed to prohibit a qualified individual from enrolling in a health insurance plan where such plan is not a qualified health plan.

''(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is not a qualified health plan to offer benefits required under State law.

''(l) CRITERIA FOR CERTIFICATION.—

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

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

"(B) employ methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice;

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

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

"(i) benefits offered, including maximums, limitations (including differential cost-sharing for out of network services), exclusions and other benefit limitations;

"(ii) the service area;

"(iii) required premiums;

"(iv) cost-sharing requirements;

"(v) the manner in which enrollees access providers; and

"(vi) the grievance and appeals procedures;

"(E) provide coverage for at least the essential health care benefits established under section 3103(a);

"(F)(i) is accredited by the National Committee for Quality Assurance or by any other

entity recognized by the Secretary for the accreditation of health insurance issuers or plans; or

"(ii) receives such accreditation within a period established by a Gateway for such accreditation that is applicable to all qualified health plans;

"(G) implement a quality improvement strategy described in subsection (m)(1);

"(H) have adequate procedures in place for appeals of coverage determinations; and

"(I) may not establish a benefit design that is likely to substantially discourage enrollment by certain qualified individuals in such plan.

"(2) REQUEST TO NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary model criteria for the certification of qualified health plans, that addresses the elements described in subparagraphs (A) through (I) of paragraph (1). In developing such criteria, the National Association of Insurance Commissioners shall consult with appro-

priate Federal agencies, consumer representatives, insurance carriers, and other stakeholders.

''(3) REQUIRED CONSIDERATION.—If the model criteria described in paragraph (2) are submitted to the Secretary by the date that is 9 months after the date on which a request is made under such paragraph, the Secretary shall consider such model criteria in promulgating the regulations under paragraph (1).

''(m) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

''(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

''(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model as defined in section 212 of the Affordable Health Choices Act, for treatment or services under the plan or coverage;

"(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

"(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

"(D) the implementation of wellness and health promotion activities.

"(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

"(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Gateway of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

''(n) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.—Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

''(o) QUALITY IMPROVEMENT.—

''(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2012 a qualified health plan may contract with—

''(A) a hospital with greater than 50 beds only if such hospital—

''(i) utilizes a patient safety evaluation system as described in part C of title IX; and

''(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

''(B) a health care provider if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

''(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

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

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

''SEC. 3102. FINANCIAL INTEGRITY.

''(a) ACCOUNTING FOR EXPENDITURES.—

''(1) IN GENERAL.—A Gateway shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

''(2) INVESTIGATIONS.—The Secretary may investigate the affairs of a Gateway, may examine the properties and records of a Gateway, and may require periodical reports in relation to activities undertaken by a Gateway. A Gateway shall fully cooperate in any investigation conducted under this paragraph.

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

''(4) PATTERN OF ABUSE.—If the Secretary determines that a Gateway or a State has engaged in serious misconduct with respect to compliance with, or carrying out activities required, under this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

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

''(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

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

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

General shall conduct an ongoing study of Gateway activities and the enrollees in qualified health plans offered through Gateways. Such study shall review—

''(1) the operations and administration of Gateways, including surveys and reports of qualified health plans offered through Gateways and on the experience of such plans (including data on enrollees in Gateways and individuals purchasing health insurance coverage outside of Gateways), the expenses of Gateways, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Gateways meets their goals;

''(2) any significant observations regarding the utilization and adoption of Gateways; and

''(3) where appropriate, recommendations for improvements in the operations or policies of Gateways.

''SEC. 3103. PROGRAM DESIGN.

''(a) PROGRAM DESIGN.—

''(1) IN GENERAL.—The Secretary shall establish the following:

''(A) Subject to paragraph (2), the essential health care benefits eligible for credits

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

''(i) Ambulatory patient services.

''(ii) Emergency services.

''(iii) Hospitalization.

''(iv) Maternity and newborn care.

''(v) Mental health and substance abuse services.

''(vi) Prescription drugs.

''(vii) Rehabilitative and habilitative services and devices.

''(viii) Laboratory services.

''(ix) Preventive and wellness services.

''(x) Pediatric services, including oral and vision care.

''(B) The criteria that coverage must meet to be considered minimum qualifying coverage.

''(C) The conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels.

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

provided under a typical employer plan, as determined by the Secretary.

''(3) CERTIFICATION.—In establishing the essential health benefits described in paragraph (1), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

''(b) REQUIRED ELEMENTS FOR CONSIDERATION.—

''(1) ESSENTIAL HEALTH CARE BENEFITS.—In establishing the essential health benefits under subsection (a)(1)(A), the Secretary shall—

''(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category; and

''(B) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

"(2) MINIMUM QUALIFYING COVERAGE.—In establishing the criteria described in subsection (a)(1)(B), the Secretary—

"(A) shall—

"(i) exclude from meeting such criteria any coverage that—

"(I) provides reimbursement for the treatment or mitigation of—

"(aa) a single disease or condition; or

"(bb) an unreasonably limited set of diseases or conditions; or

"(II) has an out of pocket limit that exceeds the amount described in section 223 of the Internal Revenue Code of 1986 for the year involved; and

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

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

''(3) AFFORDABLE COVERAGE.—The Secretary shall establish a standard under which coverage is defined to be unaffordable only if the premium paid by the individual is greater than 12.5 percent of the adjusted gross income of the individual involved. Beginning with calendar years after 2013, the Secretary shall adjust the percentage described in this paragraph by an amount that is equal to the percentage increase or decrease in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) during the preceding calendar year.

''SEC. 3104. ALLOWING STATE FLEXIBILITY.

''(a) OPTIONAL STATE ESTABLISHMENT OF GATEWAY.—During the 4-year period following the date of enactment of this section, a State may—

''(1)(A) establish a Gateway (as defined for purposes of section 3101);

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

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

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

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

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

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

''(b) ESTABLISHING STATES.—

''(1) IN GENERAL.—If the Secretary determines that a State has taken the actions described in subsection (a)(1), any resident of that State who is an eligible individual shall be eligible for credits under section 3111 beginning on the date that is 60 days after the date of such determination.

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

requirements of subsection (a). If the Secretary determines that a State has failed to maintain compliance with such requirements, the Secretary may revoke the determination under subparagraph (A).

''(3) DEEMING.—A State that is the subject of a positive determination by the Secretary under paragraph (1) (unless such determination is revoked under paragraph (2)) shall be deemed to be an 'establishing State' beginning on the date that is 60 days after the date of such determination.

''(c) REQUEST FOR THE SECRETARY TO ESTABLISH A GATEWAY.—

''(1) IN GENERAL.—In the case of a State that makes the request described in subsection (a)(2), the Secretary shall determine whether the State has enacted and has in effect the insurance reforms provided for in subtitle A of title I of the Affordable Health Choices Act.

''(2) OPERATION OF GATEWAY.—

''(A) POSITIVE DETERMINATION.—If the Secretary determines that the State has enacted and has in effect the insurance reforms described in paragraph (1), the Secretary shall establish a Gateway in such State as soon as practicable after making such determination.

"(B) NEGATIVE DETERMINATION.—If the Secretary determines that the State has not enacted or does not have in effect the insurance reforms described in paragraph (1), the Secretary shall establish a Gateway in such State as soon as practicable after the Secretary determines that such State has enacted such reforms.

"(3) PARTICIPATING STATE.—The State shall be deemed to be a 'participating State' on the date on which the Gateway established by the Secretary is in effect in such State.

"(4) ELIGIBILITY.—Any resident of a State described in paragraph (3) who is an eligible individual shall be eligible for credits under section 3111 beginning on the date that is 60 days after the date on which such Gateway is established in such State.

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

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

"(A) the Secretary shall establish and operate a Gateway in such State;

''(B) the insurance reform provisions provided for in subtitle A of title I of the Affordable Health Choices Act shall become effective in such State, notwithstanding any contrary provision of State law;

''(C) the State shall be deemed to be a 'participating State'; and

''(D) the residents of that State who are eligible individuals shall be eligible for credits under section 3111 beginning on the date that is 60 days after the date on which such Gateway is established, if the State agrees to make employers who are State or local governments subject to sections 162 and 163 of the Affordable Health Choices Act.

''(2) ELIGIBILITY OF INDIVIDUALS FOR CREDITS.—With respect to a State that makes the election described in subsection (a)(3), the residents of such State shall not be eligible for credits under section 3111 until such State becomes a participating State under paragraph (1).

''SEC. 3105. NAVIGATORS.

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

to enter into agreements with private and public entities under which such entities will serve as navigators in accordance with this section.

''(b) ELIGIBILITY.—

''(1) IN GENERAL.—To be eligible to enter into an agreement under subsection (a), an entity shall demonstrate that the entity has existing relationships with, or could readily establish relationships with, employers and employees, consumers (including the uninsured and the underinsured), and self-employed individuals, likely to be eligible to participate in the program under this title.

''(2) TYPES.—Entities described in paragraph (1) may include trade, industry and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, and other entities that the Secretary determines to be capable of carrying out the duties described in subsection (c).

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

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

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

''(3) facilitate enrollment in a qualified health plan; and

''(4) provide information in a manner determined by the Secretary to be culturally and linguistically appropriate to the needs of the population served by the Gateway.

''(d) STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish standards for navigators under this section, including provisions to avoid conflicts of interest. Under such standards, a navigator may not—

''(A) be a health insurance issuer; or

''(B) receive any consideration directly or indirectly from any health insurance issuer in connection with the participation of any employer in the program under this title or the enrollment of any eligible employee in health insurance coverage under this title.

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

"SEC. 3106. COMMUNITY HEALTH INSURANCE OPTION.

''(a) VOLUNTARY NATURE.—

''(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

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

''(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through each Gateway established under this title, health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

''(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term 'community health insurance option' means health insurance coverage that—

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

''(B) provides high value for the premium charged;

''(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

''(D) promotes high quality clinical care;

''(E) provides high quality customer service to beneficiaries; and

''(F) offers a wide choice of providers.

''(3) ESSENTIAL HEALTH BENEFITS.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), the community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 3103.

''(B) STATES MAY OFFER ADDITIONAL BENEFITS.—A State may require that a community health insurance option offered in such State offer benefits in addition to the essential health benefits required under subparagraph (A).

''(C) CREDITS.—

"(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 3111 in the same manner as an individual who is enrolled in a qualified health plan.

"(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that a community health insurance option cover benefits in addition to the essential health benefits required under subparagraph (A) shall not affect the amount of a credit provided under section 3111 with respect to such plan.

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

"(4) COST SHARING.—A community health insurance option shall offer coverage at each of the cost sharing tiers described in section 3111(b).

"(5) PREMIUMS.—

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

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

''(B) APPLICABLE RULES.—The provisions of title XXVII relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701.

''(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

''(D) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

''(6) REIMBURSEMENT RATES.—

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

''(B) LIMITATION.—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates

paid by health insurance issuers offering qualified health plans through the Gateway.

''(C) INNOVATION.—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (e)(7)(D) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.

''(7) SOLVENCY AND CONSUMER PROTECTION.—

''(A) SOLVENCY.—The Secretary shall establish a Federal solvency standard to be applied with respect to the community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.

''(B) MINIMUM REQUIRED.—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.

''(C) CONSUMER PROTECTIONS.—The consumer protection laws of a State shall apply to a community health insurance option (as defined by the Secretary).

''(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS.—

''(A) IN GENERAL.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the 'NAIC'), may promulgate regulations to establish additional requirements for a community health insurance option.

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

''(9) OMBUDSMAN.—In establishing community health insurance options, the Secretary shall establish an ombudsman or similar mechanism to provide assistance to consumers with respect to disputes, grievances, or appeals.

''(c) START-UP FUND.—

''(1) ESTABLISHMENT OF FUND.—

"(A) IN GENERAL.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Benefit Plan Start-Up Fund' (referred to in this section as the 'Start-Up Fund'), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.

"(B) FUNDING.—There are hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—

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

"(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered; and

"(iii) make payments under paragraph (3).

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

"(3) RISK CORRIDOR PAYMENTS.—

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

"(B) SUBSEQUENT YEAR.—In years after the expiration of the period referred to in subparagraph (A), the Secretary may extend or increase the risk corridors and payments provided for under subparagraph (A).

"(C) AMOUNT USED TO REDUCE COSTS.—The Secretary shall deposit any payments received from a contracting administrator under subparagraph (A) into the Start-Up Fund.

"(4) PASS THROUGH OF REBATES.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

"(5) REPAYMENT.—

"(A) IN GENERAL.—The community health insurance option shall be required to repay the Secretary (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 10 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).

"(B) SANCTIONS IN CASE OF FOR-PROFIT CONVERSION.—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined

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

''(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and

''(ii) permanently ineligible to offer a qualified health plan.

''(d) STATE ADVISORY COUNCIL.—

''(1) ESTABLISHMENT.—The State shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of the community health insurance option in the State. Such Council shall provide recommendations on at least the following:

''(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

''(B) mechanisms to facilitate public awareness of the availability of the community health insurance option; and

''(C) alternative payment structures under the community health insurance option for

health care providers that encourage quality improvement and cost control.

''(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

''(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to the community health insurance option that state, or in any other State, or in all States.

''(e) AUTHORITY TO CONTRACT; TERMS OF CONTRACT.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—The Secretary may enter into a contract with a qualified entity for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to the community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to the community health insurance option under

this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

''(B) REQUIREMENTS APPLY.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—

''(i) shall meet the criteria established under paragraph (2); and

''(ii) shall receive an administrative fee under paragraph (7).

''(C) LIMITATION.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

''(D) REFERENCE.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a 'contracting administrator'.

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

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

"(B) be a nonprofit entity for purposes of offering such option;

"(C) meet the solvency standards applicable under subsection (b)(7);

"(D) be eligible to offer health insurance or health benefits coverage;

"(E) meet quality standards specified by the Secretary;

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

"(G) meet such other requirements as the Secretary may impose.

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

"(4) LIMITATION.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).

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

''(6) REVOCATION.—A contract awarded under this subsection may be revoked by the Secretary only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.

''(7) FEE FOR ADMINISTRATION.—

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

''(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than

50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

''(i) Reducing administrative costs and promoting administrative simplification for beneficiaries.

''(ii) Promoting high quality clinical care.

''(iii) Providing high quality customer service to beneficiaries.

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

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

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

Subtitle C—Affordable Coverage for All Americans

SEC. 151. SUPPORT FOR AFFORDABLE HEALTH COVERAGE.

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

"Subtitle B—Making Coverage Affordable

"SEC. 3111. SUPPORT FOR AFFORDABLE HEALTH COVERAGE.

''(a) COST SHARING FOR A BASIC PLAN.—

''(1) BASIC PLAN.—The Secretary shall establish at least the following tiers of cost sharing for eligible individuals:

''(A) A tier for a basic plan in which—

''(i) a qualified health plan shall provide coverage for not less than 76 percent of the total allowed costs of the benefit provided; and

''(ii) the out of pocket limitation for the plan shall not be greater than the out of pocket limitation applicable under section 223(d)(2) of the Internal Revenue Code of 1986.

''(B) A tier in which—

''(i) the coverage percentage is equal to the coverage percentage of the basic plan increased by 8 percentage points; and

''(ii) the dollar value of the out of pocket limitation is 50 percent of the dollar value of the out of pocket limitation of the basic plan.

''(C) A tier in which—

''(i) the coverage percentage is equal to the coverage percentage of the basic plan increased by 17 percentage points; and

''(ii) the dollar value of the out of pocket limitation that is 20 percent of the dollar value of the out of pocket limitation of the basic plan.

''(2) OUT OF POCKET.—For purposes of this section, the term 'out of pocket' shall include all expenditures for covered qualified medical expenses (as provided for with respect to high deductible health plans under section 223(d)(2) of the Internal Revenue Code of 1986).

''(b) PAYMENT OF CREDITS.—

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

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

''(2) AMOUNT.—

''(A) IN GENERAL.—Subject to the indexing provision described in paragraph (6), and the limitation described in paragraph (4), the amount of an annual credit with respect to an eligible individual under subparagraph (A) shall be an amount determined by the Secretary so that the eligible individual involved is not required to pay in the case of an individual with an adjusted gross income that does not exceed 400 percent of the poverty line for a family of the size involved, an amount that exceeds 12.5 percent of such individual's income for the year involved.

''(B) REDUCTIONS BASED ON INCOME.—The amount that an eligible individual is required to pay under subparagraph (A) shall be ratably reduced to 1 percent of income in the case of an eligible individual with an adjusted

gross income that does not exceed 150 percent of the poverty line for a family of the size involved for the year.

''(3) SIMPLIFIED SCHEDULE.—The Secretary may establish a schedule of premium credits under this subsection in dollar amounts to simplify the administration of this section so long as any such schedule does not significantly change the value of the premium credits described in paragraph (2).

''(4) LIMITATION OF CREDITS.—

''(A) IN GENERAL.—A credit under paragraph (1) may not exceed the amount of the reference premium for the individual involved.

''(B) REFERENCE PREMIUM.—In this section, the term 'reference premium' means—

''(i) with respect to an individual enrolling in coverage whose income does not exceed 200 percent of the poverty line for a family of the size involved for the year, the weighted average annual premium of the 3 lowest cost qualified health plans that—

''(I) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(C); and

"(II) are offered in the community rating area in which the individual resides;

"(ii) with respect to an individual enrolling in coverage whose income exceeds 200, but does not exceed 300, percent of the poverty line for a family of the size involved for the year, the weighted average annual premium of the 3 lowest cost qualified health plans that—

"(I) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(B); and

"(II) are offered in the community rating area in which the individual resides; and

"(iii) with respect to an individual enrolling in coverage whose income exceeds 300, but does not exceed 400, percent of the poverty line for a family of the size involved for the year, the weighted average annual premium of the 3 lowest cost qualified health plans that—

''(I) meet the criteria for cost sharing and out of pocket limits described in subsection (a)(1)(A); and

''(II) are offered in the community rating area in which the individual resides.

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

''(D) LIMITATION.—In determining the 3 lowest cost health plans for purposes of this paragraph, the community health insurance option shall not be considered.

''(5) METHOD OF CALCULATION.—

''(A) CALCULATION OF CREDIT BASED ON ESSENTIAL HEALTH CARE BENEFITS.—In the case of a qualified health plan that provides reimbursement for benefits that are not included in the essential health benefits established by the Secretary under section 3103(a)(1)(A), the reference premium shall be determined for purposes of paragraph (2) without regard to such reimbursement.

"(B) RISK ADJUSTMENT.—The reference premium shall be determined for a standard population.

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

"(6) INDEXING.—Beginning with calendar years after 2013, the percentages described in paragraph (2) that specify the portion of the reference premium that an individual or family is responsible for paying shall be annually adjusted by a percentage that is equal to the percentage increase or decrease in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) during the preceding calendar year.

"(c) STATE FLEXIBILITY.—A State may make payments to or on behalf of an eligible individual that are greater than the amounts required under this section.

"(d) ELIGIBILITY DETERMINATIONS.—

"(1) RULE FOR ELIGIBILITY DETERMINATIONS.—The Secretary shall, by regulation, establish rules and procedures for—

"(A) the submission of applications during the fourth quarter of the calendar year involved for payments under this section, including the electronic submission and documents necessary for application and enrollment;

"(B) making determinations with respect to the eligibility of individuals submitting applications under subparagraph (A) for payments under this section and informing individuals of such determinations, including verifying income through the use of data contained in the tax returns of applicants for such credit;

"(C) making determinations of adjusted gross income in cases where the individual applicant was not required to file a tax return for the taxable year involved;

"(D) resolving appeals of such determinations;

"(E) redetermining eligibility on a periodic basis; and

"(F) making payments under this section.

''(2) CALCULATION OF ELIGIBILITY.—For purposes of paragraph (1), the Secretary shall establish rules that permit eligibility to be calculated based on—

''(A) the applicant's adjusted gross income for the second preceding taxable year; or

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

''(i) the applicant's adjusted gross income for the most recent period otherwise practicable; or

''(ii) the applicant's declaration of estimated annual adjusted gross income for the year involved.

''(3) DETERMINING ELIGIBILITY.—

''(A) AUTHORITY OF THE SECRETARY.—

''(i) IN GENERAL.—The Secretary shall have the authority to make determinations (including redeterminations) with respect to the eligibility of individuals submitting applications for credits under this section. The Secretary shall verify, through the Internal Revenue Service, the

income data received from individuals submitting applications for credits under this section.

''(ii) AUTHORITY TO USE TAX RETURNS.—To be eligible to receive a credit under this section, an individual shall authorize the disclosure of the tax return information of the individual as provided for in section 6103(l)(21) of the Internal Revenue Code.

''(B) DELEGATION OF AUTHORITY.—Except under the conditions described in subparagraph (D), the Secretary shall delegate to a Gateway (and, upon request from such State or States, to the State or States in which such Gateway operates) the authority to carry out the activities described in subparagraph (A). The Gateway may consult with the Internal Revenue Service to verify income data received from individuals submitting applications for credits under this section.

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

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

''(D) REVOCATION OF AUTHORITY.—If the Secretary determines that a Gateway (or the State or States in which such Gateway operates) is carrying out the activities described in subparagraph (A) in a manner that is substantially inconsistent with the regulations promulgated under paragraph (1), the Secretary may, after notice and opportunity for a hearing, revoke the delegation of authority under subparagraph (A). If the Secretary revokes the delegation of authority, the references to a Gateway in subparagraph (E) and (F) shall be deemed to be references to the Secretary.

''(E) REQUIREMENT TO REPORT CHANGE IN STATUS.—

''(i) IN GENERAL.—An individual that has been determined to be eligible for subsidies shall notify the Gateway of any changes that may affect such eligibility in a manner specified by the Secretary.

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

vidual under clause (i), the Gateway shall promptly redetermine the individual's eligibility for payments.

''(F) TERMINATION OF PAYMENTS.—The Gateway shall terminate payments for an individual (after providing notice to the individual) if—

''(i) the individual fails to provide information for purposes of subparagraph (E)(i) on a timely basis; or

''(ii) the Gateway determines that the individual is no longer eligible for such payments.

''(4) APPLICATION.—

''(A) METHODS.—The process established under paragraph (1)(A) shall permit applications in person, by mail, telephone, and the Internet.

''(B) FORM AND CONTENTS.—An application under paragraph (1)(A) shall be in such form and manner as specified by the Secretary, and may require documentation.

''(C) SUBMISSION.—An application under paragraph (1)(A) may be submitted to the

Gateway, or to a State agency for a determination under this section.

''(D) ASSISTANCE.—A Gateway, or a State agency under this section, shall assist individuals in the filing of applications under paragraph (1)(A).

''(5) RECONCILIATION.—

''(A) FILING OF STATEMENT.—In the case of an individual who has received payments under this section for a year and who is claiming a significant decrease (as determined by the Secretary) in adjusted gross income from such year, such individual shall file with the Secretary an income reconciliation statement, at such time, in such manner, and containing such information as the Secretary may require.

''(B) RECONCILIATION.—

''(i) IN GENERAL.—Based on and using the adjusted gross income reported in the statement filed by an individual under subparagraph (A), the Secretary shall compute the amount of payments that should have been provided to the individual for the year involved.

''(ii) OVERPAYMENT OF PAYMENTS.—

"(I) IN GENERAL.—Subject to the limitation in subclause (II), if the amount of payments provided to an individual for a year under this section was significantly greater (as determined by the Secretary) than the amount computed under clause (i), the individual shall be liable to the Secretary for such excess amount. The Secretary may establish methods under which such liability may be assessed through a reduction in the amount of any credit otherwise applicable under section 3111 with respect to such individual.

"(II) LIMITATION.—With respect to any individual described in subclause (I) who had a verified adjusted gross income that did not exceed 400 percent of the poverty line for a family of the size involved for such year, the amount of any repayment under such subclause (I) shall not exceed—

"(aa) $250 for an individual who filed an individual tax return for such year; or

"(bb) $400 for an individual who filed a joint tax return for such year.

Any such individual with a adjusted gross income that exceeds 400 percent of the poverty line for a family of the size involved for such year shall repay the entire amount so received.

"(iii) UNDERPAYMENT OF PAYMENTS.—If the amount of payments provided to an individual for a year under this section was less than the amount computed under clause (i), the Secretary shall pay to the individual the amount of such deficit. The Secretary may establish methods under which such payments may be provided through an increase in the amount of any credit otherwise applicable under section 3111 with respect to such individual.

"(iv) COORDINATION WITH IRS.—The Secretary shall coordinate with the Secretary of the Treasury to develop proce-

dures to enable the Internal Revenue Service to administer this subparagraph with respect to the collection of overpayments.

''(C) FAILURE TO FILE.—In the case of an individual who fails to file a statement for a year as required under subparagraph (A), the individual shall not be eligible for further payments until such statement is filed. The Secretary shall waive the application of this subparagraph if the individual establishes, to the satisfaction of the Secretary, good cause for the failure to file the statement on a timely basis.

''(D) DETERMINATIONS.—The Secretary shall make determinations with respect to statements submitted under this paragraph based on income data from the most recent tax return filed by the individual.

''(6) DETERMINATIONS MADE WITH RESPECT TO SAME TAXABLE YEARS.—In making determinations under this section with respect to adjusted gross income as compared to the poverty line, the Secretary shall ensure that the poverty line data used relates to the same taxable year for which the adjusted gross income is determined.

''(7) OUTREACH.—The Gateway shall conduct outreach activities to provide information to individuals that may potentially be eligible for payments under this section. Such activities shall include information on the application process with respect to such payments.

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

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

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

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

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

"SEC. 3112. SMALL BUSINESS HEALTH OPTIONS PROGRAM CREDIT.

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

"(b) GENERAL CREDIT AMOUNT.—For purposes of this section:

"(1) IN GENERAL.—The credit amount described in this subsection shall be the product of—

"(A) the applicable amount specified in paragraph (2);

"(B) the employer size factor specified in paragraph (3); and

"(C) the percentage of year factor specified in paragraph (4).

"(2) APPLICABLE AMOUNT.—For purposes of paragraph (1):

"(A) IN GENERAL.—The applicable amount shall be equal to—

"(i) $1,000 for each employee of the employer who receives self-only health insurance coverage through the employer;

"(ii) $2,000 for each employee of the employer who receives family health insurance coverage through the employer; and

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

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

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

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

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

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

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

"(E) With respect to an employer with more than 50 full-time employees, the percentage shall be 0 percent.

"(4) PERCENTAGE OF YEAR FACTOR.—For purposes of paragraph (1), the percentage of year factor shall be equal to the ratio of—

"(A) the number of months during the taxable year for which the employer paid or incurred qualified employee health insurance expenses; and

"(B) 12.

"(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

"(1) QUALIFIED SMALL EMPLOYER.—

"(A) IN GENERAL.—The term 'qualified small employer' means an employer (as defined in section 3001(a)(4) of the Public Health Service Act) that—

"(i) pays or incurs at least 60 percent of the qualified employee health insurance expenses of such employer, or who is self-employed; and

"(ii) was—

"(I) an employer that—

"(aa) employed an average of 50 or fewer full-time employees during the preceding taxable year; and

"(bb) had an average wage of less than $50,000 for full time employees in the preceding taxable year; or

"(II) a self-employed individual that—

"(aa) had not less than $5,000 in net earnings or not less than $15,000 in gross earn-

ings from self-employment in the preceding taxable year;

"(bb) had not greater than $50,000 in net earnings or not greater than $150,000 in gross earnings from self-employment in the preceding taxable year; and

"(cc) has elected not to receive a credit under section 3111.

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

"(2) QUALIFIED EMPLOYEE HEALTH INSURANCE EXPENSES.—

"(A) IN GENERAL.—The term 'qualified employee health insurance expenses' means any amount paid by an employer or an employee of such employer for health insurance coverage under this Act to the extent such amount is for coverage—

"(i) provided to any employee (as defined in subsection 3001(a)(3) of such Act), or

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

"(B) EXCEPTION FOR AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred for health insurance coverage pursuant to a salary reduction arrangement shall be taken into account for purposes of subparagraph (A).

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

"(d) INFLATION ADJUSTMENT.—

"(1) IN GENERAL.—For each calendar year after 2009, the dollar amounts specified in subsections (b)(2)(A), (b)(2)(B), and (c)(1)(A)(iii) (after the application of this paragraph) shall be the amounts in effect in the preceding calendar year or, if greater, the product of—

"(A) the corresponding dollar amount specified in such subsection; and

"(B) the ratio of the index of wage inflation (as determined by the Bureau of Labor Statistics) for August of the preceding calendar

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

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

''(e) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this section:

''(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence for the full preceding taxable year, the determination of whether such employer meets the requirements of this section shall be based on the average number of full-time employees that it is reasonably expected such employer will employ on business days in the employer's first full taxable year.

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

SEC. 152. PROGRAM INTEGRITY.

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

''(21) VOLUNTARY AUTHORIZATION FOR INCOME VERIFICATION.—

''(A) VOLUNTARY AUTHORIZATION.—The Secretary shall provide a mechanism for each taxpayer to indicate whether such taxpayer authorizes the Secretary to disclose to the Secretary of Health and Human Services (or, pursuant to a delegation described in subsection (d)(4)(B), to a State or a Gateway (as defined in section 3101 of the Public Health Service Act) return information of a taxpayer who may be eligible for credits under section 3111 of the Public Health Service Act.

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

section (d)(4)(B), to a State or a Gateway) the minimum necessary amount of information necessary to establish whether such individual is eligible for credits under section 3111 of the Public Health Service Act.

''(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by the Secretary (or, pursuant to a delegation described in subsection (d)(4)(B), a State or a Gateway) only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any payments under section 3111 of the Public Health Service Act.''.

(b) COLLECTION OF AMOUNTS.—Section 6305(a) of the Internal Revenue Code of 1986 is amended by inserting ''or under section 3111 of the Public Health Service Act'' after ''Social Security Act''.

(c) CONFORMING AMENDMENTS.—

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

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

(19), or (20)'' each place it appears and inserting ''(l)(10), (16), (18), (19), (20), or (21)''.

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

Subtitle D—Shared Responsibility for Health Care

SEC. 161. INDIVIDUAL RESPONSIBILITY.

(a) PAYMENTS.—

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

''PART VIII—SHARED RESPONSIBILITY PAYMENTS

''Sec. 59B. Shared responsibility payments.

''SEC. 59B. SHARED RESPONSIBILITY PAYMENTS.

''(a) REQUIREMENT.—Every individual shall ensure that such individual, and each dependent of such individual, is covered under qualifying coverage at all times during the taxable year.

''(b) PAYMENT.—

''(1) IN GENERAL.—In the case of any individual who did not have in effect qualifying coverage (as defined in section 3116 of the Public Health

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

''(2) AMOUNT ESTABLISHED.—

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

''(B) EFFECTIVE DATE.—The amount established under subparagraph (A) shall be effective with respect to the taxable year following the date on which the amount under subparagraph (A) is established.

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

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

''(D) LIMITATION.—In no case may the Secretary establish an amount that is less than 50 percent of the average annual premium (family coverage in the case of a failure with respect to more than one individual) under the basic plan described in section 3111(a)(1)(A) of the Public Health Service Act, as determined by the Secretary of Health and Human Services for the calendar year preceding the calendar year in which the taxable year begins.

''(c) EXEMPTIONS.—Subsection (b) shall not apply to any individual—

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

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

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

''(4) for whom affordable health care coverage is not available (as such terms are defined by the Secretary of Health and Human Services under section 3103 of the Public Health Service Act), or

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

''(d) COORDINATION WITH OTHER PROVISIONS.—

''(1) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The amount imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(A) the amount of any credit allowable under this chapter, or

''(B) the amount of the minimum tax imposed by section 55.

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

''(3) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the amount imposed by this section.

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

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

''(e) REGULATIONS.—The Secretary may prescribe such regulations as may be appropriate to carry out the purposes of this section.''.

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

''PART VIII—SHARED RESPONSIBILITY PAYMENTS''.

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

(b) REPORTING OF HEALTH INSURANCE COVERAGE.—

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

''Subpart D—Information Regarding Health Insurance Coverage

''Sec. 6055. Reporting of health insurance coverage.

"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

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

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

"(1) is in such form as the Secretary prescribes,

"(2) contains—

"(A) the name, address, and taxpayer identification number of each individual who is covered under health insurance that is qualifying coverage provided by such person, and

"(B) the number of months during the calendar year during which each such individual was covered under such health insurance, and

"(3) such other information as the Secretary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

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

''(A) the name, address, and phone number of the information contact of the person required to make such return, and

''(B) the number of months during the calendar year during which such individual was covered under health insurance that is qualifying coverage provided by such person.

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

''(d) QUALIFYING COVERAGE.—For purposes of this section, the term 'qualifying coverage' has the meaning given such term under section 3116 of the Public Health Service Act.''.

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

''SUBPART D—HEALTH INSURANCE COVERAGE''.

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

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

acting through the Internal Revenue Service and in consultation with the Secretary of Health and Human Services, shall send a notification each individual who files an individual income tax return and who is not enrolled in qualifying coverage (as defined in section 3116 of the Public Health Service Act). Such notification shall contain information on the services available through the Gateway operating in the State in which such individual resides.

SEC. 162. NOTIFICATION ON THE AVAILABILITY OF AFFORDABLE HEALTH CHOICES.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

"SEC. 18A. NOTICE TO EMPLOYEES.

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

''(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning 90 days after the date on which the State becomes an establishing or participating State under section 3104 of the Public Health Service. Act.''.

SEC. 163. SHARED RESPONSIBILITY OF EMPLOYERS.

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

''SEC. 3115. SHARED RESPONSIBILITY OF EMPLOYERS.

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

''(1) who is not offered qualifying coverage by such employer during each month where such employee is not offered qualifying coverage; or

''(2) on behalf of whom such employer is not contributing at least 60 percent of the monthly premiums for such coverage for each such month.

''(b) AMOUNT.—

''(1) IN GENERAL.—The annual amount described in this subsection shall be equal to $750 for each full-time employee described in subsection (a). Such amount shall be pro-rated with respect to each

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

''(2) PRO RATA APPLICATION FOR PART-TIME EMPLOYEES.—The provisions of paragraph (1) shall apply with respect to part-time employees employed by the employer, except that the annual payment amount described in such paragraph shall be reduced to $375 for each part-time employee.

''(c) PROCEDURES.—The Secretary shall develop procedures for making determinations with respect to qualifying coverage and for making the payments required under subsection (a). Such procedures shall provide for the making of payments on a quarterly basis.

''(d) USE OF FUNDS.—Amounts shall be collected under subsection (a) and be available for obligation only to the extent and in the amount provided in advance in appropriations Acts. Such amounts are authorized to remain available until expended.

''(e) INFLATION ADJUSTMENT.—Beginning with calendar years after 2013, the amounts described in subsection (b) shall be adjusted by the Secretary by notice, published in the Federal Register, for each fiscal year to reflect the total percentage change that occurred in the medical care component of the Consumer Price Index for

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

''(f) EXEMPTION FOR SMALL EMPLOYERS.—

''(1) IN GENERAL.—For purposes of this section, the term 'employer' means an employer that employs more than 25 employees on business days during the preceding calendar year.

''(2) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(3) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

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

Secretary of Labor, shall establish procedures for determining the number of employees of employers who are not offered qualifying coverage.

''(h) REGULATIONS.—The Secretary, in consultation with the Secretary of Labor, shall promulgate such regulations as may be appropriate to carry out activities under this section.

''SEC. 3116. DEFINITIONS.

''(a) IN GENERAL.—In this title:

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is—

''(A) a citizen or national of the United States or an alien lawfully admitted to the United States for permanent residence or an alien lawfully present in the United States;

''(B) a qualified individual;

''(C) enrolled in a qualified health plan; and

''(D) not receiving full benefits coverage under a State child health plan under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) (or full benefits coverage under a demonstration project funded through such title XXI).

''(2) QUALIFIED EMPLOYER.—

"(A) IN GENERAL.—The term 'qualified employer' means an employer that—

"(i) elects to make all full-time employees of such employer eligible for a qualified health plan; and

"(ii)(I) in the case of an employer that elects to enroll in a qualified health plan made available through a Gateway in an establishing State, meets criteria (including criteria regarding the size of a qualified employer) established by such State; or

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

"(aa) employs fewer than the number of employees specified in subparagraph (B); and

"(bb) meets criteria established by the Secretary.

"(B) NUMBER OF EMPLOYEES.—

"(i) ESTABLISHMENT.—The Secretary may by regulation establish the number of

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

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

''(3) QUALIFIED HEALTH PLAN.—

''(A) IN GENERAL.—The term 'qualified health plan' means health plan that—

''(i) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 3101(l) issued or recognized by each Gateway through which such plan is offered; and

''(ii) is offered by a health insurance issuer that—

''(I) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

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

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

''(III) complies with the regulations developed by the Secretary under section 3101(l) and such other requirements as an applicable Gateway may establish; and

''(IV) agrees to pay any surcharge assessed under section 3101(d)(5).

''(B) INCLUSION OF COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a community health insurance option, unless specifically provided for otherwise.

''(4) QUALIFIED INDIVIDUAL.—

''(A) IN GENERAL.—The term 'qualified individual' means an individual who is—

''(i) residing in a participating State or an establishing State (as defined in section 3104);

''(ii) not incarcerated, except individuals in custody pending the disposition of charges;

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

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

"(v) not eligible for coverage under—

"(I) the Medicaid program under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or under a waiver under section 1115 of such Act;

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

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

"(IV) employer-sponsored coverage (except as provided under subparagraph (B)).

"(B) EMPLOYEE.—An individual who is eligible for employer-sponsored coverage shall be

deemed to be a qualified individual under subparagraph (A) only if such coverage—

"(i) does not meet the criteria established under section 3103 for minimum qualifying coverage; or

"(ii) is not affordable (as such term is defined by the Secretary under section 3103) for such employee.

"(C) INDIVIDUALS AT LESS THAN 150 PERCENT OF POVERTY.—An individual with an adjusted gross income that does not exceed 150 percent of the poverty line for a family of the size involved shall not be considered a qualified individual for purposes of this title.

"(5) QUALIFYING COVERAGE.—The term 'qualifying coverage' means—

"(A) a group health plan or health insurance coverage—

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

"(ii) that is described in clause (i) and that is renewed by an enrollee;

"(B) a group health plan or health insurance coverage that—

"(i) is not described in subparagraph (A); and

"(ii) meets or exceeds the criteria for minimum qualifying coverage (as defined in subsection (d));

"(C) Medicare coverage under parts A and B of title XVIII of the Social Security Act or under part C of such title;

"(D) Medicaid coverage under a State plan under title XIX of the Social Security Act (or under a waiver under section 1115 of such Act), other than coverage consisting solely of benefits under section 1928 of such Act;

"(E) coverage under title XXI of the Social Security Act;

"(F) coverage under the TRICARE program under chapter 55 of title 10, United States Code;

"(G) coverage under the veteran's health care program under chapter 17 of title 38, United States Code, but only if the coverage for the individual involved is determined by the Secretary to be not less than the coverage provided under a qualified health plan, based on

the individual's priority for services as provided under section 1705(a) of such title;

"(H) coverage under the Federal employees health benefits program under chapter 89 of title 5, United States Code;

"(I) a State health benefits high risk pool;

"(J) a health benefit plan under section 2504(e) of title 22, United States Code; or

"(K) coverage under a qualified health plan.

For purposes of this paragraph, an individual shall be deemed to have qualifying coverage if such individual is an individual described in section 1402(e) and (g) of the Internal Revenue Code of 1986.

"(6) ADJUSTED GROSS INCOME.—The term 'adjusted gross income' with respect to an individual has the meaning given such term for purposes of section 62(a) of the Internal Revenue Code of 1986.

"(b) INCORPORATION OF ADDITIONAL DEFINITIONS.—Unless specifically provided for otherwise, the definitions contained in section 2791 shall apply with respect to this title.".

Subtitle E—Improving Access to Health Care Services

SEC. 171. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

''(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

''(A) For fiscal year 2010, $2,988,821,592.

''(B) For fiscal year 2011, $3,862,107,440.

''(C) For fiscal year 2012, $4,990,553,440.

''(D) For fiscal year 2013, $6,448,713,307.

''(E) For fiscal year 2014, $7,332,924,155.

''(F) For fiscal year 2015, $8,332,924,155.

''(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for

the preceding fiscal year adjusted by the product of—

''(i) one plus the average percentage increase in costs incurred per patient served; and

''(ii) one plus the average percentage increase in the total number of patients served.''.

SEC. 172. OTHER PROVISIONS.

(a) SETTINGS FOR SERVICE DELIVERY.—Section 330(a)(1) of the Public Health Service Act (42 U.S.C. 254b(a)(1)) is amended by adding at the end the following: ''Required primary health services and additional health services may be provided either at facilities directly operated by the center or at any other inpatient or outpatient settings determined appropriate by the center to meet the needs of its patents.''.

(b) LOCATION OF SERVICE DELIVERY SITES.—Section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)) is amended by adding at the end the following:

''(3) CONSIDERATIONS.—

''(A) LOCATION OF SITES.—Subject to subparagraph (B), a center shall not be required to locate its service facility or facilities within a designated medically underserved area

in order to serve either the residents of its catchment area or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, or residents of public housing, if that location is determined by the center to be reasonably accessible to and appropriate to meet the needs of the medically underserved residents of the center's catchment area or the special medically underserved population, in accordance with subparagraphs (A) and (J) of subsection (k)(3).

''(B) LOCATION WITHIN ANOTHER CENTER'S AREA.—The Secretary may permit applicants for grants under this section to propose the location of a service delivery site within another center's catchment area if the applicant demonstrates sufficient unmet need in such area and can otherwise justify the need for additional Federal resources in the catchment area. In determining whether to approve such a proposal, the Secretary shall take into consideration whether collaboration between the two centers exists, or whether the applicant has made reasonable attempts to establish such collaboration, and shall consider any comments

timely submitted by the affected center concerning the potential impact of the proposal on the availability or accessibility of services the affected center currently provides or the financial viability of the affected center.''.

(c) AFFILIATION AGREEMENTS.—Section 330(k)(3)(B) of the Public Health Service Act (42 U.S.C. 254b(k)(3)(B)) is amended by inserting before the semicolon the following: ``, including contractual arrangements as appropriate, while maintaining full compliance with the requirements of this section, including the requirements of subparagraph (H) concerning the composition and authorities of the center's governing board, and, except as otherwise provided in clause (ii) of such subparagraph, ensuring full autonomy of the center over policies, direction, and operations related to health care delivery, personnel, finances, and quality assurance''.

(d) GOVERNANCE REQUIREMENTS.—Section 330(k)(3) of the Public Health Service Act (42 U.S.C. 254b(k)(3)) is amended—

(1) in subparagraph (H)—

(A) in clause (ii), strike ``; and'' and inserting ``, except that in the case of a public center (as defined in the second sentence of this paragraph), the public entity may retain au-

thority to establish financial and personnel policies for the center; and'';

(B) in clause (iii), by adding ''and'' at the end; and

(C) by inserting after clause (iii) the following:

''(iv) in the case of a co-applicant with a public entity, meets the requirements of clauses (i) and (ii);''; and

(2) in the second sentence, by inserting before the period the following: ''that is governed by a board that satisfies the requirements of subparagraph (H) or that jointly applies (or has applied) for funding with a co-applicant board that meets such requirements''.

(e) ADJUSTMENT IN CENTER'S OPERATING PLAN AND BUDGET.—Section 330(k)(3)(I)(i) of the Public Health Service Act (42 U.S.C. 254b(k)(3)(I)(i)) is amended by adding before the semicolon the following: '', which may be modified by the center at any time during the fiscal year involved if such modifications do not require additional grant funds, do not compromise the availability or accessibility of services currently provided by the center, and otherwise meet the conditions of subsection (a)(3)(B), except that any such modifications that do not comply

with this clause, as determined by the health center, shall be submitted to the Secretary for approval''.

(f) JOINT PURCHASING ARRANGEMENTS FOR REDUCED COST.—Section 330(l) of the Public Health Service Act (42 U.S.C. 254b(l)) is amended—

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary''; and

(2) by adding at the end the following:

''(2) ASSISTANCE WITH SUPPLIES AND SERVICES COSTS.—The Secretary, directly or through grants or contracts, may carry out projects to establish and administer arrangements under which the costs of providing the supplies and services needed for the operation of federally qualified health centers are reduced through collaborative efforts of the centers, through making purchases that apply to multiple centers, or through such other methods as the Secretary determines to be appropriate.''.

(g) OPPORTUNITY TO CORRECT MATERIAL FAILURE REGARDING GRANT CONDITIONS.—Section 330(e) of the Public Health Service Act (42 U.S.C. 254b(e)) is amended by adding at the end the following:

''(6) OPPORTUNITY TO CORRECT MATERIAL FAILURE REGARDING GRANT CONDITIONS.—If the

Secretary finds that a center materially fails to meet any requirement (except for any requirements waived by the Secretary) necessary to qualify for its grant under this subsection, the Secretary shall provide the center with an opportunity to achieve compliance (over a period of up to 1 year from making such finding) before terminating the center's grant. A center may appeal and obtain an impartial review of any Secretarial determination made with respect to a grant under this subsection, or may appeal and receive a fair hearing on any Secretarial determination involving termination of the center's grant entitlement, modification of the center's service area, termination of a medically underserved population designation within the center's service area, disallowance of any grant expenditures, or a significant reduction in a center's grant amount.''.

SEC. 173. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 174. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a des-

ignation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 175. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.

(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amend-

ed by striking ", except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.

SEC. 176. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking "3-year period (with an optional 4th year" and inserting "4-year period (with an optional 5th year"; and

(2) in subsection (d)—

(A) by striking "and such sums" and inserting "such sums"; and

(B) by inserting before the period the following: ", $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014".

Subtitle F—Making Health Care More Affordable for Retirees

SEC. 181. REINSURANCE FOR RETIREES.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this section, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for the cost of providing health benefits to retirees whose primary residence is located in any State that is not a participating State or an establishing State (as described in section 3104) for the cost of providing health insurance coverage to retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on the date on which such State becomes a participating State or an establishing State.

(2) REFERENCE.—In this section:

(A) HEALTH BENEFITS.—The term ''health benefits'' means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, wheth-

er self-funded, or delivered through the purchase of insurance or otherwise.

(B) EMPLOYMENT-BASED PLAN.—The term ''employment-based plan'' means a group health benefits plan that—

(i) is—

(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

(ii) provides health benefits to retirees.

(C) RETIREES.—The term ''retirees'' means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not ac-

tive employees of an employer maintaining , or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

(b) PARTICIPATION.—

(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—To be eligible to participate in the program established under this section, an employment-based plan (as defined in subsection (a)(2) and referred to in this section as a ''participating employment-based plan'' shall—

(A) provide employment-based health plan benefits; and

(B) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require.

(2) APPROPRIATE EMPLOYMENT-BASED HEALTH BENEFITS.—Appropriate employment-based health benefits described in this paragraph shall—

(A) meet the requirements established under section 3103(a)(1)(B);

(B) implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(C) provide documentation of the actual cost of medical claims involved; and

(D) be certified as appropriate by the Secretary.

(c) PAYMENTS.—

(1) SUBMISSION OF CLAIMS.—

(A) IN GENERAL.—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

(B) BASIS FOR CLAIMS.—Claims submitted under paragraph (1) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the appropriate employment-based health benefits provided to a retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) ob-

tained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

(2) PROGRAM PAYMENTS.—If the Secretary determines that a participating employment-based plan has submitted a valid claim under paragraph (1), the Secretary shall reimburse such plan for 80 percent of that portion of the costs attributable to such claim that exceed $15,000, subject to the limits contained in paragraph (3).

(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

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

(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(6) APPEALS.—The Secretary shall establish—

(A) an appeals process to permit participating employment-based plans to appeal a determination of the Secretary with respect to claims submitted under this section; and

(B) procedures to protect against fraud, waste, and abuse under the program.

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

(e) RETIREE RESERVE TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

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

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

(C) APPROPRIATIONS FROM THE TRUST FUND.—Amounts in the Trust Fund may be appropriated to provide funding to carry out this program under this section

(2) USE OF TRUST FUND.—The Secretary shall use amounts contained in the Trust Fund to carry out the program under this section.

(3) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation in the program to comply with the funding limit provided for in paragraph (1)(B).

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

SEC. 185. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended by adding at the end the following:

"Subtitle C—Other Provisions

"SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.

''(a) IN GENERAL.—

''(1) STANDARDS AND PROTOCOLS.—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

''(2) METHODS.—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which shall include providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under such programs.

''(b) CONTENT.—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for the following:

''(1) Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

''(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

''(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

''(4) Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

''(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

''(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

''(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

''(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under subsection (a) that has been approved by the HIT Policy Committee and the HIT Standards Committee, the Secretary—

''(1) shall notify States of such standards or protocols; and

''(2) may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments.

''(d) GRANTS FOR IMPLEMENTATION OF APPROPRIATE ENROLLMENT HIT.—

''(1) IN GENERAL.—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as 'appropriate HIT technology').

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant under this subsection, an entity shall—

''(A) be a State, political subdivision of a State, or a local governmental entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing—

''(i) a plan to adopt and implement appropriate enrollment technology that includes—

"(I) proposed reduction in maintenance costs of technology systems;

"(II) elimination or updating of legacy systems; and

"(III) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

"(ii) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

"(iii) such other information as the Secretary may require.

"(3) SHARING.—

"(A) IN GENERAL.—The Secretary shall ensure that appropriate enrollment HIT adopted under grants under this subsection is made available to other qualified State, qualified political subdivisions of a State, or other appropriate qualified entities (as described in subparagraph (B)) at no cost.

"(B) QUALIFIED ENTITIES.—The Secretary shall determine what entities are quali-

fied to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.''.

SEC. 186. RULE OF CONSTRUCTION REGARDING HAWAII'S PREPAID HEALTH CARE ACT.

Nothing in this title (or an amendment made by this title) shall be construed to modify or limit the application of the exemption for Hawaii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)).

SEC. 187. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as

the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.——Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the

Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.——

(A) IN GENERAL.——As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate

governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indica-

tors within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and

progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.——There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.——Amounts appropriated under paragraph (1) shall remain available until expended.

On page 598, line 4, insert ''(2),'' after ''paragraphs''.

On page 598, strike lines 8 through 10, and insert the following:

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''.

On page 601, between lines 4 and 5, insert the following:

''(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, pur-

chasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.''.

On page 601, strike lines 5 through 7 and insert the following:

(d) MEDICAID CREDITS ON INPATIENT DRUGS.—Section 340B(a)(5) of the Public Health Service Act (42 U.S.C. 256b(a)(5)) is amended by adding at the end the following

:

On page 601, line 9, strike ''hospitals'' and insert ''hospital's''.

On page 601, line 16, insert ''and section 612'' after ''this section''.

On page 601, line 20, insert ''and section 612'' after ''this section''.

Beginning on page 601, line 24, strike ''and of'' and all that follows through ''(5))'' on line 1 on page 602.

On page 602, strike line 3 and all that follows through line 20 on page 603.