

**PATIENT PROTECTION AND AFFORDABLE CARE ACT; ELDER JUSTICE
ACT, 111 P.L. 148, Part 1 of 3**

Enacted, March 23, 2010

Reporter

124 Stat. 119 *; 111 P.L. 148; 2010 Enacted H.R. 3590; 111 Enacted H.R. 3590

UNITED STATES PUBLIC LAWS > 111th Congress 2nd Session > PUBLIC LAW 111-148 > [H.R. 3590]

Synopsis

An Act

Entitled The Patient Protection and Affordable Care Act.

Text

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1.

SHORT TITLE; TABLE OF CONTENTS.

(a) [<<Notes>>](#)

Short Title.--This Act may be cited as the "Patient Protection and Affordable Care Act".

(b) Table of Contents.-- The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

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"Sec. 2702. Guaranteed availability of coverage.

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"Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.

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- Sec. 10221. Indian health care improvement.

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- Sec. 10301. Plans for a Value-Based purchasing program for ambulatory surgical centers.
- Sec. 10302. Revision to national strategy for quality improvement in health care.
- Sec. 10303. Development of outcome measures.
- Sec. 10304. Selection of efficiency measures.
- Sec. 10305. Data collection; public reporting.
- Sec. 10306. Improvements under the Center for Medicare and Medicaid Innovation.
- Sec. 10307. Improvements to the Medicare shared savings program.
- Sec. 10308. Revisions to national pilot program on payment bundling.

- Sec. 10309. Revisions to hospital readmissions reduction program.
- Sec. 10310. Repeal of physician payment update.
- Sec. 10311. Revisions to extension of ambulance add-ons.
- Sec. 10312. Certain payment rules for long-term care hospital services and moratorium on the establishment of certain hospitals and facilities.
- Sec. 10313. Revisions to the extension for the rural community hospital demonstration program.
- Sec. 10314. Adjustment to low-volume hospital provision.
- Sec. 10315. Revisions to home health care provisions.
- Sec. 10316. Medicare DSH.
- Sec. 10317. Revisions to extension of section 508 hospital provisions.
- Sec. 10318. Revisions to transitional extra benefits under Medicare Advantage.
- Sec. 10319. Revisions to market basket adjustments.
- Sec. 10320. Expansion of the scope of, and additional improvements to, the Independent Medicare Advisory Board.
- Sec. 10321. Revision to community health teams.
- Sec. 10322. Quality reporting for psychiatric hospitals.
- Sec. 10323. Medicare coverage for individuals exposed to environmental health hazards.
- Sec. 10324. Protections for frontier States.
- Sec. 10325. Revision to skilled nursing facility prospective payment system.
- Sec. 10326. Pilot testing pay-for-performance programs for certain Medicare providers.
- Sec. 10327. Improvements to the physician quality reporting system.
- Sec. 10328. Improvement in part D medication therapy management (MTM) programs.
- Sec. 10329. Developing methodology to assess health plan value.
- Sec. 10330. Modernizing computer and data systems of the Centers for Medicare & Medicaid services to support improvements in care delivery.
- Sec. 10331. Public reporting of performance information.
- Sec. 10332. Availability of Medicare data for performance measurement.
- Sec. 10333. Community-based collaborative care networks.
- Sec. 10334. Minority health.
- Sec. 10335. Technical correction to the hospital value-based purchasing program.
- Sec. 10336. GAO study and report on Medicare beneficiary access to high-quality dialysis services.

Subtitle D--Provisions Relating to Title IV

- Sec. 10401. Amendments to subtitle A.
- Sec. 10402. Amendments to subtitle B.
- Sec. 10403. Amendments to subtitle C.
- Sec. 10404. Amendments to subtitle D.

- Sec. 10405. Amendments to subtitle E.
- Sec. 10406. Amendment relating to waiving coinsurance for preventive services.
- Sec. 10407. Better diabetes care.
- Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.
- Sec. 10409. Cures Acceleration Network.
- Sec. 10410. Centers of Excellence for Depression.
- Sec. 10411. Programs relating to congenital heart disease.
- Sec. 10412. Automated Defibrillation in Adam's Memory Act.
- Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.

Subtitle E--Provisions Relating to Title V

- Sec. 10501. Amendments to the Public Health Service Act, the Social Security Act, and title V of this Act.
- [*130]** Sec. 10502. Infrastructure to Expand Access to Care.
- Sec. 10503. Community Health Centers and the National Health Service Corps Fund.
- Sec. 10504. Demonstration project to provide access to affordable care.

Subtitle F--Provisions Relating to Title VI

- Sec. 10601. Revisions to limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.
- Sec. 10602. Clarifications to patient-centered outcomes research.
- Sec. 10603. Striking provisions relating to individual provider application fees.
- Sec. 10604. Technical correction to section 6405.
- Sec. 10605. Certain other providers permitted to conduct face to face encounter for home health services.
- Sec. 10606. Health care fraud enforcement.
- Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation.
- Sec. 10608. Extension of medical malpractice coverage to free clinics.
- Sec. 10609. Labeling changes.

Subtitle G--Provisions Relating to Title VIII

- Sec. 10801. Provisions relating to title VIII.

Subtitle H--Provisions Relating to Title IX

- Sec. 10901. Modifications to excise tax on high cost employer-sponsored health coverage.
- Sec. 10902. Inflation adjustment of limitation on health flexible spending arrangements under cafeteria plans.

Sec. 10903. Modification of limitation on charges by charitable hospitals.

Sec. 10904. Modification of annual fee on medical device manufacturers and importers.

Sec. 10905. Modification of annual fee on health insurance providers.

Sec. 10906. Modifications to additional hospital insurance tax on high-income taxpayers.

Sec. 10907. Excise tax on indoor tanning services in lieu of elective cosmetic medical procedures.

Sec. 10908. Exclusion for assistance provided to participants in State student loan repayment programs for certain health professionals.

Sec. 10909. Expansion of adoption credit and adoption assistance programs.

TITLE I--QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A--Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001.

AMENDMENTS 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 inserting the following:

"PART A--

INDIVIDUAL AND GROUP MARKET REFORMS";

(2) [<<Notes>>](#)

by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) [<<Notes>>](#)

by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) [<<Notes>>](#)

by inserting after section 2702, the following:

[*131] "Subpart II--Improving Coverage

"Sec. 2711.

[<<Notes>>](#)

NO LIFETIME OR ANNUAL LIMITS.

"(a) In General.-- A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish--

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

"(2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

"(b) Per Beneficiary Limits.-- Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.

"Sec. 2712.

[<<Notes>>](#)

PROHIBITION ON RESCISSIONS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

"Sec. 2713.[<<Notes>>](#)

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, at a minimum provide coverage for and shall not impose any cost sharing requirements for--

- "(1)** evidence-based 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, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- "(4)** with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
- "(5)** for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall **[*132]** be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

"(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 interval described in paragraph (1) shall not be less than 1 year.

"(c) Value-based Insurance Design.--The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

"Sec. 2714.[<<Notes>>](#)

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 dependent coverage of children shall continue to make such coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

"(b) Regulations.-- The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

"(c) Rule of Construction.-- Nothing in this section shall be construed to modify the definition of 'dependent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

"Sec. 2715.

[<<Notes>>](#)

DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

"(a) In General.-- Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the 'NAIC'), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

"(b) Requirements.-- The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

[*133] "(1) Appearance.-- The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

"(2) Language.-- The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

"(3) Contents.-- The standards shall ensure that the summary of benefits and coverage includes--

"(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

"(B) a description of the coverage, including cost sharing for--

"(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

"(ii) other benefits, as identified by the Secretary;

"(C) the exceptions, reductions, and limitations on coverage;

"(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

"(E) the renewability and continuation of coverage provisions;

- "(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;
 - "(G) a statement of whether the plan or coverage--
 - "(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and
 - "(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;
 - "(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and
 - "(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.
- "(c) **Periodic Review and Updating.**--The Secretary shall periodically review and update, as appropriate, the standards developed under this section.
- "(d) **Requirement To Provide.**--
- "(1) **In general.**-- Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior [*134] to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to--
 - "(A) an applicant at the time of application;
 - "(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and
 - "(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.
 - "(2) **Compliance.**-- An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.
 - "(3) **Entities in general.**--An entity described in this paragraph is--
 - "(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or
 - "(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).
 - "(4) **Notice of modifications.**--If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.
- "(e) **Preemption.**-- The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.
- "(f) **Failure To Provide.**-- An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than \$ 1,000 for each

such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

"(g) Development of Standard Definitions.--

"(1) In general.-- The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

"(2) Insurance-related terms.--The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

[*135] "(3) Medical terms.-- The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

"Sec. 2716.

[<<Notes>>](#)

PROHIBITION OF DISCRIMINATION BASED ON SALARY.

"(a) In General.-- The plan sponsor of a group health plan (other than a self-insured plan) 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 or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

"(b) Limitation.-- Subsection (a) shall not be construed to prohibit a plan sponsor 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 similarly situated employees with a higher hourly or annual compensation.

"Sec. 2717.

[<<Notes>>](#)

ENSURING THE QUALITY OF CARE.

"(a) Quality Reporting.--

"(1) In general.-- Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that--

"(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

"(B) implement 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) implement 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) implement wellness and health promotion activities.

"(2) Reporting requirements.-- [*136] "(A) In general.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

"(B) Timing of reports.--A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

"(C) Availability of reports.--The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

"(D) Penalties.-- In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

"(E) Exceptions.-- In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

"(b) Wellness and Prevention Programs.--For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

"(1) Smoking cessation.

"(2) Weight management.

"(3) Stress management.

"(4) Physical fitness.

"(5) Nutrition.

"(6) Heart disease prevention.

"(7) Healthy lifestyle support.

"(8) Diabetes prevention.

"(c) Regulations.-- Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

"(d) Study and Report.-- Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report

regarding the impact the activities under this section have had on the quality and cost of health care.

"Sec. 2718.

[<<Notes>>](#)

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, with **[*137]** respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends--

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

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

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

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

"(b) Ensuring That Consumers Receive Value for Their Premium Payments.--

"(1) Requirement to provide value for premium payments.--A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds--

"(A) with respect to a health insurance issuer offering coverage in the group market, 20 percent, or such lower percentage as a State may by regulation determine; or

"(B) with respect to a health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual market in such State.

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

"(3) Termination.-- The provisions of this subsection shall have no force or effect after December 31, 2013.

"(c) Standard Hospital Charges.--Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

"(d) Definitions.-- The Secretary, in consultation with the National Association of Insurance Commissions, shall establish uniform definitions for the activities reported under subsection (a).

"Sec. 2719.

[<<Notes>>](#)

APPEALS PROCESS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum--

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

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

"(3) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and

"(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans."

Sec. 1002.

HEALTH INSURANCE CONSUMER INFORMATION.

Part C of title XXVII of the Public Health Service Act ([42 U.S.C. 300gg-91](#) et seq.) is amended by adding at the end the following:

"Sec. 2793.

[<<Notes>>](#)

HEALTH INSURANCE CONSUMER INFORMATION.

"(a) **In General.**-- The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for--

"(1) offices of health insurance consumer assistance; or

"(2) health insurance ombudsman programs.

"(b) **Eligibility.**--

"(1) **In general.**-- To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

"(2) **Criteria.**-- A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

"(c) **Duties.**-- The office of health insurance consumer assistance or health insurance ombudsman shall--

"(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

"(2) collect, track, and quantify problems and inquiries encountered by consumers;

"(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

"(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

"(5) resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986.

[*139] "(d) Data Collection.--As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

"(e) Funding.--

"(1) Initial funding.-- There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, \$ 30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

"(2) Authorization for subsequent years.--There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section."

Sec. 1003.

ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act ([42 U.S.C. 300gg-91](#) et seq.), as amended by section 1002, is further amended by adding at the end the following:

"Sec. 2794.

[<<Notes>>](#)

ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

"(a) Initial Premium Review Process.--

"(1) In general.-- The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

"(2) Justification and disclosure.--The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

"(b) Continuing Premium Review Process.--

"(1) Informing secretary of premium increase patterns.--As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall--

"(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

"(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

"(2) Monitoring by secretary of premium increases.--

"(A) In general.-- Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States **[*140]** and consistent with the provisions of subsection (a)(2), shall monitor

premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

"(B) Consideration in opening exchange.--In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

"(c) Grants in Support of Process.--

"(1) Premium review grants during 2010 through 2014.--The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including--

"(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage; and

"(B) in providing information and recommendations to the Secretary under subsection (b)(1).

"(2) Funding.--

"(A) In general.-- Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary \$ 250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

"(B) Further availability for insurance reform and consumer protection.--If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

"(C) Allocation.-- The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula--

"(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

"(ii) no State qualifying for a grant under paragraph (1) shall receive less than \$ 1,000,000, or more than \$ 5,000,000 for a grant year."

Sec. 1004.

[<<Notes>>](#)

EFFECTIVE DATES.

(a) In General.-- Except as provided for in subsection (b), this subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010.

(b) Special Rule.-- The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act.

[*141] Subtitle B--Immediate Actions to Preserve and Expand Coverage

Sec. 1101.

[<<Notes>>](#)

IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) In General.-- Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) Administration.--

(1) In general.-- The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) Eligible entities.-- To be eligible for a contract under paragraph (1), an entity shall--

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(3) Maintenance of effort.--To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) Qualified High Risk Pool.--

(1) In general.-- Amounts made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

(2) Requirements.-- A qualified high risk pool meets the requirements of this paragraph if such pool--

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;

(B) provides health insurance coverage--

(i) in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit not greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall--

(i) except as provided in clause (ii), vary only as provided for under section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect);

[*142] **(ii)** vary on the basis of age by a factor of not greater than 4 to 1; and

(iii) be established at a standard rate for a standard population; and

(D) meets any other requirements determined appropriate by the Secretary.

(d) Eligible Individual.-- An individual shall be deemed to be an eligible individual for purposes of this section if such individual--

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411);

- (2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and
- (3) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

(e) Protection Against Dumping Risk by Insurers.--

- (1) **In general.--** The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.
- (2) **Sanctions.--** An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:
 - (A) In the case of prior coverage obtained through an employer, the provision by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.
 - (B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan--
 - (i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or
 - (ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage)--
 - (I) the prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer; or
 - (II) the prior coverage is a policy for which duration of coverage from issue or health status are factors that can be considered in determining premiums at renewal.
- (3) **Construction.--** Nothing in this subsection shall be construed as constituting exclusive remedies for violations of criteria established under paragraph (1) or as preventing States [*143] from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(f) Oversight.-- The Secretary shall establish--

- (1) an appeals process to enable individuals to appeal a determination under this section; and
- (2) procedures to protect against waste, fraud, and abuse.

(g) Funding; Termination of Authority.--

- (1) **In general.--** There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$ 5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.
- (2) **Insufficient funds.--** If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.
- (3) **Termination of authority.--**
 - (A) **In general.--** Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(B) Transition to exchange.--The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health plans offered through an Exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

(4) Limitations.-- The Secretary has the authority to stop taking applications for participation in the program under this section to comply with the funding limitation provided for in paragraph (1).

(5) Relation to state laws.--The standards established under this section shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to qualified high risk pools which are established in accordance with this section.

Sec. 1102.

[<<Notes>>](#)

REINSURANCE FOR EARLY RETIREES.

(a) Administration.--

(1) In general.-- Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early 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 January 1, 2014.

(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, **[*144]** whether 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 early retirees.

(C) Early retirees.-- The term "early 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 active 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.--A participating employment-based plan is an employment-based plan that--

(A) meets the requirements of paragraph (2) with respect to health benefits provided under the plan; and

(B) submits 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) Employment-based health benefits.--An employment-based plan meets the requirements of this paragraph if the plan--

(A) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;

(B) provides documentation of the actual cost of medical claims involved; and

(C) is certified 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 subparagraph (A) shall be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early 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 [*145] employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the early 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 the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

(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) **Funding.**-- There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, \$ 5,000,000,000 to carry out the program under this section. Such funds shall be available without fiscal year limitation.
- (f) **Limitation.**-- The Secretary has the authority to stop taking applications for participation in the program based on the availability of funding under subsection (e).

[*146] Sec. 1103. <<Notes>>

IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) Internet Portal to Affordable Coverage Options.--

- (1) **Immediate establishment.**--Not later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.
- (2) **Connecting to affordable coverage.**--An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:
 - (A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of--
 - (i) a single disease or condition; or
 - (ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary);
 - (B) Medicaid coverage under title XIX of the Social Security Act.
 - (C) Coverage under title XXI of the Social Security Act.
 - (D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and
 - (E) Coverage under a high risk pool under section 1101.

(b) Enhancing Comparative Purchasing Options.--

- (1) **In general.**-- Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format to be used for the presentation of information relating to the coverage options described in subsection (a)(2). Such format shall, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.
- (2) **Use of format.**-- The Secretary shall utilize the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).
- (c) **Authority To Contract.**-- The Secretary may carry out this section through contracts entered into with qualified entities.

Sec. 1104.

ADMINISTRATIVE SIMPLIFICATION.

(a) Purpose of Administrative Simplification.--Section 261 of the Health Insurance Portability and Accountability Act of 1996 ([42 U.S.C. 1320d](#) note) is amended--

(1) by inserting "uniform" before "standards"; and

(2) by inserting "and to reduce the clerical burden on patients, health care providers, and health plans" before the period at the end.

(b) Operating Rules for Health Information Transactions.--**[*147]** (1) Definition of operating rules.-- Section 1171 of the Social Security Act ([42 U.S.C. 1320d](#)) is amended by adding at the end the following:

"(9) Operating rules.-- The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part."

(2) Transaction standards; operating rules and compliance.--Section 1173 of the Social Security Act ([42 U.S.C. 1320d-2](#)) is amended--

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

"(J) Electronic funds transfers.";

(B) in subsection (a), by adding at the end the following new paragraph:

"(4) Requirements for financial and administrative transactions.--

"(A) In general.-- The standards and associated operating rules adopted by the Secretary shall--

"(i) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care;

"(ii) be comprehensive, requiring minimal augmentation by paper or other communications;

"(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

"(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse).

"(B) Reduction of clerical burden.--In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers."; and

(C) by adding at the end the following new subsections:

"(g) Operating Rules.--

"(1) In general.-- The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

"(2) Operating rules development.--In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

[*148] "(A) The entity focuses its mission on administrative simplification.

"(B) The entity demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

"(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

"(D) The entity builds on the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

"(E) The entity allows for public review and updates of the operating rules.

"(3) Review and recommendations.--The National Committee on Vital and Health Statistics shall--

"(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

"(B) review the operating rules developed and recommended by such nonprofit entity;

"(C) determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

"(D) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

"(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

"(4) Implementation.--

"(A) In general.-- The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the operating rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(E) and having ensured consultation with providers.

"(B) Adoption requirements; effective dates.--

"(i) Eligibility for a health plan and health claim status.--The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

"(ii) Electronic funds transfers and health care payment and remittance advice.--The set of operating rules for electronic funds transfers and health care payment and remittance advice transactions shall--

"(I) allow for automated reconciliation of the electronic payment with the remittance advice; and

[*149] "(II) be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.

"(iii) Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization.--The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.

"(C) Expedited rulemaking.--The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

"(h) Compliance.--

"(1) Health plan certification.--

"(A) Eligibility for a health plan, health claim status, electronic funds transfers, health care payment and remittance advice.--Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

"(B) Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, referral certification and authorization.--Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

"(2) Documentation of compliance.--A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate [*150] documentation and shall not be certified as being in compliance with such standards, unless the health plan--

"(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

"(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

"(3) Service contracts.-- A health plan shall be required to ensure that any entities that provide services pursuant to a contract with such health plan shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection.

"(4) Certification by outside entity.--The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

"(5) Compliance with revised standards and operating rules.--

"(A) In general.-- A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable revised standards and associated operating rules under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that--

"(i) amends any standard or operating rule described under paragraph (1) of this subsection; or

"(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

"(B) Date of compliance.--A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

"(6) Audits of health plans.--The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (i)(5).

"(i) Review and Amendment of Standards and Operating Rules.--

"(1) Establishment.-- Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

"(2) Evaluations and reports.--

"(A) Hearings.-- Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

[*151] "(B) Report.--Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a single set of operating rules per transaction

standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

"(3) Interim final rulemaking.--

"(A) In general.-- Any recommendations to amend adopted standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

"(B) Public comment.--

"(i) Public comment period.-- The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

"(ii) Effective date.-- The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

"(4) Review committee.--

"(A) Definition.-- For the purposes of this subsection, the term 'review committee' means a committee chartered by or within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including--

"(i) the National Committee on Vital and Health Statistics; or

"(ii) any appropriate committee as determined by the Secretary.

"(B) Coordination of hit standards.-- In developing recommendations under this subsection, the review committee shall ensure coordination, as appropriate, with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology.

"(5) Operating rules for other standards adopted by the secretary.-- The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard had been adopted pursuant to subsection (a)(1)(B).

"(j) Penalties.--

"(1) Penalty fee.--

"(A) In general.-- Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with--

"(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

[*152] "(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

"(B) Fee amount.-- Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of \$ 1 per

covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

"(C) Additional penalty for misrepresentation.--A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

"(D) Annual fee increase.--The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

"(E) Penalty limit.-- A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis--

"(i) an amount equal to \$ 20 per covered life under such plan; or

"(ii) an amount equal to \$ 40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

"(F) Determination of covered individuals.--The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

"(2) Notice and dispute procedure.--The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

"(3) Penalty fee report.-- Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

"(4) Collection of penalty fee.--

"(A) In general.-- The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

"(B) Notice.-- Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall [*153] provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

"(C) Payment due date.-- Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

"(D) Unpaid penalty fees.--Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be--

"(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6621 of the Internal Revenue Code of 1986; and

"(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

"(E) Administrative fees.--Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan."

(c) <<Notes>>

Promulgation of Rules.--

(1) Unique health plan identifier.--The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act ([42 U.S.C. 1320d-2\(b\)](#))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) Electronic funds transfer.--The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(3) Health claims attachments.--The Secretary shall promulgate a final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B) of the Social Security Act ([42 U.S.C. 1320d-2\(a\)\(2\)\(B\)](#))) that is consistent with the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

(d) Expansion of Electronic Transactions in Medicare.--Section 1862(a) of the Social Security Act ([42 U.S.C. 1395y\(a\)](#)) is amended--

(1) in paragraph (23), by striking the "or" at the end;

[*154] **(2)** in paragraph (24), by striking the period and inserting "; or"; and

(3) by inserting after paragraph (24) the following new paragraph:

"(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard."

Sec. 1105.

<<Notes>>

EFFECTIVE DATE.

This subtitle shall take effect on the date of enactment of this Act.

Subtitle C--

Quality Health Insurance Coverage for All Americans

PART I--HEALTH INSURANCE MARKET REFORMS

Sec. 1201.

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.), as amended by section 1001, is further amended--

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

"Subpart I--General Reform";

(2)

(A) in section 2701 ([42 U.S.C. 300gg](#)), by striking the section heading and subsection (a) and inserting the following:

"Sec. 2704.

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) [<<Notes>>](#)

by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3) [<<Notes>>](#)

(A) in section 2702 ([42 U.S.C. 300gg-1](#))--

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

(ii) 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"; and

(II) in paragraph (2)(A)--

(aa) by inserting "or individual" after "employer"; and

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

(iii) in subsection (e)--

[*155] (I) by striking "(a)(1)(F)" and inserting "(a)(6)";

(II) by striking "2701" and inserting "2704"; and

(III) by striking "2721(a)" and inserting "2735(a)"; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

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

"Sec. 2701.

[<<Notes>>](#)

FAIR HEALTH INSURANCE PREMIUMS.

"(a) Prohibiting Discriminatory Premium Rates.--

"(1) In general.-- With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market--

"(A) such rate shall vary with respect to the particular plan or coverage involved only by--

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

"(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

"(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

"(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

"(2) Rating area.--

"(A) In general.-- Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

"(B) Secretarial review.--The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

"(3) Permissible age bands.--The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

"(4) Application of variations based on age or tobacco use.--With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

"(5) Special rule for large group market.--If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) **[*156]** of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

"Sec. 2702.

[<<Notes>>](#)

GUARANTEED AVAILABILITY OF COVERAGE.

"(a) Guaranteed 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.-- The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

"Sec. 2703.

[<<Notes>>](#)

GUARANTEED RENEWABILITY OF COVERAGE.

"(a) In General.-- 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. 2705.

[<<Notes>>](#)

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.

"(j) Programs of Health Promotion or Disease Prevention.--

"(1) General provisions.--

"(A) General rule.-- For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed [*157] to promote health or prevent disease that meets the applicable requirements of this subsection.

"(B) No conditions based on health status factor.--If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

"(C) Conditions based on health status factor.--If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such

wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

"(2) Wellness programs not subject to requirements.--If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

"(A) A program that reimburses all or part of the cost for memberships in a fitness center.

"(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

"(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

"(E) A program that provides a reward to individuals for attending a periodic health education seminar.

"(3) Wellness programs subject to requirements.--If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

"(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in [*158] addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

"(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

"(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

"(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

"(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows--

"(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

"(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

"(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

[*159] **"(E)** The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

"(k) Existing Programs.-- Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

"(l) Wellness Program Demonstration Project.--

"(1) In general.-- Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

"(2) Expansion of demonstration project.--If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

"(3) Requirements.--

"(A) Maintenance of coverage.--The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that--

"(i) will not result in any decrease in coverage; and

"(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

"(B) Other requirements.--States that participate in the demonstration project under this subsection--

"(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

"(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

"(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts--

[*160] **"(I)** do not create undue burdens for individuals insured in the individual market;

"(II) do not lead to cost shifting; and

"(III) are not a subterfuge for discrimination;

"(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 ([42 U.S.C. 1320d-2](#) note); and

"(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

"(m) Report.--

"(1) In general.-- Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning--

"(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

"(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

"(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

"(D) the effectiveness of different types of rewards.

"(2) Data collection.-- In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

"(n) Regulations.-- Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

"Sec. 2706.

[<<Notes>>](#)

NON-DISCRIMINATION IN HEALTH CARE.

"(a) Providers.-- A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or

health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

"(b) Individuals.-- The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

[*161] "Sec. 2707. [<<Notes>>](#)

COMPREHENSIVE HEALTH INSURANCE COVERAGE.

"(a) Coverage for Essential Health Benefits Package.--A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

"(b) Cost-sharing Under Group Health Plans.--A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

"(c) Child-only Plans.-- If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

"(d) Dental Only.-- This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

"Sec. 2708.

[<<Notes>>](#)

PROHIBITION ON EXCESSIVE WAITING PERIODS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days."

PART II--OTHER PROVISIONS

Sec. 1251.

[<<Notes>>](#)

PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.

(a) No Changes to Existing 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 on the date of enactment of this Act.

(2) Continuation of coverage.--With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) 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 on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(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 subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

[*162] (d) 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 Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) 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 subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) Definition.-- In this title, the term "grandfathered health plan" means any group health plan or health insurance coverage to which this section applies.

Sec. 1252.

[<<Notes>>](#)

RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d).

Sec. 1253.

[<<Notes>>](#)

EFFECTIVE DATES.

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after January 1, 2014.

Subtitle D--

Available Coverage Choices for All Americans

PART I--ESTABLISHMENT OF QUALIFIED HEALTH PLANS

Sec. 1301.

[<<Notes>>](#)

QUALIFIED HEALTH PLAN DEFINED.

(a) Qualified Health Plan.-- In this title:

(1) In general.-- The term "qualified health plan" means a health plan that--

(A) 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 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) 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;

[*163] **(ii)** agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) Inclusion of co-op plans and community health insurance option.--Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322 or a community health insurance option under section 1323, unless specifically provided for otherwise.

(b) Terms Relating to Health Plans.--In this title:

(1) Health plan.--

(A) In general.-- The term "health plan" means health insurance coverage and a group health plan.

(B) Exception for self-insured plans and MEWAS.--Except to the extent specifically provided by this title, the term "health plan" shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) Health insurance coverage and issuer.--The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) Group health plan.-- The term "group health plan" has the meaning given such term by section 2791(a) of the Public Health Service Act.

Sec. 1302.

[<<Notes>>](#)

ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) Essential Health Benefits Package.--In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that--

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential Health Benefits.--

(1) In general.-- Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

[*164] (E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) Limitation.--

(A) In general.-- The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) Certification.-- In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), 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).

(3) Notice and hearing.-- In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) Required elements for consideration.--In defining the essential health benefits under paragraph (1), 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;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

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

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that--

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan [*165] for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

- (ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;
 - (F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and
 - (G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--
 - (i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;
 - (ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;
 - (iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;
 - (iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and
 - (H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).
- (5) Rule of construction.--**Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.
- (c) Requirements Relating to Cost-Sharing.--**
- (1) Annual limitation on cost-sharing.--**
- (A) **2014.--** The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
 - (B) **2015 and later.--** In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--
 - [*166]** (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
 - (ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$ 50, such increase shall be rounded to the next lowest multiple of \$ 50.
- (2) Annual limitation on deductibles for employer-sponsored plans.--**
- (A) **In general.--** In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed--
 - (i) \$ 2,000 in the case of a plan covering a single individual; and
 - (ii) \$ 4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) Indexing of limits.--In the case of any plan year beginning in a calendar year after 2014--

- (i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
- (ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of \$ 50, such increase shall be rounded to the next lowest multiple of \$ 50.

(C) Actuarial value.-- The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) Coordination with preventive limits.--Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) Cost-sharing.-- In this title--

(A) In general.-- The term "cost-sharing" includes--

- (i) deductibles, coinsurance, copayments, or similar charges; and
- (ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

[*167] (B) Exceptions.--Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) Premium adjustment percentage.--For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) Levels of Coverage.--

(1) Levels of coverage defined.--The levels of coverage described in this subsection are as follows:

- (A) Bronze level.**-- A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.
- (B) Silver level.**-- A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
- (C) Gold level.**-- A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
- (D) Platinum level.**-- A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) Actuarial value.--

(A) In general.-- Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) Employer contributions.-- The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) Application.-- In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) Allowable variance.-- The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

[*168] (4) Plan reference.-- In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) Catastrophic Plan.--

(1) In general.-- A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if--

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides--

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) Individuals eligible for enrollment.-- An individual is described in this paragraph for any plan year if the individual--

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of--

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) Restriction to individual market.-- If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) Child-only Plans.-- If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

[<<Notes>>](#)

SPECIAL RULES.

(a) Special Rules Relating to Coverage of Abortion Services.--

(1) Voluntary choice of coverage of abortion services.--

(A) In general.-- Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)--

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

[*169] **(ii)** the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) Abortion services.--

(i) Abortions for which public funding is prohibited.--The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) Abortions for which public funding is allowed.--The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(C) Prohibition on federal funds for abortion services in community health insurance option.-

(i) Determination by secretary.--The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary--

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) State requirement.--If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) Exceptions.-- Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance **[*170]** option. Services described in

subparagraph (B)(ii) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) Assured availability of varied coverage through exchanges.--

(i) In general.-- The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title--

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) Special rules.-- For purposes of clause (i)--

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

(2) Prohibition on the use of federal funds.--

(A) In general.-- If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

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

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

(B) Segregation of funds.-- In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

(C) Actuarial value of optional service coverage.--

(i) In general.-- The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) Considerations.-- In making such estimate, the Secretary--

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated [*171] to result from such services, including prenatal care, delivery, or postnatal care;

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

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

(3) Provider conscience protections.-- No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

(b) Application of State and Federal Laws Regarding Abortion.--

- (1) No preemption of state laws regarding abortion.--**Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.
- (2) No effect on federal laws regarding abortion.--**
 - (A) In general.--** Nothing in this Act shall be construed to have any effect on Federal laws regarding--
 - (i) conscience protection;
 - (ii) willingness or refusal to provide abortion; and
 - (iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.
- (3) No effect on federal civil rights law.--**Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.
- (c) Application of Emergency Services Laws.--**Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as "EMTALA").

Sec. 1304.

[<<Notes>>](#)

RELATED DEFINITIONS.

(a) Definitions Relating to Markets.--In this title:

- (1) Group market.--** The term "group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.
- (2) Individual market.--** The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
- (3) Large and small group markets.--**The terms "large group market" and "small group market" mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection [*172] (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(b) Employers.-- In this title:

- (1) Large employer.--** The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
- (2) Small employer.--** The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
- (3) State option to treat 50 employees as small.--**In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting "51 employees" for "101 employees" in paragraph (1) and by substituting "50 employees" for "100 employees" in paragraph (2).
- (4) Rules for determining employer size.--**For purposes of this subsection--

(A) 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.

(B) 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.

(C) Predecessors.--Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) Continuation of participation for growing small employers.--If--

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subtitle for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) Secretary.-- In this title, the term "Secretary" means the Secretary of Health and Human Services.

(d) State.-- In this title, the term "State" means each of the 50 States and the District of Columbia.

[*173] PART II--CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

Sec. 1311.

[<<Notes>>](#)

AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) Assistance to States to Establish American Health Benefit Exchanges.--

(1) Planning and establishment grants.--There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) Amount specified.-- For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(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 Exchange, as described in subsection (b).

(4) Renewability of grant.--

(A) In general.-- Subject to subsection (d)(4), 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 an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

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

(B) Limitation.-- No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in shop exchanges.--The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges.--

(1) In general.-- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an "Exchange") for the State that--

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) Merger of individual and shop exchanges.--A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only [*174] if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary.--

(1) In general.-- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum--

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;(D)

(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

- (G) utilize the standard format established for presenting health benefits plan options; and
- (H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

[*175] (2) Rule of construction.-- Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

- (3) **Rating system.**-- The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

- (4) **Enrollee satisfaction system.**--The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

- (5) **Internet portals.**-- The Secretary shall--

- (A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

- (B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

- (6) **Enrollment periods.**-- The Secretary shall require an Exchange to provide for--

- (A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

- (B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

- (C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

- (D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

[*176] (d) Requirements.--

- (1) **In general.**-- An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

- (2) **Offering of coverage.**--

- (A) **In general.**-- An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation.--

(i) **In general.--** An Exchange may not make available any health plan that is not a qualified health plan.

(ii) **Offering of stand-alone dental benefits.--** Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J)).

(3) Rules relating to additional required benefits.--

(A) **In general.--** Except as provided in subparagraph (B), an Exchange 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 1302(b).

(B) States may require additional benefits.--

(i) **In general.--** Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) **State must assume cost.--** A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).

(4) Functions.-- An Exchange shall, at a minimum--

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

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use [*177] of the uniform outline of coverage established under section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an

individual is exempt from the individual requirement or from the penalty imposed by such section because--

- (i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
- (ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury--

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because--

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) Funding limitations.-- [*178] (A) No federal funds for continued operations.--In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds.--In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) Consultation.-- An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including--

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

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

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs.--An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such

Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification.--

(1) In general.-- An Exchange may certify a health plan as a qualified health plan if--

- (A)** such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and
- (B)** the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan--
 - (i)** on the basis that such plan is a fee-for-service plan;
 - (ii)** through the imposition of premium price controls; or
 - (iii)** on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) Premium considerations.-- The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under [*179] section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) Flexibility.--

(1) Regional or other interstate exchanges.-- An Exchange may operate in more than one State if--

- (A)** each State in which such Exchange operates permits such operation; and
- (B)** the Secretary approves such regional or interstate Exchange.

(2) Subsidiary exchanges.-- A State may establish one or more subsidiary Exchanges if--

- (A)** each such Exchange serves a geographically distinct area; and
- (B)** the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) Authority to contract.--

(A) In general.-- A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) Eligible entity.-- In this paragraph, the term "eligible entity" means--

- (i)** a person--
 - (I)** incorporated under, and subject to the laws of, 1 or more States;
 - (II)** that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and
 - (III)** that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or
- (ii)** the State Medicaid agency under title XIX of the Social Security Act.

(g) 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, for treatment or services under the plan or coverage;
 - [*180] (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 Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality Improvement.--

- (1) Enhancing patient safety.--**Beginning on January 1, 2015, 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 of the Public Health Service Act; 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 only 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).
 - (i) Navigators.--**
 - (1) In general.--** An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).
 - (2) Eligibility.--**
 - (A) In general.--** To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types.-- Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused **[*181]** nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that--

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) Duties.-- An entity that serves as a navigator under a grant under this subsection shall--

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards.--

(A) In general.-- The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not--

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) Fair and impartial information and services.--The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) Funding.-- Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) Applicability of Mental Health Parity.--Section 2726 of the Public Health Service Act 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.

(k) Conflict.-- An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

[*182] Sec. 1312. [<<Notes>>](#)

CONSUMER CHOICE.

(a) 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 level.--A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) Employee may choose plans within a level.--Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) 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.

(c) Single Risk Pool.--

(1) Individual market.-- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) Small group market.-- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) Merger of markets.-- A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) State law.-- A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) Empowering Consumer Choice.--

(1) Continued operation of market outside exchanges.--Nothing in this title shall be construed to prohibit--

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(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 offered outside of an Exchange to offer benefits.

(3) Voluntary nature of an exchange.--

(A) Choice to enroll or not to enroll.--Nothing in this title shall be construed to restrict the choice of [*183] a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) Prohibition against compelled enrollment.--Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) Individuals allowed to enroll in any plan.--A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section

1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) Members of congress in the exchange.--

(i) Requirement.-- Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are--

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) Definitions.-- In this section:

(I) Member of congress.--The term "Member of Congress" means any member of the House of Representatives or the Senate.

(II) Congressional staff.--The term "congressional staff" means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) No penalty for transferring to minimum essential coverage outside exchange.--An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) Enrollment Through Agents or Brokers.--The Secretary shall establish procedures under which a State may allow agents or brokers--

(1) to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

(f) Qualified Individuals and Employers; Access Limited to Citizens and Lawful Residents.--

(1) Qualified individuals.-- In this title:

[*184] (A) In general.--The term "qualified individual" means, with respect to an Exchange, an individual who--

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

(B) Incarcerated individuals excluded.--An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) Qualified employer.-- In this title:

(A) In general.-- The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) Extension to large groups.--

(i) In general.-- Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) Large employers eligible.-- If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) Access limited to lawful residents.-- If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

Sec. 1313.

[<<Notes>>](#)

FINANCIAL INTEGRITY.

(a) Accounting for Expenditures.--

(1) In general.-- An Exchange 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, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) Audits.-- An Exchange shall be subject to annual audits by the Secretary.

[*185] (4) Pattern of abuse.-- If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of 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 Exchange 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 to implement under this title or any other Act.

(6) Application of the false claims act.--

(A) In general.-- Payments made by, through, or in connection with an Exchange are subject to the False Claims Act ([31 U.S.C. 3729](#) et seq.) if those payments include any Federal funds.

Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

- (B) Damages.--** Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.
- (b) GAO Oversight.--** Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review--
- (1)** the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;
 - (2)** any significant observations regarding the utilization and adoption of Exchanges;
 - (3)** where appropriate, recommendations for improvements in the operations or policies of Exchanges; and
 - (4)** how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

[*186] PART III--STATE FLEXIBILITY RELATING TO EXCHANGES

Sec. 1321.

[<<Notes>>](#)

STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) Establishment of Standards.--

- (1) In general.--** The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to--
- (A)** the establishment and operation of Exchanges (including SHOP Exchanges);
 - (B)** the offering of qualified health plans through such Exchanges;
 - (C)** the establishment of the reinsurance and risk adjustment programs under part V; and
 - (D)** such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

- (2) Consultation.--** In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) State Action.-- Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect--

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) Failure To Establish Exchange or Implement Requirements.--

(1) In general.-- If--

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State--

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement--

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles; the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

[*187] (2) Enforcement authority.-- The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) 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.

(e) Presumption for Certain State-Operated Exchanges.--

(1) In general.-- In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) Process.-- The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

Sec. 1322.

[<<Notes>>](#)

FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) Establishment of Program.--

(1) In general.-- The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) Purpose.-- It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) Loans and Grants Under the CO-OP Program.--

(1) In general.-- The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of--

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) Requirements for awarding loans and grants.--

(A) In general.-- In awarding loans and grants under the CO-OP program, the Secretary shall--

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance [*188] issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) States without issuers in program.--If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) Agreement.--

(i) In general.-- The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)--

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) Restrictions on use of federal funds.--The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used--

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing. Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) Failure to meet requirements.--If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of--

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding. The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) Time for awarding loans and grants.--The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) Advisory board.-- [*189] (A) In general.--The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) Rules relating to appointments.--

(i) Standards.-- Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) Original appointments.--The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) Vacancy.-- Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) Pay and reimbursement.--

(i) No compensation for members of advisory board.--Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) Travel expenses.--Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) Application of FACA.--The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) Termination.-- The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) Qualified Nonprofit Health Insurance Issuer.--For purposes of this section--

(1) In general.-- The term "qualified nonprofit health insurance issuer" means a health insurance issuer that is an organization--

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) Certain organizations prohibited.--An organization shall not be treated as a qualified nonprofit health insurance issuer if--

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) Governance requirements.--An organization shall not be treated as a qualified nonprofit health insurance issuer unless--

[*190] (A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) Profits inure to benefit of members.--An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower

premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) Compliance with state insurance laws.--An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).

(6) Coordination with state insurance reforms.--An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(d) Establishment of Private Purchasing Council.--

(1) In general.-- Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) Council may not set payment rates.--The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) Continued application of antitrust laws.--

(A) In general.-- Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) Antitrust laws.-- For purposes of this subparagraph, the term "antitrust laws" has the meaning given the term in subsection (a) of the first section of the Clayton Act ([15 U.S.C. 12](#)(a)). Such term also includes section 5 of the Federal Trade Commission Act ([15 U.S.C. 45](#)) to **[*191]** the extent that such section 5 applies to unfair methods of competition.

(e) Limitation on Participation.--No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) Limitations on Secretary.--

(1) In general.-- The Secretary shall not--

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) Competition.-- Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) Appropriations.-- There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, \$ 6,000,000,000 to carry out this section.

(h) Tax Exemption for Qualified Nonprofit Health Insurance Issuer.--

(1) [<<Notes>>](#)

In general.-- Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

“(29) CO-OP health insurance issuers.--

“(A) In general.-- A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

“(B) Conditions for exemption.--Subparagraph (A) shall apply to an organization only if--

“(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

“(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

“(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

“(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.”.

[*192] (2) Additional reporting requirement.-- Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

“(m) Additional Information Required From CO-OP Insurers.--An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

“(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

“(2) The amount of reserves on hand.”.

(3) Application of tax on excess benefit transactions.--Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking “paragraph (3) or (4)” and inserting “paragraph (3), (4), or (29)”.

(i) GAO Study and Report.--

(1) Study.-- The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) Report.-- The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

Sec. 1323.

[<<Notes>>](#)

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.
- (3) State opt out.--**
 - (A) In general.--** A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.
 - (B) Termination of opt out.--**A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.

(b) Establishment of Community Health Insurance Option.--

- (1) Establishment.--** The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges [*193] in States that elect to opt out as provided for in subsection (a)(3)), 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;
 - (F)** offers a sufficient choice of providers; and
 - (G)** complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).
- (3) Essential health benefits.--**
 - (A) General rule.--** Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).
 - (B) States may offer additional benefits.--**Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.
 - (C) Credits.--**
 - (i) In general.--** An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 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 benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(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).

(E) Ensuring access to all services.--Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health [*194] insurance option for a service otherwise not included as an essential health benefit.

(F) Protecting access to end of life care.--A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) Cost sharing.-- A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) Premiums.--

(A) Premiums sufficient to cover costs.--The Secretary shall establish geographically adjusted 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 of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) Collection of data.--The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) National pooling.-- Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) 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 Exchange.

(C) Innovation.-- Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (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 a 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.

[*195] **(C) Consumer protections.**--The consumer protection laws of a State shall apply to a community health insurance option.

(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.

(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 is 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; and

(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.

(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 (4)) for the purposes described in paragraph (1)(B).

(3) 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.

(4) Repayment.--

(A) In general.-- A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 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 [*196] 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.-- A State (other than a State that elects to opt out as provided for in subsection (a)(3)) 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 a 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 a community health insurance option; and

(C) alternative payment structures under a 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 a community health insurance option in that State, 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 or contracts with one or more qualified entities 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 a 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 a 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".

[*197] (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.

Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front-end, prepayment intelligent data-matching technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

(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 shall be revoked by the Secretary, upon the recommendation of the Inspector General, 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, waste, abuse of power, negligence, mismanagement of taxpayer dollars, 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.

[*198] (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)** Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.
- (ii)** Reducing administrative costs and promoting administrative simplification for beneficiaries.
- (iii)** Promoting high quality clinical care.
- (iv)** 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) Report by HHS and Insolvency Warnings.--

- (1) In general.--** On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.
- (2) Result.--** If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.

(3) Submission of plan and procedure.--

- (A) In general.--** If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.
- (B) Procedure.--** In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a Medicare funding warning.

(g) Marketing Parity.-- In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

[*199] (h) Authorization of Appropriations.--There is authorized to be appropriated such sums as may be necessary to carry out this section.

Sec. 1324.

[<<Notes>>](#)

LEVEL PLAYING FIELD.

(a) In General.-- Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.

(b) Laws Described.-- The Federal and State laws described in this subsection are those Federal and State laws relating to--

- (1)** guaranteed renewal;
- (2)** rating;
- (3)** preexisting conditions;
- (4)** non-discrimination;
- (5)** quality improvement and reporting;
- (6)** fraud and abuse;
- (7)** solvency and financial requirements;
- (8)** market conduct;
- (9)** prompt payment;
- (10)** appeals and grievances;
- (11)** privacy and confidentiality;
- (12)** licensure; and
- (13)** benefit plan material or information.

PART IV--

STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

Sec. 1331.

[<<Notes>>](#)

STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

(a) Establishment of Program.--

(1) In general.-- The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange.

(2) Certifications as to benefit coverage and costs.--Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that--

(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides--

(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had **[*200]** enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an Exchange; and

(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed--

(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

(II) the cost-sharing required under a gold plan in the case of an eligible individual not described in subclause (I); and

(B) the benefits provided under the standard health plans offered through the program cover at least the essential health benefits described in section 1302(b).

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium tax credits and cost-sharing reductions allowable with respect to either plan.

(b) Standard Health Plan.-- In this section, the term "standard health plan" means a health benefits plan that the State contracts with under this section--

(1) under which the only individuals eligible to enroll are eligible individuals;

(2) that provides at least the essential health benefits described in section 1302(b); and

(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(c) Contracting Process.--

(1) In general.-- A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) Specific items to be considered.--A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) Innovation.-- Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including--

(i) care coordination and care management for enrollees, especially for those with chronic health conditions;

- (ii) incentives for use of preventive services; and
- (iii) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate utilization under the plan.

[*201] (B) Health and resource differences.--Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.

(C) Managed care.-- Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

(D) Performance measures.--Establishing specific performance measures and standards for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

(3) Enhanced availability.--

(A) Multiple plans.-- A State shall, to the maximum extent feasible, seek to make multiple standard health plans available to eligible individuals within a State to ensure individuals have a choice of such plans.

(B) Regional compacts.-- A State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(4) Coordination with other state programs.--A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State Medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

(d) Transfer of Funds to States.--

(1) In general.-- If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

(2) Use of funds.-- A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

(3) Amount of payment.--

(A) Secretarial determination.--

(i) In general.-- The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits under section 36B of the Internal [*202] Revenue Code of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange established under this subtitle.

(ii) Specific requirements.--The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals described in clause (i), including the age and income of the enrollee, whether the enrollment is for self-only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange, and whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled. This determination shall take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty.

(iii) Certification.-- The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(B) Corrections.-- The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(4) Application of special rules.--The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) Eligible Individual.--

(1) In general.-- In this section, the term "eligible individual" means, with respect to any State, an individual--

(A) who a resident of the State who is not eligible to enroll in the State's Medicaid program under title XIX of the Social Security Act for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

[*203] (B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2) of such Code); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) Eligible individuals may not use exchange.--An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange established under section 1311.

(f) Secretarial Oversight.-- The Secretary shall each year conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets--

(1) eligibility verification requirements for participation in the program;

(2) the requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

- (g) Standard Health Plan Offerors.--**A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program.
- (h) Definitions.--** Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

Sec. 1332.

[<<Notes>>](#)

WAIVER FOR STATE INNOVATION.

(a) Application.--

- (1) In general.--** A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2017. Such application shall--

- (A)** be filed at such time and in such manner as the Secretary may require;

- (B)** contain such information as the Secretary may require, including--

- (i)** a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

- (ii)** a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

- (C)** provide an assurance that the State has enacted the law described in subsection (b)(2).

[*204] (2) Requirements.-- The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

- (A)** Part I of subtitle D.

- (B)** Part II of subtitle D.

- (C)** Section 1402.

- (D)** Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

- (3) Pass through of funding.--**With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(4) Waiver consideration and transparency.--

- (A) In general.--** An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

- (B) Regulations.--** Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide--

- (i)** a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

- (ii) a process for the submission of an application that ensures the disclosure of--
 - (I) the provisions of law that the State involved seeks to waive; and
 - (II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);
- (iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;
- (iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and
- (v) a process for the periodic evaluation by the Secretary of the program under the waiver.

[*205] (C) Report.--The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) Coordinated waiver process.--The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) Definition.-- In this section, the term "Secretary" means--

- (A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and
- (B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) Granting of Waivers.--

(1) In general.-- The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan--

- (A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;
- (B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
- (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
- (D) will not increase the Federal deficit.

(2) Requirement to enact a law.--

(A) In general.-- A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) Termination of opt out.--A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) Scope of Waiver.--

(1) In general.-- The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) Limitation.-- The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) Determinations by Secretary.--

(1) Time for determination.-- The Secretary shall make a determination under subsection (a)(1) not later than 180 [*206] days after the receipt of an application from a State under such subsection.

(2) Effect of determination.--

(A) Granting of waivers.-- If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) Denial of waiver.-- If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) Term of Waiver.-- No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

Sec. 1333.

[<<Notes>>](#)

PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) Health Care Choice Compacts.--

(1) In general.-- Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which--

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies--

(i) would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides.

(2) State authority.-- A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

(3) Approval of compacts.--The Secretary may approve interstate health care choice compacts under paragraph (1) [*207] only if the Secretary determines that such health care choice compact--

- (A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title;
 - (B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
 - (C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;
 - (D) will not increase the Federal deficit; and
 - (E) will not weaken enforcement of laws and regulations described in paragraph (1)(B)(i) in any State that is included in such compact.
- (4) **Effective date.**-- A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) Authority for Nationwide Plans.--

- (1) **In general.**-- Except as provided in paragraph (2), if an issuer (including a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark) of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection a "nationwide qualified health plan")--
- (A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and
 - (B) with respect to State laws mandating benefit coverage by a health plan, only the State laws of the State in which such plan is written or issued shall apply to the nationwide qualified health plan.
- (2) **State opt-out.**-- A State may, by specific reference in a law enacted after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.
- (3) **Plan requirements.**-- An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary--
- (A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6);
 - (B) the issuer is licensed in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this section, including but not limited to, the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;
 - (C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver and gold levels of the plan in each Exchange in the State for the market in which the plan is offered;
- [*208] (D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;
- (E) the issuer offers the nationwide qualified health plan in at least 60 percent of the participating States in the first year in which the plan is offered, 65 percent of such States in the second year, 70 percent of such States in the third year, 75 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;
 - (F) the issuer shall offer the plan in participating States across the country, in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act; and
 - (G) the issuer clearly notifies consumers that the policy may not contain some benefits otherwise mandated for plans in the State in which the purchaser resides and provides a detailed statement

of the benefits offered and the benefit differences in that State, in accordance with rules promulgated by the Secretary.

- (4) Form review for nationwide plans.**--Notwithstanding any contrary provision of State law, at least 3 months before any nationwide qualified health plan is offered, the issuer shall file all nationwide qualified health plan forms with the regulator in each participating State in which the plan will be offered. An issuer may appeal the disapproval of a nationwide qualified health plan form to the Secretary.
- (5) Applicable rules.**-- The Secretary shall, in consultation with the National Association of Insurance Commissioners, issue rules for the offering of nationwide qualified health plans under this subsection. Nationwide qualified health plans may be offered only after such rules have taken effect.
- (6) Coverage.**-- The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.
- (7) State law mandating benefit coverage by a health benefits plan.**--For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific health services or specific diseases. A law that mandates health insurance coverage or reimbursement for services provided by certain classes of providers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V--REINSURANCE AND RISK ADJUSTMENT

Sec. 1341.

[<<Notes>>](#)

TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

- (a) In General.**-- Each State shall, not later than January 1, 2014--

[*209] (1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subsection (b); and

- (2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

- (b) Model Regulation.**--

- (1) In general.**-- In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that enable States to establish and maintain a program under which--

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

- (2) High-risk individual; payment amounts.**--The Secretary shall include the following in the provisions under paragraph (1):

(A) Determination of high-risk individuals.--The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of--

- (i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or
- (ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) Payment amount.-- The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed--

- (i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or
- (ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) Determination of required contributions.-- [*210] (A) In general.--The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) Specific requirements.--The method under this paragraph shall be designed so that--

- (i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;
- (ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;
- (iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal \$ 10,000,000,000 for plan years beginning in 2014, \$ 6,000,000,000 for plan years beginning 2015, and \$ 4,000,000,000 for plan years beginning in 2016; and
- (iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional \$ 2,000,000,000 for 2014, an additional \$ 2,000,000,000 for 2015, and an additional \$ 1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) Expenditure of funds.--The provisions under paragraph (1) shall provide that--

- (A)** the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

[*211] (c) Applicable Reinsurance Entity.--For purposes of this section--

(1) In general.-- The term "applicable reinsurance entity" means a not-for-profit organization--

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) State discretion.-- A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) Entities are tax-exempt.--An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination With State High-risk Pools.--The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

Sec. 1342.

[<<Notes>>](#)

ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

(a) In General.-- The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) Payment Methodology.--

(1) Payments out.-- The Secretary shall provide under the program established under subsection (a) that if--

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

[*212] (2) Payments in.-- The Secretary shall provide under the program established under subsection (a) that if--

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) **Definitions.**-- In this section:

(1) **Allowable costs.**--

(A) **In general.**-- The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) **Reduction for risk adjustment and reinsurance payments.**--Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.

(2) **Target amount.**-- The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

Sec. 1343.

[<<Notes>>](#)

RISK ADJUSTMENT.

(a) **In General.**--

(1) **Low actuarial risk plans.**--Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (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).

(2) **High actuarial risk plans.**--Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (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 section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included **[*213]** in the standards and requirements the Secretary prescribes under section 1321.

(c) **Scope.**-- A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

Subtitle E--

Affordable Coverage Choices for All Americans

PART I--

PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A--

Premium Tax Credits and Cost-sharing Reductions

Sec. 1401.

REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) In General.-- Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"Sec. 36B.

[<<Notes>>](#)

REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

"(a) In General.-- In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

"(b) Premium Assistance Credit Amount.--For purposes of this section--

"(1) In general.-- The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

"(2) Premium assistance amount.--The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of--

"(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

"(B) the excess (if any) of--

"(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

[*214] **"(ii)** an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

"(3) Other terms and rules relating to premium assistance amounts.--For purposes of paragraph (2)--

"(A) Applicable percentage.--

"(i) In general.-- Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 2.8 percent, increased by the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as--

"(I) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

"(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

"(ii) **Special rule for taxpayers under 133 percent of poverty line.**--If a taxpayer's household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer's applicable percentage shall be 2 percent.

"(iii) **Indexing.**-- In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(B) **Applicable second lowest cost silver plan.**--The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which--

"(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

"(ii) provides--

"(I) self-only coverage in the case of an applicable taxpayer--

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

"(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed [***215**] under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

"(C) **Adjusted monthly premium.**--The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

"(D) **Additional benefits.**--If--

"(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

"(E) Special rule for pediatric dental coverage.--For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

"(c) Definition and Rules Relating to Applicable Taxpayers, Coverage Months, and Qualified Health Plan.--For purposes of this section--

"(1) Applicable taxpayer.--

"(A) In general.-- The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

"(B) Special rule for certain individuals lawfully present in the United States.--If--

[*216] "(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

"(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

"(C) Married couples must file joint return.--If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

"(D) Denial of credit to dependents.--No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(2) Coverage month.-- For purposes of this subsection--

"(A) In general.-- The term 'coverage month' means, with respect to an applicable taxpayer, any month if--

"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

"(B) Exception for minimum essential coverage.--

"(i) In general.-- The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

"(ii) Minimum essential coverage.--The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).

"(C) Special rule for employer-sponsored minimum essential coverage.--For purposes of subparagraph (B)--

"(i) Coverage must be affordable.--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage--

"(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

"(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with [*217] respect to the plan exceeds 9.8 percent of the applicable taxpayer's household income. This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

"(ii) Coverage must provide minimum value.--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

"(iii) Employee or family must not be covered under employer plan.--Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

"(iv) Indexing.-- In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

"(3) Definitions and other rules.--

"(A) Qualified health plan.-- The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

"(B) Grandfathered health plan.--The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

"(d) Terms Relating to Income and Families.--For purposes of this section--

"(1) Family size.-- The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(2) Household income.--

"(A) Household income.-- The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of--

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals who--

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(B) Modified gross income.--The term 'modified gross income' means gross income--

[*218] "(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iii) determined without regard to sections 911, 931, and 933.

"(3) Poverty line.--

"(A) In general.-- The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act ([42 U.S.C. 1397jj](#)(c)(5)).

"(B) Poverty line used.--In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

"(e) Rules for Individuals Not Lawfully Present.--

"(1) In general.-- If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present--

"(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

"(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

"(i) A method under which--

"(I) the taxpayer's family size is determined by not taking such individuals into account, and

"(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction--

"(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

"(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

"(ii) A comparable method reaching the same result as the method under clause (i).

"(2) Lawfully present.-- For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

"(3) Secretarial authority.--The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes **[*219]** of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in

qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

"(f) Reconciliation of Credit and Advance Credit.--

"(1) In general.-- The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

"(2) Excess advance payments.--

"(A) In general.-- If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

"(B) Limitation on increase where income less than 400 percent of poverty line.--

"(i) In general.-- In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed \$ 400 (\$ 250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

"(ii) Indexing of amount.--In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to--

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof. If the amount of any increase under clause (i) is not a multiple of \$ 50, such increase shall be rounded to the next lowest multiple of \$ 50.

"(g) Regulations.-- The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for--

"(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

"(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit."

(b) Disallowance of Deduction.--Section 280C of the Internal Revenue Code of 1986 [<<Notes>>](#)

is amended by adding at the end the following new subsection:

"(g) Credit for Health Insurance Premiums.--No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums."

[*220] (c) Study on Affordable Coverage.--

(1) Study and report.--

(A) In general.-- Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including--

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) Report.-- The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) Appropriate committees of congress.--In this subsection, the term "appropriate committees of Congress" means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) Conforming Amendments.--

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "36A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

"Sec. 36B.

Refundable credit for coverage under a qualified health plan."

(e) <<Notes>>

Effective Date.--The amendments made by this section shall apply to taxable years ending after December 31, 2013.

Sec. 1402.

<<Notes>>

REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) In General.-- In the case of an eligible insured enrolled in a qualified health plan--

(1) the Secretary shall notify the issuer of the plan of such eligibility; and

(2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

[*221] (b) Eligible Insured.--In this section, the term "eligible insured" means an individual--

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) Determination of Reduction in Cost-sharing.--

(1) **Reduction in out-of-pocket limit.--**

- (A) In general.--** The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of--
- (i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;
 - (ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and
 - (iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.
- (B) Coordination with actuarial value limits.--**
- (i) **In general.--** The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above--
 - (I) 90 percent in the case of an eligible insured described in paragraph (2)(A);
 - (II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and
 - (III) 70 percent in the case of an eligible insured described in clause (ii) or (iii) of subparagraph (A).
 - (ii) **Adjustment.--** The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).
- (2) Additional reduction for lower income insureds.--**The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to--
- (A)** in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed [*222] costs of benefits provided under the plan to 90 percent of such costs; and
 - (B)** in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.
- (3) Methods for reducing cost-sharing.--**
- (A) In general.--** An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.
 - (B) Capitated payments.--**The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.
- (4) Additional benefits.--** If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.
- (5) Special rule for pediatric dental plans.--**If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the

Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) Special Rules for Indians.--

(1) Indians under 300 percent of poverty.--If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act ([25 U.S.C. 450b\(d\)](#))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section--

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) Items or services furnished through Indian health providers.--If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services--

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount **[*223]** of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) Payment.-- The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) Rules for Individuals Not Lawfully Present.--

(1) In general.-- If an individual who is an eligible insured is not lawfully present--

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which--

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction--

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present.-- For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority.--The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Definitions and Special Rules.--In this section:

- (1) In general.--** Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.
- (2) Limitations on reduction.--** No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.
- (3) Data used for eligibility.--** Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section [*224] 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B--Eligibility Determinations

Sec. 1411.[<<Notes>>](#)

PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) Establishment of Program.--The Secretary shall establish a program meeting the requirements of this section for determining--

- (1)** whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;
- (2)** in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402--
 - (A)** whether the individual meets the income and coverage requirements of such sections; and
 - (B)** the amount of the tax credit or reduced cost-sharing;
- (3)** whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and
- (4)** whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) Information Required To Be Provided by Applicants.--

- (1) In general.--** An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide--
 - (A)** the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an "enrollee"); and
 - (B)** the information required by any of the following paragraphs that is applicable to an enrollee.
- (2) Citizenship or immigration status.--** The following information shall be provided with respect to every enrollee:
 - (A)** In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

[*225] (3) Eligibility and amount of tax credit or reduced cost-sharing.-- In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) Information regarding income and family size.--The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) Changes in circumstances.--The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) Employer-sponsored coverage.--In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) Exemptions from individual responsibility requirements.--In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

[*226] (B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) Verification of Information Contained in Records of Specific Federal Officials.--

(1) Information transferred to secretary.--An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) Citizenship or immigration status.--

(A) Commissioner of social security.--The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

- (i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
- (ii) The attestation of an individual that the individual is a citizen.

(B) Secretary of homeland security.--

(i) In general.-- In the case of an individual--

- (I) who attests that the individual is an alien lawfully present in the United States; or
- (II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner; the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) Information.-- The information described in clause (ii) is the following:

- (I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).
- (II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) Eligibility for tax credit and cost-sharing reduction.--The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) Methods.--

(A) In general.-- The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland [*227] Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done--

- (i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or
- (ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) Flexibility.-- The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) Verification by Secretary.--In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) Actions Relating to Verification.--

- (1) In general.--** Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) Verification.--

- (A) Eligibility for enrollment and premium tax credits and cost-sharing reductions.--**If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)--

- (i)** the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and
- (ii)** the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

- (B) Exemption from individual responsibility.--**If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary [***228**] shall issue the certification of exemption described in section 1311(d)(4)(H).

- (3) Inconsistencies involving attestation of citizenship or lawful presence.--**If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the Medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) Inconsistencies involving other information.--

- (A) In general.--** If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

- (i) Reasonable effort.--**The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

- (ii) Notice and opportunity to correct.--**In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall--

- (I)** notify the applicant of such fact;

- (II)** provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant. The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) Specific actions not involving citizenship or lawful presence.--

- (i) In general.--** Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) Eligibility or amount of credit or reduction.--If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) Employer affordability.--If the Secretary notifies an Exchange that an enrollee is eligible for [*229] a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) Exemption.-- In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) Appeals process.-- The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) Appeals and Redeterminations.--

(1) In general.-- The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers--

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) Employer liability.--

(A) In general.-- The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to--

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) Confidentiality.-- Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that--

[*230] (i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

- (ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) Confidentiality of Applicant Information.--

- (1) In general.--** An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.
- (2) Receipt of information.--** Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall--
 - (A)** use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and
 - (B)** not disclose the information to any other person except as provided in this section.

(h) Penalties.--

(1) False or fraudulent information.--

(A) Civil penalty.--

(i) In general.-- If--

- (I)** any person fails to provide correct information under subsection (b); and
- (II)** such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$ 25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) Reasonable cause exception.-- No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) Knowing and willful violations.-- Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$ 250,000.

[*231] (2) Improper use or disclosure of information.-- Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$ 25,000.

(3) Limitations on liens and levies.-- The Secretary (or, if applicable, the Attorney General of the United States) shall not--

- (A)** file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or
- (B)** levy on any such property with respect to such failure.

(i) Study of Administration of Employer Responsibility.--

- (1) In general.--** The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

- (A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.
 - (B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.
- (2) **Report.**-- Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

Sec. 1412.

<<Notes>>

ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

- (a) **In General.**-- The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which--
- (1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;
 - (2) the Secretary notifies--
 - (A) the Exchange and the Secretary of the Treasury of the advance determinations; and
 - (B) the Secretary of the Treasury of the name and employer identification number of each employer with respect to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because--
 - [*232] (i) the employer did not provide minimum essential coverage; or
 - (ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
 - (3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.

(b) **Advance Determinations.**--

- (1) **In general.**-- The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made--
 - (A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and
 - (B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.
- (2) **Changes in circumstances.**--The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in

family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including--

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) Payment of Premium Tax Credits and Cost-sharing Reductions.--

(1) **In general.--** The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) Premium tax credit.--

(A) **In general.--** The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) **Issuer responsibilities.--**An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall--

[*233] (i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured--

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) **Cost-sharing reductions.--**The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) **No Federal Payments for Individuals Not Lawfully Present.--**Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) **State Flexibility.--** Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

Sec. 1413.

[<<Notes>>](#)

STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) In General.-- The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for medical assistance under the State Medicaid plan under title XIX, or eligible for enrollment under a State children's health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) Requirements Relating to Forms and Notice.--

(1) Requirements relating to forms.--

(A) In general.-- The Secretary shall develop and provide to each State a single, streamlined form that--

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

[*234] **(iii)** may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) State authority to establish form.--A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) Supplemental eligibility forms.--The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(2) Notice.-- The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) Requirements Relating to Eligibility Based on Data Exchanges.--

(1) Development of secure interfaces.--Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) Data matching program.--Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that--

(A) provides access to data described in paragraph (3);

(B) applies only to individuals who--

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance--

(I) by filing a form described in subsection (b); or

(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such programs.

[*235] (3) Determination of eligibility.--

(A) **In general.**-- Each applicable State health subsidy program shall, to the maximum extent practicable--

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a) of the Social Security Act, obtained through such arrangement.

(B) **Exception.**-- This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) **Secretarial standards.**--The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) **Administrative Authority.**--

(1) **Agreements.**-- Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) **Authority of exchange to contract out.**--Nothing in this section shall be construed to--

(A) prohibit contractual arrangements through which a State Medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's Medicaid program must be determined by a public agency.

(e) **Applicable State Health Subsidy Program.**--In this section, the term "applicable State health subsidy program" means--

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State Medicaid program under title XIX of the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

[*236] Sec. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) Disclosure of Taxpayer Return Information and Social Security Numbers.--**(1) Taxpayer return information.--**Subsection (l) of section 6103 of the Internal Revenue Code of 1986 <<Notes>>

is amended by adding at the end the following new paragraph:

"(21) Disclosure of return information to carry out eligibility requirements for certain programs.--

"(A) In general.-- The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State Medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of Patient Protection and Affordable Care Act. Such return information shall be limited to--

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

"(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

"(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and

"(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

"(B) Information to exchange and state agencies.--The Secretary of Health and Human Services may disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

"(C) Restriction on use of disclosed information.--Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an Exchange, or a State agency only for the purposes of, and to the extent necessary in--

[*237] "(i) establishing eligibility for participation in the Exchange, and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

"(ii) determining eligibility for participation in the State programs described in subparagraph (A).".

(2) Social security numbers.--Section 205(c)(2)(C) of the Social Security Act <<Notes>>

is amended by adding at the end the following new clause:

"(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect

and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, the such Act."

(b) Confidentiality and Disclosure.--Paragraph (3) of section 6103(a) of such Code [<<Notes>>](#) is amended by striking "or (20)" and inserting "(20), or (21)".

(c) Procedures and Recordkeeping Related to Disclosures.--Paragraph (4) of section 6103(p) of such Code is amended--

(1) by inserting ", or any entity described in subsection (l)(21)," after "or (20)" in the matter preceding subparagraph (A),

(2) by inserting "or any entity described in subsection (l)(21)," after "or (o)(1)(A)" in subparagraph (F)(ii), and

(3) by inserting "or any entity described in subsection (l)(21)," after "or (20)" both places it appears in the matter after subparagraph (F).

(d) Unauthorized Disclosure or Inspection.--Paragraph (2) of section 7213(a) of such Code is amended by striking "or (20)" and inserting "(20), or (21)".

Sec. 1415.

[<<Notes>>](#)

PREMIUM TAX CREDIT AND COST-SHARING REDUCTION PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any 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--

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under such section 36B that is made under section 1402 or 1412 shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II--SMALL BUSINESS TAX CREDIT

Sec. 1421.

CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) In General.-- Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related [***238**] credits) is amended by inserting after section 45Q the following:

"Sec. 45R.

[<<Notes>>](#)

EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

"(a) General Rule.-- For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

"(b) Health Insurance Credit Amount.--Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of--

"(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans offered by the employer to its employees through an Exchange, or

"(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

"(c) Phaseout of Credit Amount Based on Number of Employees and Average Wages.--The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

"(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

"(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is such dollar amount.

"(d) Eligible Small Employer.--For purposes of this section--

"(1) **In general.--** The term 'eligible small employer' means, with respect to any taxable year, an employer--

"(A) which has no more than 25 full-time equivalent employees for the taxable year,

"(B) the average annual wages of which do not exceed an amount equal to twice the dollar amount in effect under paragraph (3)(B) for the taxable year, and

"(C) which has in effect an arrangement described in paragraph (4).

"(2) Full-time equivalent employees.--

"(A) **In general.--** The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing--

"(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

"(ii) 2,080.

[*239] Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

"(B) **Excess hours not counted.--**If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

"(C) **Hours of service.--** The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(3) Average annual wages.--

"(A) **In general.--** The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing--

"(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

"(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of \$ 1,000 if not otherwise such a multiple.

"(B) Dollar amount.-- For purposes of paragraph (1)(B)--

"(i) 2011, 2012, and 2013.--The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is \$ 20,000.

"(ii) Subsequent years.--In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to \$ 20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

"(4) Contribution arrangement.--An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

"(5) Seasonal worker hours and wages not counted.--For purposes of this subsection--

"(A) In general.-- The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

"(B) Definition of seasonal worker.--The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

[*240] "(e) Other Rules and Definitions.--For purposes of this section--

"(1) Employee.--

"(A) Certain employees excluded.--The term 'employee' shall not include--

"(i) an employee within the meaning of section 401(c)(1),

"(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

"(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

"(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

"(B) Leased employees.-- The term 'employee' shall include a leased employee within the meaning of section 414(n).

"(2) Credit period.-- The term 'credit period' means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

"(3) Nonelective contribution.--The term 'nonelective contribution' means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

"(4) Wages.-- The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

"(5) Aggregation and other rules made applicable.--

"(A) Aggregation rules.-- All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

"(B) Other rules.-- Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

"(f) Credit Made Available to Tax-exempt Eligible Small Employers.--

"(1) In general.-- In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of--

"(A) the amount of the credit determined under this section with respect to such employer, or

"(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

"(2) Tax-exempt eligible small employer.--For purposes of this section, the term 'tax-exempt eligible small employer' means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

"(3) Payroll taxes.-- For purposes of this subsection--

"(A) In general.-- The term 'payroll taxes' means--

[*241] "(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

"(ii) amounts required to be withheld from such employees under section 3101(b), and

"(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

"(B) Special rule.-- A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

"(g) Application of Section for Calendar Years 2011, 2012, and 2013.--In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

"(1) No credit period required.--The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2013, no credit period shall be treated as beginning with a taxable year beginning before 2014.

"(2) Amount of credit.-- The amount of the credit determined under subsection (b) shall be determined--

"(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '50 percent (35 percent in the case of a tax-exempt eligible small employer)',

"(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

"(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

"(3) Contribution arrangement.--An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

"(h) Insurance Definitions.-- Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

"(i) Regulations.-- The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under subsection (c) through the use of multiple entities."

(b) Credit To Be Part of General Business Credit.--Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) [<<Notes>>](#)

is amended by striking "plus" at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting ", plus", and by inserting after paragraph (35) the following:

[*242] "(36) the small employer health insurance credit determined under section 45R."

(c) Credit Allowed Against Alternative Minimum Tax.--Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) [<<Notes>>](#)

is amended by redesignating clauses (vi), (vii), and (viii) as clauses (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

"(vi) the credit determined under section 45R,".

(d) Disallowance of Deduction for Certain Expenses for Which Credit Allowed.--

(1) In general.-- Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1401(b), is amended by adding at the end the following new subsection:

"(h) Credit for Employee Health Insurance Expenses of Small Employers.--No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 1301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit determined under section 45R(a) with respect to the premiums."

(2) Deduction for expiring credits.--Section 196(c) of such Code is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", and", and by adding at the end the following new paragraph:

"(14) the small employer health insurance credit determined under section 45R(a)."

(e) Clerical Amendment.-- The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 45R.

Employee health insurance expenses of small employers."

(f) Effective Dates.--

(1) [<<Notes>>](#)

In general.-- The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

- (2) **Minimum tax.**-- The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle F--Shared Responsibility for Health Care

PART I--INDIVIDUAL RESPONSIBILITY

Sec. 1501.

[<<Notes>>](#)

REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

- (a) **Findings.**-- Congress makes the following findings:

- (1) **In general.**-- The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

[*243] (2) Effects on the national economy and interstate commerce.-- The effects described in this paragraph are the following:

- (A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.
- (B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$ 2,500,000,000,000, or 17.6 percent of the economy, in 2009 to \$ 4,700,000,000,000 in 2019. Private health insurance spending is projected to be \$ 854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.
- (C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.
- (D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.
- (E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.
- (F) Under the Employee Retirement Income Security Act of 1974 ([29 U.S.C. 1001](#) et seq.), the Public Health Service Act ([42 U.S.C. 201](#) et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.
- (G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health

insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were \$ 90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group **[*244]** markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme court ruling.--In *United States v. South-Eastern Underwriters Association* ([322 U.S. 533 \(1944\)](#)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) In General.-- Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48--

MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A.

Requirement to maintain minimum essential coverage.

"Sec. 5000A.

[<<Notes>>](#)

REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) Requirement To Maintain Minimum Essential Coverage.--An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) Shared Responsibility Payment.--

"(1) In general.-- If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

"(2) Inclusion with return.--Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) Payment of penalty.-- If an individual with respect to whom a penalty is imposed by this section for any month--

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) Amount of Penalty.--

"(1) In general.-- The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.

"(2) Dollar limitation.-- The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection

(b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without [*245] regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(3) Applicable dollar amount.--For purposes of paragraph (1)--

"(A) In general.-- Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$ 750.

"(B) Phase in.-- The applicable dollar amount is \$ 95 for 2014 and \$ 350 for 2015.

"(C) Special rule for individuals under age 18.--If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) Indexing of amount.--In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$ 750, increased by an amount equal to--

"(i) \$ 750, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$ 50, such increase shall be rounded to the next lowest multiple of \$ 50.

"(4) Terms relating to income and families.--For purposes of this section--

"(A) Family size.-- The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) Household income.-- The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of--

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals who--

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) Modified gross income.--The term 'modified gross income' means gross income--

"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iii) determined without regard to sections 911, 931, and 933.

"(D) Poverty line.-- [*246] "(i) In general.--The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act ([42 U.S.C. 1397j\(c\)\(5\)](#)).

"(ii) Poverty line used.--In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

"(d) Applicable Individual.-- For purposes of this section--

"(1) In general.-- The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) Religious exemptions.--

"(A) Religious conscience exemption.--Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) Health care sharing ministry.--

"(i) In general.-- Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) Health care sharing ministry.--The term 'health care sharing ministry' means an organization--

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) Individuals not lawfully present.--Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

"(4) Incarcerated individuals.--Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) Exemptions.-- No penalty shall be imposed under subsection (a) with respect to--

"(1) Individuals who cannot afford coverage.-- [*247] "(A) In general.--Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

"(B) Required contribution.--For purposes of this paragraph, the term 'required contribution' means--

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual

premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) **Special rules for individuals related to employees.**--For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

"(D) **Indexing.**-- In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) **Taxpayers with income under 100 percent of poverty line.**--Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

"(3) **Members of Indian tribes.**--Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

"(4) **Months during short coverage gaps.**--

"(A) **In general.**-- Any month the last day of which occurred during a period in which the applicable individual [*248] was not covered by minimum essential coverage for a continuous period of less than 3 months.

"(B) **Special rules.**-- For purposes of applying this paragraph--

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) **Hardships.**-- Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

"(f) **Minimum Essential Coverage.**--For purposes of this section--

"(1) **In general.**-- The term 'minimum essential coverage' means any of the following:

"(A) **Government sponsored programs.**--Coverage under--

- "(i) the Medicare program under part A of title XVIII of the Social Security Act,
- "(ii) the Medicaid program under title XIX of the Social Security Act,
- "(iii) the CHIP program under title XXI of the Social Security Act,
- "(iv) the TRICARE for Life program,
- "(v) the veteran's health care program under chapter 17 of title 38, United States Code, or
- "(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) **Employer-sponsored plan.**--Coverage under an eligible employer-sponsored plan.

"(C) **Plans in the individual market.**--Coverage under a health plan offered in the individual market within a State.

"(D) **Grandfathered health plan.**--Coverage under a grandfathered health plan.

"(E) **Other coverage.**-- Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

"(2) **Eligible employer-sponsored plan.**--The term 'eligible employer-sponsored plan' means, with respect to any [*249] employee, a group health plan or group health insurance coverage offered by an employer to the employee which is--

"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) **Excepted benefits not treated as minimum essential coverage.**--The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits--

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) **Individuals residing outside United States or residents of territories.**--Any applicable individual shall be treated as having minimum essential coverage for any month--

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) **Insurance-related terms.**--Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) **Administration and Procedure.**--

"(1) **In general.**-- The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) **Special rules.**-- Notwithstanding any other provision of law--

"(A) Waiver of criminal penalties.--In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) Limitations on liens and levies.--The Secretary shall not--

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure."

(c) Clerical Amendment.-- The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48--

Maintenance of Minimum Essential Coverage."

(d) <<Notes>>

Effective Date.--The amendments made by this section shall apply to taxable years ending after December 31, 2013.

[*250] Sec. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) In General.-- Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

"Subpart D-- Information Regarding Health Insurance Coverage

"Sec. 6055.

Reporting of health insurance coverage.

"Sec. 6055.

<<Notes>>

REPORTING OF HEALTH INSURANCE COVERAGE.

"(a) In General.-- Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

"(b) Form and Manner of Return.--

"(1) In general.-- A return is described in this subsection if such return--

"(A) is in such form as the Secretary may prescribe, and

"(B) contains--

"(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

"(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

"(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning--

"(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

"(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act

of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

"(iv) such other information as the Secretary may require.

"(2) Information relating to employer-provided coverage.--If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include--

"(A) the name, address, and employer identification number of the employer maintaining the plan,

"(B) the portion of the premium (if any) required to be paid by the employer, and

"(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R [*251] (relating to credit for employee health insurance expenses of small employers).

"(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 and address of the person required to make such return and the phone number of the information contact for such person, and

"(B) the information required to be shown on the return with respect to such individual.

"(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) Coverage Provided by Governmental Units.--In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

"(e) Minimum Essential Coverage.--For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).".

(b) Assessable Penalties.--

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) <<Notes>>

is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or", and by inserting after clause (xxiii) the following new clause:

"(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and".

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or" and by inserting after subparagraph (FF) the following new subparagraph:

"(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).".

(c) <<Notes>>

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 to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) Conforming Amendment.-- 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:

[*252] "Subpart D--Information Regarding Health Insurance Coverage".

(e) [<<Notes>>](#)

Effective Date.--The amendments made by this section shall apply to calendar years beginning after 2013.

PART II--EMPLOYER RESPONSIBILITIES

Sec. 1511.

AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

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

"Sec. 18A.

[<<Notes>>](#)

AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

"In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section."

Sec. 1512.

EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

"Sec. 18B.

[<<Notes>>](#)

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, not later than March 1, 2013), written notice--

"(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

"(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

"(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

[*253] "(b) Effective Date.--Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013."

Sec. 1513.

SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) In General.-- Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 4980H.

[<<Notes>>](#)

SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

"(a) Large Employers Not Offering Health Coverage.--If--

"(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,
then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(b) Large Employers With Waiting Periods Exceeding 30 Days.--

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

"(2) Amount.-- For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is--

"(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, \$ 400, and

"(B) in the case of an extended waiting period which exceeds 60 days, \$ 600.

"(3) Extended waiting period.--The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.

"(c) Large Employers Offering Coverage With Employees Who Qualify for Premium Tax Credits or Cost-sharing Reductions.--

"(1) In general.-- If--

"(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health [*254] plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

"(2) Overall limitation.-- The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(d) Definitions and Special Rules.--For purposes of this section--

"(1) Applicable payment amount.--The term 'applicable payment amount' means, with respect to any month, 1/12 of \$ 750.

"(2) Applicable large employer.--

"(A) In general.-- The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

"(B) Exemption for certain employers.--

"(i) In general.-- An employer shall not be considered to employ more than 50 full-time employees if--

"(I) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

"(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

"(ii) Definition of seasonal workers.--The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

"(C) Rules for determining employer size.--For purposes of this paragraph--

"(i) 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.

"(ii) 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 an applicable 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.

"(iii) Predecessors.-- Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

[*255] "(3) Applicable premium tax credit and cost-sharing reduction.-- The term 'applicable premium tax credit and cost-sharing reduction' means--

"(A) any premium tax credit allowed under section 36B,

"(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

"(C) any advance payment of such credit or reduction under section 1412 of such Act.

"(4) Full-time employee.--

"(A) In general.-- The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

"(B) Hours of service.-- The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(5) Inflation adjustment.--

"(A) In general.-- In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of--

"(i) such dollar amount, and

"(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

"(B) Rounding.-- If the amount of any increase under subparagraph (A) is not a multiple of \$ 10, such increase shall be rounded to the next lowest multiple of \$ 10.

"(6) Other definitions.-- Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

"(7) Tax nondeductible.-- For denial of deduction for the tax imposed by this section, see section 275(a)(6).

"(e) Administration and Procedure.--

"(1) In general.-- Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) Time for payment.-- The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

"(3) Coordination with credits, etc.--The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment."

[*256] (b) Clerical Amendment.--The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

"Sec. 4980H.

Shared responsibility for employers regarding health coverage."

(c) Study and Report of Effect of Tax on Workers' Wages.--

(1) In general.-- The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) Report.-- The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) <<Notes>>

Effective Date.--The amendments made by this section shall apply to months beginning after December 31, 2013.

Sec. 1514.

REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) In General.-- Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

"Sec. 6056.

<<Notes>>

LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

"(a) In General.-- Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, 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 may prescribe, and

"(2) contains--

"(A) the name, date, and employer identification number of the employer,

"(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

"(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll--

"(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage,

"(ii) the months during the calendar year for which coverage under the plan was available,

"(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

"(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,

[*257] "(D) the number of full-time employees for each month during the calendar year,

"(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

"(F) such other information as the Secretary may require.

"(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 full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing--

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

"(B) the information required to be shown on the return with respect to such individual.

"(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) Coordination With Other Requirements.--To the maximum extent feasible, the Secretary may provide that--

"(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

"(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

"(e) Coverage Provided by Governmental Units.--In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

"(f) Definitions.-- For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H."

(b) Assessable Penalties.--

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), [<<Notes>>](#)

as amended by section 1502, is amended by striking "or" at the end of clause (xxiii), by striking "and" at the end of clause (xxiv) and inserting "or", and by inserting after clause (xxiv) the following new clause:

"(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and".

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking "or" at the end of subparagraph (FF), by striking the period at the end of subparagraph [*258] (GG) and inserting ", or" and by inserting after subparagraph (GG) the following new subparagraph:

"(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).".

(c) Conforming Amendment.-- The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

"Sec. 6056.

Large employers required to report on health insurance coverage."

(d) [<<Notes>>](#)

Effective Date.--The amendments made by this section shall apply to periods beginning after December 31, 2013.

Sec. 1515.

OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) In General.-- Subsection (f) of section 125 of the Internal Revenue Code of 1986 [<<Notes>>](#)

is amended by adding at the end the following new paragraph:

"(3) Certain exchange-participating qualified health plans not qualified.--

"(A) In general.-- The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

"(B) Exception for exchange-eligible employers.--Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market."

(b) Conforming Amendments.-- Subsection (f) of section 125 of such Code is amended--

(1) by striking "For purposes of this section, the term" and inserting "For purposes of this section--

"(1) In General.-- The term", and

(2) by striking "Such term shall not include" and inserting the following:

"(2) Long-term care insurance not qualified.--The term 'qualified benefit' shall not include".

(c) [<<Notes>>](#)

Effective Date.--The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G--Miscellaneous Provisions

Sec. 1551.

[<<Notes>>](#)

DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act ([42 U.S.C. 300gg-91](#)) shall apply with respect to this title.

Sec. 1552.

[<<Notes>>](#)

TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the authorities provided to the Secretary under this Act (and the amendments made by this Act).

[*259] Sec. 1553. [<<Notes>>](#)

PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

- (a) **In General.**-- The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.
- (b) **Definition.**-- In this section, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.
- (c) **Construction and Treatment of Certain Services.**--Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to--
- (1) the withholding or withdrawing of medical treatment or medical care;
 - (2) the withholding or withdrawing of nutrition or hydration;
 - (3) abortion; or
 - (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.
- (d) **Administration.**-- The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

Sec. 1554.

[<<Notes>>](#)

ACCESS TO THERAPIES.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that--

- (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
- (2) impedes timely access to health care services;
- (3) interferes with communications regarding a full range of treatment options between the patient and the provider;
- (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;
- (5) violates the principles of informed consent and the ethical standards of health care professionals; or
- (6) limits the availability of health care treatment for the full duration of a patient's medical needs.

[*260] Sec. 1555. [<<Notes>>](#)

FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

Sec. 1556.

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 amended 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) [<<Notes>>](#)

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. 1557.

[<<Notes>>](#)

NONDISCRIMINATION.

- (a) **In General.**-- Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 ([42 U.S.C. 2000d](#) et seq.), title IX of the Education Amendments of 1972 ([20 U.S.C. 1681](#) et seq.), the Age Discrimination Act of 1975 ([42 U.S.C. 6101](#) et seq.), or section 504 of the Rehabilitation Act of 1973 ([29 U.S.C. 794](#)), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.
- (b) **Continued Application of Laws.**--Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 ([42 U.S.C. 2000d](#) et seq.), title VII of the Civil Rights Act of 1964 ([42 U.S.C. 2000e](#) et seq.), title IX of the Education Amendments of 1972 ([20 U.S.C. 1681](#) et seq.), section 504 of the Rehabilitation Act of 1973 ([29 U.S.C. 794](#)), or the Age Discrimination Act of 1975 ([42 U.S.C. 611](#) et seq.), or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).
- (c) **Regulations.**-- The Secretary may promulgate regulations to implement this section.

[*261] Sec. 1558. PROTECTIONS FOR EMPLOYEES.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18B (as added by section 1512) the following:

"Sec. 18C.

[<<Notes>>](#)

PROTECTIONS FOR EMPLOYEES.

"(a) **Prohibition.**-- No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has--

"(1) received a credit under section 36B of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

"(2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to

any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

"(3) testified or is about to testify in a proceeding concerning such violation;

"(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

"(5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

"(b) Complaint Procedure.--

"(1) In general.-- An employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

"(2) No limitation on rights.--Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment."

Sec. 1559.

[<<Notes>>](#)

OVERSIGHT.

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

Sec. 1560.

[<<Notes>>](#)

RULES OF CONSTRUCTION.

(a) No Effect on Antitrust Laws.--Nothing in this title (or an amendment made by this title) shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term "antitrust laws" has the meaning given such term in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

[*262] (b) 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 from 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\(b\)\(5\)](#)).

(c) Student Health Insurance Plans.--Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(d) No Effect on Existing Requirements.--Nothing in this title (or an amendment made by this title, unless specified by direct statutory reference) shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for programs identified in section 1413.

Sec. 1561.

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.

[<<Notes>>](#)

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.

[*263] **"(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.

[*264] "(B) Qualified entities.--The Secretary shall determine what entities are qualified to receive enrollment HIT under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee."

Sec. 1562.

CONFORMING AMENDMENTS.

(a) Applicability.-- Section 2735 of the Public Health Service Act ([42 U.S.C. 300gg-21](#)), as so redesignated by section 1001(4), 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 inserting "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".

(b) **Definitions.**-- Section 2791(d) of the Public Health Service Act ([42 U.S.C. 300gg-91](#)(d)) is amended by adding at the end the following:

"(20) **Qualified health plan.**--The term 'qualified health plan' has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

"(21) **Exchange.**-- The term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act."

(c) **Technical and Conforming Amendments.**--Title XXVII of the Public Health Service Act ([42 U.S.C. 300gg](#) et seq.) is amended--

(1) [Notes](#)

in section 2704 ([42 U.S.C. 300gg](#)), as so redesignated by section 1201(2)--

(A) in subsection (c)--

[*265] (i) in paragraph (2), by striking "group health plan" each place that such term appears and inserting "group or individual health plan"; and

(ii) in paragraph (3)--

(I) by striking "group health insurance" each place that such term 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 term 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 second heading for subpart 2 of part A (relating to other requirements);

(3) [Notes](#)

in section 2725 ([42 U.S.C. 300gg-4](#)), as so redesignated by section 1001(2)--

(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) <<Notes>>

in section 2726 ([42 U.S.C. 300gg-5](#)), as so redesignated by section 1001(2)--

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

(C) in subsection (c)--

[*266] (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 connection with such a plan)" each place that such term appears and inserting "or a health insurance issuer offering group or individual health insurance coverage";

(5) <<Notes>>

in section 2727 ([42 U.S.C. 300gg-6](#)), as so redesignated by section 1001(2), 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) <<Notes>>

in section 2728 ([42 U.S.C. 300gg-7](#)), as so redesignated by section 1001(2)--

(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) <<Notes>>

in section 2731 ([42 U.S.C. 300gg-11](#)), as so redesignated by section 1001(3)--

(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";

[*267] **(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 striking subsection (f); and

(F) by transferring such section (as amended by this paragraph) to appear at the end of section 2702 (as added by section 1001(4));

(9) <<Notes>>

in section 2732 ([42 U.S.C. 300gg-12](#)), as so redesignated by section 1001(3)--

(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";

[*268] (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 such section (as amended by this paragraph) to appear at the end of section 2703 (as added by section 1001(4));

(10) [<<Notes>>](#)

in section 2733 ([42 U.S.C. 300gg-13](#)), as so redesignated by section 1001(4)--

(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 employer" 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 term 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 amended by this paragraph) as section 2709 and transferring such section to appear after section 2708 (as added by section 1001(5));
- (11) by redesignating subpart 4 as subpart 2;
- (12) in section 2735 ([42 U.S.C. 300gg-21](#)), as so redesignated by section 1001(4)--
 - [*269] (A) by striking subsection (a);
 - (B) by striking "subparts 1 through 3" each place that such appears and inserting "subpart 1";
 - (C) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and
 - (D) by redesignating such section (as amended by this paragraph) [<<Notes>>](#) as section 2722;
- (13) in section 2736 ([42 U.S.C. 300gg-22](#)), as so redesignated by section 1001(4)--
 - (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";
 - (B) in subsection (b)(1)(B), by inserting "individual health insurance coverage or" after "respect to"; and
 - (C) by redesignating such section (as amended by this paragraph) as section 2723;
- (14) [<<Notes>>](#)
 - in section 2737(a)(1) ([42 U.S.C. 300gg-23](#)), as so redesignated by section 1001(4)--
 - (A) by inserting "individual or" before "group health insurance"; and
 - (B) by redesignating such section(as amended by this paragraph) as section 2724;
- (15) in section 2762 ([42 U.S.C. 300gg-62](#)) [<<Notes>>](#)
 -
 - (A) in the section heading by inserting "and application" before the period; and
 - (B) by adding at the end the following:
 - "(c) **Application of Part A Provisions.--**
 - "(1) **In general.--** The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.
 - "(2) **Clarification.--** To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply."; and

(16) in section 2791(e) ([42 U.S.C. 300gg-91](#)(e))--

(A) in paragraph (2), by striking "51" and inserting "101"; and

(B) in paragraph (4)--

(i) by striking "at least 2" each place that such appears and inserting "at least 1"; and

(ii) by striking "50" and inserting "100".

(d) [<<Notes>>](#)

Application.--Notwithstanding any other provision of the Patient Protection and Affordable Care Act, nothing in such Act (or an amendment made by such Act) shall be construed to--

(1) prohibit (or authorize the Secretary of Health and Human Services to promulgate regulations that prohibit) a group health plan or health insurance issuer from carrying out utilization management techniques that are commonly used as of the date of enactment of this Act; or

(2) restrict the application of the amendments made by this subtitle.

[*270] (e) 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.

[<<Notes>>](#)

ADDITIONAL MARKET REFORMS.

"(a) **General Rule.**-- Except as provided in subsection (b)--

"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care 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 part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

"(b) **Exception.**-- Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care 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."

(f) **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.

[<<Notes>>](#)

ADDITIONAL MARKET REFORMS.

"(a) **General Rule.**-- Except as provided in subsection (b)--

"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care 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 part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

"(b) **Exception.**-- Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care 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. 1563.

SENSE OF THE SENATE PROMOTING FISCAL RESPONSIBILITY.

(a) **Findings.**-- The Senate makes the following findings:

- (1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019.
- (2) CBO projects this Act will continue to reduce budget deficits after 2019.
- [*271] (3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.
- (4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.
- (5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.

(b) **Sense of the Senate.**-- It is the sense of the Senate that--

- (1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and
- (2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes.

TITLE II--ROLE OF PUBLIC PROGRAMS Subtitle A--Improved Access to Medicaid

Sec. 2001.

MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) **Coverage for Individuals With Income at or Below 133 Percent of the Poverty Line.**--

(1) **Beginning 2014.**-- Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended--

- (A) by striking "or" at the end of subclause (VI);
- (B) by adding "or" at the end of subclause (VII); and
- (C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) **Provision of at least minimum essential coverage.**--

(A) In general.-- Section 1902 of such Act (*42 U.S.C. 1396a*) is amended by inserting after subsection (j) the following:

"(k)

(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) **[*272]** of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section."

(B) Conforming amendment.-- Section 1903(i) of the Social Security Act, [<<Notes>>](#) as amended by section 6402(c), is amended--

- (i)** in paragraph (24), by striking "or" at the end;
- (ii)** in paragraph (25), by striking the period and inserting "; or"; and
- (iii)** by adding at the end the following:

"(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2)."

(3) Federal funding for cost of covering newly eligible individuals.-- Section 1905 of the Social Security Act (*42 U.S.C. 1396d*), is amended--

(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and

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

"(y) Increased FMAP for Medical Assistance for Newly Eligible Mandatory Individuals.--

"(1) Amount of increase.--

"(A) 100 percent FMAP.-- During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

"(B) 2017 and 2018.--

"(i) In general.-- During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

"(ii) Applicable percentage point increase.--

"(I) In general.-- For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

[*273] "For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the appli- cable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

"(II) Expansion state defined.-- For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

"(C) 2019 and succeeding years.-- Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

"(D) Limitation.-- The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

"(2) Definitions.-- In this subsection:

"(A) Newly eligible.-- The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

["*274] "(B) Full benefits.--The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i)."

(4) State options to offer coverage earlier and presumptive eligibility; children required to have coverage for parents to be eligible.--

(A) In general.-- Subsection (k) of section 1902 of the Social Security Act [<<Notes>>](#)

(as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931."

(B) Presumptive eligibility.-- Section 1920 of the Social Security Act ([42 U.S.C. 1396r-1](#)) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish."

(5) Conforming amendments.--

(A) Section 1902(a)(10) of such Act ([42 U.S.C. 1396a\(a\)\(10\)](#)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act ([42 U.S.C. 1396a\(l\)\(2\)\(C\)](#)) is amended by striking "100" and inserting "133".

[*275] (C) Section 1905(a) of such Act ([42 U.S.C. 1396d\(a\)](#)) is amended in the matter preceding paragraph (1)--

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

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

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII)."

(D) Section 1903(f)(4) of such Act ([42 U.S.C. 1396b\(f\)\(4\)](#)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII)."

(E) Section 1937(a)(1)(B) of such Act ([42 U.S.C. 1396u-7\(a\)\(1\)\(B\)](#)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) Maintenance of Medicaid Income Eligibility.-- Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended--

(1) in subsection (a)--

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection:

"(gg) Maintenance of Effort.--

"(1) General requirement to maintain eligibility standards until state exchange is fully operational.-- Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) Continuation of eligibility standards for children until October 1, 2019.--

- The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) Nonapplication.-- During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible [*276] for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) Determination of compliance.--

"(A) States shall apply modified gross income.-- A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient

Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) States may expand eligibility or move waived populations into coverage under the state plan.-- With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph(1), (2), or (3).".

(c) Medicaid Benchmark Benefits Must Consist of at Least Minimum Essential Coverage.-- Section 1937(b) of such Act ([42 U.S.C. 1396u-7\(b\)](#)) is amended--

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)--

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

[*277] (B) in subparagraph (A)--

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)--

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) Minimum standards.-- Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) Mental health services parity.--

"(A) In general.-- In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a Medicaid managed care organization

and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) Deemed compliance.-- Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) Annual Reports on Medicaid Enrollment.--

(1) State reports.-- Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended--

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains--

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other **[*278]** categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.".

(2) <<Notes>>

Reports to congress.-- Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) State Option for Coverage for Individuals With Income That Exceeds 133 Percent of the Poverty Line.--

(1) Coverage as optional categorically needy group.-- Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended--

(A) in subsection (a)(10)(A)(ii)--

(i) in subclause (XVIII), by striking "or" at the end;

(ii) in subclause (XIX), by adding "or" at the end; and

(iii) by adding at the end the following new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

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

"(hh)

(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, [*279] the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931."

(2) Conforming amendments.--

(A) Section 1905(a) of such Act ([42 U.S.C. 1396d](#)(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)--

(i) by striking "or" at the end of clause (xiii);

(ii) by inserting "or" at the end of clause (xiv); and

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

"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX);".

(B) Section 1903(f)(4) of such Act ([42 U.S.C. 1396b](#)(f)(4)) is amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(XIX);".

(C) Section 1920(e) of such Act ([42 U.S.C. 1396r-1](#)(e)), as added by subsection (a)(4)(B), is amended by inserting "or clause (ii)(XX)" after "clause (i)(VIII)".

Sec. 2002.

INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) **In General.**-- Section 1902(e) of the Social Security Act ([42 U.S.C. 1396a](#)(e)) is amended by adding at the end the following:

"(14) **Income determined using modified gross income.**--

"(A) In general.-- Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

"(B) No income or expense disregards.-- No type of expense, block, or other income disregard shall be applied [*280] by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

"(C) No assets test.-- A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

"(D) Exceptions.--

"(i) Individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for Medicare cost-sharing.-- Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

"(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

"(II) Individuals who have attained age 65.

"(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

"(IV) Individuals described in subsection (a)(10)(C).

"(V) Individuals described in any clause of subsection (a)(10)(E).

"(ii) Express lane agency findings.-- In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating

to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

"(iii) Medicare prescription drug subsidies determinations.-- Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in [*281] accordance with section 1860D-14 made by the State pursuant to section 1935(a)(2).

"(iv) Long-term care.-- Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

"(v) Grandfather of current enrollees until date of next regular redetermination.-- An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

"(E) Transition planning and oversight.-- Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

"(F) Limitation on secretarial authority.-- The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

[*282] "(G) Definitions of modified gross income and household income.--In this paragraph, the terms 'modified gross income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

"(H) Continued application of Medicaid rules regarding point-in-time income and sources of income.-- The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of--

"(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

"(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income."

(b) Conforming Amendment.-- Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting "(e)(14)," before "(l)(3)".

(c) <<Notes>>

Effective Date.--The amendments made by subsections (a) and (b) take effect on January 1, 2014.

Sec. 2003.

REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) In General.-- Section 1906A of such Act ([42 U.S.C. 1396e-1](#)) is amended--

(1) in subsection (a)--

(A) by striking "may elect to" and inserting "shall";

(B) by striking "under age 19"; and

(C) by inserting ", in the case of an individual under age 19," after "(and";

(2) in subsection (c), in the first sentence, by striking "under age 19"; and

(3) in subsection (d)--

(A) in paragraph (2)--

(i) in the first sentence, by striking "under age 19"; and

(ii) by striking the third sentence and inserting "A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section."; and

(B) in paragraph (3), by striking "the parent of an individual under age 19" and inserting "an individual (or the parent of an individual)"; and

(4) in subsection (e), by striking "under age 19" each place it appears.

[*283] **(b) Conforming Amendment.--**The heading for section 1906A of such Act ([42 U.S.C. 1396e-1](#)) is amended by striking "option for children".

(c) <<Notes>>

Effective Date.--The amendments made by this section take effect on January 1, 2014.

Sec. 2004.

MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) In General.-- Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended--

(1) by striking "or" at the end of subclause (VII);

(2) by adding "or" at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

"(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age;"

(b) Option To Provide Presumptive Eligibility.-- Section 1920(e) of such Act ([42 U.S.C. 1396r-1\(e\)](#)), as added by section 2001(a)(4)(B) and amended by section 2001(e)(2)(C), is amended by inserting ", clause (i)(IX)," after "clause (i)(VIII)".

(c) Conforming Amendments.--

(1) Section 1903(f)(4) of such Act ([42 U.S.C. 1396b\(f\)\(4\)](#)), as amended by section 2001(a)(5)(D), is amended by inserting "1902(a)(10)(A)(i)(IX)," after "1902(a)(10)(A)(i)(VIII)".

(2) Section 1937(a)(2)(B)(viii) of such Act ([42 U.S.C. 1396u-7\(a\)\(2\)\(B\)\(viii\)](#)) is amended by inserting ", or the individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(i)(IX)" before the period.

(d) <<Notes>>

Effective Date.--The amendments made by this section take effect on January 1, 2019.

Sec. 2005.

PAYMENTS TO TERRITORIES.

(a) Increase in Limit on Payments.-- Section 1108(g) of the Social Security Act ([42 U.S.C. 1308\(g\)](#)) is amended--

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking "paragraph (3)" and inserting "paragraphs (3) and (5)";

(2) in paragraph (4), by striking "and (3)" and inserting "(3), and (4)"; and

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

"(5) Fiscal year 2011 and thereafter.-- The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent."

(b) Disregard of Payments for Mandatory Expanded Enrollment.-- Section 1108(g)(4) of such Act ([42 U.S.C. 1308\(g\)\(4\)](#)) is amended--

(1) by striking "to fiscal years beginning" and inserting "to--

"(A) fiscal years beginning";

[*284] (2) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a waiver on the date of enactment of the Patient Protection and Affordable Care Act, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year."

(c) Increased FMAP.--

(1) In general.-- The first sentence of section 1905(b) of the Social Security Act ([42 U.S.C. 1396d\(b\)](#)) is amended by striking "shall be 50 per centum" and inserting "shall be 55 percent".

(2) <<Notes>>

Effective date.-- The amendment made by paragraph (1) takes effect on January 1, 2011.

Sec. 2006.

SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act ([42 U.S.C. 1396d](#)), as amended by sections 2001(a)(3) and 2001(b)(2), is amended--

(1) in subsection (b), in the first sentence, by striking "subsection (y)" and inserting "subsections (y) and (aa)"; and

(2) by adding at the end the following new subsection:

"(aa)

(1) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

"(A) In the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5.

"(B) In the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the preceding fiscal year under this subsection for the State, increased by 25 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State **[*285]** for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

"(2) In this subsection, the term 'disaster-recovery FMAP adjustment State' means a State that is one of the 50 States or the District of Columbia, for which, at any time during the preceding 7 fiscal years, the President has declared a major disaster under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which--

"(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111-5 (if applicable to the

preceding fiscal year) and without regard to this subsection, subsection (y), and subsections (b) and (c) of section 5001 of Public Law 111-5, by at least 3 percentage points; and

"(B) in the case of the second or any succeeding fiscal year for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection by at least 3 percentage points.

"(3) The Federal medical assistance percentage determined for a disaster-recovery FMAP adjustment State under paragraph (1) shall apply for purposes of this title (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced FMAP described in 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI."

Sec. 2007.

MEDICAID IMPROVEMENT FUND RESCISSION.

(a) Rescission.-- Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act ([42 U.S.C. 1396w-1](#)) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) Conforming Amendments.-- Section 1941(b)(1) of the Social Security Act ([42 U.S.C. 1396w-1](#)(b)(1)) is amended--

(1) in subparagraph (A), by striking "\$ 100,000,000" and inserting "\$ 0"; and

(2) in subparagraph (B), by striking "\$ 150,000,000" and inserting "\$ 0".

[*286] Subtitle B--Enhanced Support for the Children's Health Insurance Program

Sec. 2101.

ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) In General.-- Section 2105(b) of the Social Security Act ([42 U.S.C. 1397ee](#)(b)) is amended by adding at the end the following: "Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b)."

(b) Maintenance of Effort.--

(1) In general.-- Section 2105(d) of the Social Security Act ([42 U.S.C. 1397ee](#)(d)) is amended by adding at the end the following:

"(3) Continuation of eligibility standards for children until October 1, 2019.--

"(A) In general.-- During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or

waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from--

"(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

"(ii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

"(B) Assurance of exchange coverage for targeted low-income children unable to be provided child health assistance as a result of funding shortfalls.-- In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall [*287] establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act."

(2) Conforming amendment to title xxi Medicaid maintenance of effort.-- Section 2105(d)(1) of the Social Security Act ([42 U.S.C. 1397ee](#)(d)(1)) is amended by adding before the period ", except as required under section 1902(e)(14)".

(c) No Enrollment Bonus Payments for Children Enrolled After Fiscal Year 2013.-- Section 2105(a)(3)(F)(iii) of the Social Security Act ([42 U.S.C. 1397ee](#)(a)(3)(F)(iii)) is amended by inserting "or any children enrolled on or after October 1, 2013" before the period.

(d) Income Eligibility Determined Using Modified Gross Income.--

(1) State plan requirement.-- Section 2102(b)(1)(B) of the Social Security Act ([42 U.S.C. 1397bb](#)(b)(1)(B)) is amended--

(A) in clause (iii), by striking "and" after the semicolon;

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

(C) by adding at the end the following:

"(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14)."

(2) Conforming amendment.-- Section 2107(e)(1) of the Social Security Act ([42 U.S.C. 1397gg](#)(e)(1)) is amended--

(A) by redesignating subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

"(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income)."

(e) Application of Streamlined Enrollment System.-- Section 2107(e)(1) of the Social Security Act ([42 U.S.C. 1397gg](#)(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

"(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency)."

(f) <<Notes>>

CHIP Eligibility for Children Ineligible for Medicaid as a Result of Elimination of Disregards.-- Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of an income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 2110(b) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether [*288] implemented under title XIX or XXI, or both, of the Social Security Act).

Sec. 2102.

TECHNICAL CORRECTIONS.

(a) <<Notes>>

CHIPRA.--Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) (in this section referred to as "CHIPRA"):

(1) Section 2104(m) of the Social Security Act, <<Notes>>

as added by section 102 of CHIPRA, is amended--

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) Adjustment of fiscal year 2010 allotments to account for changes in projected spending for certain previously approved expansion programs.-- For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population."

(2) <<Notes>>

Section 605 of CHIPRA is amended by striking "legal residents" and insert "lawfully residing in the United States".

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act ([42 U.S.C. 1397ee](#)(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking ", respectively".

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act ([42 U.S.C. 1397ee](#)(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act ([42 U.S.C. 1397e](#)(c)(9)(B)), <<Notes>>

as added by section 211(c)(1) of CHIPRA, is amended by striking "section 1903(a)(3)(F)" and inserting "section 1903(a)(3)(G)".

(6) Section 2109(b)(2)(B) of the Social Security Act ([42 U.S.C. 1397ii](#)(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking "the child population growth factor under section 2104(m)(5)(B)" and inserting "a high-performing State under section 2111(b)(3)(B)".

(7) Section 2110(c)(9)(B)(v) of the Social Security Act ([42 U.S.C. 1397jj](#)(c)(9)(B)(v)), as added by section 505(b) of CHIPRA, is amended by striking "school or school system" and inserting "local

educational agency (as defined under section 9101 of the Elementary and Secondary Education Act of 1965".

(8) [<<Notes>>](#)

Section 211(a)(1)(B) of CHIPRA is amended--

(A) by striking "is amended" and all that follows through "adding" and inserting "is amended by adding"; and

(B) by redesignating the new subparagraph to be added by such section to section 1903(a)(3) of the Social Security Act as a new subparagraph (H).

[*289] (b) [<<Notes>>](#)

ARRA.--Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), the second sentence of section 1916A(a)(1) of the Social Security Act ([42 U.S.C. 1396o-1](#)(a)(1)) is amended by striking "or (i)" and inserting ", (i), or (j)".

Subtitle C--

Medicaid and CHIP Enrollment Simplification

Sec. 2201.

ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act ([42 U.S.C. 1397aa](#) et seq.) is amended by adding at the end the following:

"Sec. 1943.

[<<Notes>>](#)

ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

"(a) Condition for Participation in Medicaid.-- As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2014, a State shall ensure that the requirements of subsection (b) is met.

"(b) Enrollment Simplification and Coordination With State Health Insurance Exchanges and Chip.--

"(1) In general.-- A State shall establish procedures for--

"(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

"(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for--

"(i) medical assistance under the State plan or under a waiver of the plan; or

"(ii) child health assistance under the State child health plan under title XXI;

"(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are screened for eligibility for enrollment in qualified

health plans offered through such an Exchange and, if applicable, premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and that such individuals receive information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable [*290] Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

"(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the 'State Medicaid agency'), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the 'State CHIP agency') and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or premium assistance, and enrollment in the State plan under this title, title XXI, or a qualified health plan, as appropriate;

"(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

"(F) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

"(2) Agreements with state health insurance exchanges.-- The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1412 of the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

"(3) Streamlined enrollment system.-- The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

[*291] "(4) Enrollment website requirements.-- The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, an Internet website that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health plan under section 36B of the

Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

"(5) Continued need for assessment for home and community-based services.-- Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).".

Sec. 2202.

PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) In General.-- Section 1902(a)(47) of the Social Security Act (*42 U.S.C. 1396a(a)(47)*) is amended--

(1) by striking "at the option of the State, provide" and inserting "provide--

"(A) at the option of the State,";

(2) by inserting "and" after the semicolon; and

(3) by adding at the end the following:

"(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;".

(b) Conforming Amendment.-- Section 1903(u)(1)(D)(v) of such Act (*42 U.S.C. 1396b(u)(1)(D)(v)*) is amended--

(1) by striking "or for" and inserting "for"; and

(2) by inserting before the period at the end the following: ", or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination [***292**] of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose".

(c) [<<Notes>>](#)

Effective Date.--The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D--Improvements to Medicaid Services

Sec. 2301.

COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) In General.-- Section 1905 of the Social Security Act (*42 U.S.C. 1396d*), is amended--

(1) in subsection (a)--

- (A) in paragraph (27), by striking "and" at the end;
- (B) by redesignating paragraph (28) as paragraph (29); and
- (C) by inserting after paragraph (27) the following new paragraph:

"(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and"; and

(2) in subsection (l), by adding at the end the following new paragraph:

"(3)

(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

(B) The term 'freestanding birth center' means a health facility--

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman's residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term 'birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant."

(b) **Conforming Amendment.--** Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the [*293] matter preceding clause (i) by striking "and (21)" and inserting ", (21), and (28)".

(c) [<<Notes>>](#)

Effective Date.--

(1) **In general.--** Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) **Exception if state legislation required.--** In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet

this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Sec. 2302.

CONCURRENT CARE FOR CHILDREN.

(a) In General.-- Section 1905(o)(1) of the Social Security Act ([42 U.S.C. 1396d](#)(o)(1)) is amended--

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraph:

"(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.".

(b) Application to CHIP.-- Section 2110(a)(23) of the Social Security Act ([42 U.S.C. 1397j](#)(a)(23)) is amended by inserting "(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made" after "hospice care".

Sec. 2303.

STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) Coverage as Optional Categorically Needy Group.--

(1) In general.-- Section 1902(a)(10)(A)(ii) of the Social Security Act ([42 U.S.C. 1396a](#)(a)(10)(A)(ii)), as amended by section 2001(e), is amended--

(A) in subclause (XIX), by striking "or" at the end;

(B) in subclause (XX), by adding "or" at the end; and

(C) by adding at the end the following new subclause:

"(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);".

(2) Group described.-- Section 1902 of such Act ([42 U.S.C. 1396a](#)), as amended by section 2001(d), is amended by adding at the end the following new subsection:

[*294] "(ii) (1) Individuals described in this subsection are individuals--

"(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

"(B) who are not pregnant.

"(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

"(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient."

(3) Limitation on benefits.-- Section 1902(a)(10) of the Social Security Act (*42 U.S.C. 1396a(a)(10)*), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)--

(A) by striking "and (XV)" and inserting "(XV)"; and

(B) by inserting ", and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting" before the semicolon.

(4) Conforming amendments.--

(A) Section 1905(a) of the Social Security Act (*42 U.S.C. 1396d(a)*), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)--

(i) in clause (xiv), by striking "or" at the end;

(ii) in clause (xv), by adding "or" at the end; and

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

"(xvi) individuals described in section 1902(ii)."

(B) Section 1903(f)(4) of such Act (*42 U.S.C. 1396b(f)(4)*), as amended by section 2001(e)(2)(B), is amended by inserting "1902(a)(10)(A)(ii)(XXI)," after "1902(a)(10)(A)(ii)(XX),".

(b) Presumptive Eligibility.--

(1) In general.-- Title XIX of the Social Security Act (*42 U.S.C. 1396* et seq.) is amended by inserting after section 1920B the following:

" Presumptive Eligibility for Family Planning Services

"Sec. 1920C.

[<<Notes>>](#)

(a) State Option.--State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided [***295**] in conjunction with a family planning service in a family planning setting.

"(b) Definitions.-- For purposes of this section:

"(1) Presumptive eligibility period.-- The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that--

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

"(B) ends with (and includes) the earlier of--

"(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

"(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(2) Qualified entity.--

"(A) In general.-- Subject to subparagraph (B), the term 'qualified entity' means any entity that--

"(i) is eligible for payments under a State plan approved under this title; and

"(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

"(B) Rule of construction.-- Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

"(c) Administration.--

"(1) In general.-- The State agency shall provide qualified entities with--

"(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

"(B) information on how to assist such individuals in completing and filing such forms.

"(2) Notification requirements.-- A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall--

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) Application for medical assistance.-- In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

[*296] "(d) Payment.--Notwithstanding any other provision of law, medical assistance that--

"(1) is furnished to an individual described in subsection (a)--

"(A) during a presumptive eligibility period; and

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) Conforming amendments.--

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 2202(a), is amended--

(i) in subparagraph (A), by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section"; and

(ii) in subparagraph (B), by striking "or 1920B" and inserting "1920B, or 1920C".

(B) Section 1903(u)(1)(D)(v) of such Act ([42 U.S.C. 1396b](#)(u)(1)(D)(v)), as amended by section 2202(b), is amended by inserting "or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section," after "1920B during a presumptive eligibility period under such section,".

(c) **Clarification of Coverage of Family Planning Services and Supplies.--** Section 1937(b) of the Social Security Act ([42 U.S.C. 1396u-7](#)(b)), as amended by section 2001(c), is amended by adding at the end the following:

"(7) **Coverage of family planning services and supplies.--** Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section."

(d) [<<Notes>>](#)

Effective Date.--The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

Sec. 2304.

CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act ([42 U.S.C. 1396d](#)(a)) is amended by inserting "or the care and services themselves, or both" before "(if provided in or after".

[*297] Subtitle E--New Options for States to Provide Long-Term Services and Supports

Sec. 2401.

COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act ([42 U.S.C. 1396n](#)) is amended by adding at the end the following:

"(k) State Plan Option To Provide Home and Community-based Attendant Services and Supports.--

"(1) In general.-- Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

"(A) Availability.-- The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily

living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing--

"(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

"(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

"(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

"(iv) the furnishing of which--

"(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

"(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

"(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

"(B) Included services and supports.-- In addition to assistance in accomplishing activities of daily living, [*298] instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include--

"(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

"(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

"(iii) voluntary training on how to select, manage, and dismiss attendants.

"(C) Excluded services and supports.-- Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include--

"(i) room and board costs for the individual;

"(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

"(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

"(iv) medical supplies and equipment; or

"(v) home modifications.

"(D) Permissible services and supports.-- The home and community-based attendant services and supports may include--

"(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

"(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

"(2) Increased federal financial participation.-- For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1905(b)) shall be increased by 6 percentage points.

"(3) State requirements.-- In order for a State plan amendment to be approved under this subsection, the State shall--

"(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their [*299] representatives and consults and collaborates with such individuals;

"(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

"(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

"(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community- based attendant services and supports that--

"(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

"(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

"(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

"(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

"(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

"(4) Compliance with certain laws.-- A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant

services and supports under a State plan **[*300]** amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding--

"(A) withholding and payment of Federal and State income and payroll taxes;

"(B) the provision of unemployment and workers compensation insurance;

"(C) maintenance of general liability insurance; and

"(D) occupational health and safety.

"(5) Evaluation, data collection, and report to congress.--

"(A) Evaluation.-- The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

"(B) Data collection.-- The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

"(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

"(ii) The number of individuals that received such services and supports during the preceding fiscal year.

"(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

"(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

"(C) Reports.-- Not later than--

"(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

"(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

"(6) Definitions.-- In this subsection:

"(A) Activities of daily living.-- The term 'activities of daily living' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

[*301] "(B) Consumer controlled.--The term 'consumer controlled' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

"(C) Delivery models.--

"(i) Agency-provider model.-- The term 'agency-provider model' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

"(ii) Other models.-- The term 'other models' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

"(D) Health-related tasks.-- The term 'health-related tasks' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

"(E) Individual's representative.-- The term 'individual's representative' means a parent, family member, guardian, advocate, or other authorized representative of an individual

"(F) Instrumental activities of daily living.-- The term 'instrumental activities of daily living' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community."

Sec. 2402.

REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) <<Notes>>

Oversight and Assessment of the Administration of Home and Community-based Services.--The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to--

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other than the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

[*302] (3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to--

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure--

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.

(b) Additional State Options.-- Section 1915(i) of the Social Security Act ([42 U.S.C. 1396n](#)(i)) is amended by adding at the end the following new paragraphs:

"(6) State option to provide home and community-based services to individuals eligible for services under a waiver.--

"(A) In general.-- A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

"(B) Application of same requirements for individuals satisfying needs-based criteria.-- Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

"(C) Authority to offer different type, amount, duration, or scope of home and community-based services.-- A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

[*303] "(7) State option to offer home and community-based services to specific, targeted populations.--

"(A) In general.-- A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

"(B) 5-year term.--

"(i) In general.-- An election by a State under this paragraph shall be for a period of 5 years.

"(ii) Phase-in of services and eligibility permitted during initial 5-year period.-- A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

"(C) Renewal.-- An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has--

"(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

"(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes."

(c) Removal of Limitation on Scope of Services.-- Paragraph (1) of section 1915(i) of the Social Security Act ([42 U.S.C. 1396n\(i\)](#)), as amended by subsection (a), is amended by striking "or such other services requested by the State as the Secretary may approve".

(d) Optional Eligibility Category To Provide Full Medicaid Benefits to Individuals Receiving Home and Community-based Services Under a State Plan Amendment.--

(1) In general.-- Section 1902(a)(10)(A)(ii) of the Social Security Act ([42 U.S.C. 1396a\(a\)\(10\)\(A\)\(ii\)](#)), as amended by section 2304(a)(1), is amended--

- (A) in subclause (XX), by striking "or" at the end;
- (B) in subclause (XXI), by adding "or" at the end; and
- (C) by inserting after subclause (XXI), the following new subclause:

"(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;"

(2) Conforming amendments.--

(A) Section 1903(f)(4) of the Social Security Act ([42 U.S.C. 1396b\(f\)\(4\)](#)), as amended by section 2304(a)(4)(B), is amended in the matter preceding subparagraph (A), **[*304]** by inserting "1902(a)(10)(A)(ii)(XXII)," after "1902(a)(10)(A)(ii)(XXI),".

(B) Section 1905(a) of the Social Security Act ([42 U.S.C. 1396d\(a\)](#)), as so amended, is amended in the matter preceding paragraph (1)--

- (i) in clause (xv), by striking "or" at the end;
- (ii) in clause (xvi), by adding "or" at the end; and
- (iii) by inserting after clause (xvi) the following new clause:

"(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,"

(e) Elimination of Option To Limit Number of Eligible Individuals or Length of Period for Grandfathered Individuals if Eligibility Criteria Is Modified.-- Paragraph (1) of section 1915(i) of such Act ([42 U.S.C. 1396n\(i\)](#)) is amended--

- (1) by striking subparagraph (C) and inserting the following:

"(C) Projection of number of individuals to be provided home and community-based services.-- The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services."; and

- (2) in subclause (II) of subparagraph (D)(ii), by striking "to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services" and inserting "to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria".

(f) Elimination of Option To Waive Statewideness; Addition of Option To Waive Comparability.-- Paragraph (3) of section 1915(i) of such Act ([42 U.S.C. 1396n\(3\)](#)) is amended by striking "1902(a)(1) (relating to statewideness)" and inserting "1902(a)(10)(B) (relating to comparability)".

(g) <<Notes>>

Effective Date.--The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) Extension of Demonstration.--

(1) In general.-- Section 6071(h) of the Deficit Reduction Act of 2005 ([42 U.S.C. 1396a](#) note) is amended--

(A) in paragraph (1)(E), by striking "fiscal year 2011" and inserting "each of fiscal years 2011 through 2016"; and

(B) in paragraph (2), by striking "2011" and inserting "2016".

[*305] (2) Evaluation.-- Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking "2011" and inserting "2016".

(b) Reduction of Institutional Residency Period.--

(1) In general.-- Section 6071(b)(2) of the Deficit Reduction Act of 2005 ([42 U.S.C. 1396a](#) note) is amended--

(A) in subparagraph (A)(i), by striking ", for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State" and inserting "for a period of not less than 90 consecutive days"; and

(B) by adding at the end the following:

"Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i)."

(2) <<Notes>>

Effective date.-- The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

Sec. 2404.<<Notes>>

PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act ([42 U.S.C. 1396r-5](#)(h)(1)(A)) shall be applied as though "is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)" were substituted in such section for "(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)".

Sec. 2405.

FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, \$ 10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 ([42 U.S.C. 3012](#)).

Sec. 2406.

SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) Findings.-- The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper Commission", released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.*, [527 U.S. 581 \(1999\)](#), individuals [*306] with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) Sense of the Senate.-- It is the sense of the Senate that--

(1) during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

Subtitle F--Medicaid Prescription Drug Coverage

Sec. 2501.

PRESCRIPTION DRUG REBATES.

(a) Increase in Minimum Rebate Percentage for Single Source Drugs and Innovator Multiple Source Drugs.--

(1) **In general.--** Section 1927(c)(1)(B) of the Social Security Act ([42 U.S.C. 1396r-8\(c\)\(1\)\(B\)](#)) is amended--

(A) in clause (i)--

(i) in subclause (IV), by striking "and" at the end;

(ii) in subclause (V)--

(I) by inserting "and before January 1, 2010" after "December 31, 1995,"; and

(II) by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following new subclause:

"(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent."; and

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

"(iii) Minimum rebate percentage for certain drugs.--

"(I) In general.-- In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

[*307] "(II) Drug described.--For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

"(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

"(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications."

(2) Recapture of total savings due to increase.-- Section 1927(b)(1) of such Act ([42 U.S.C. 1396r-8\(b\)\(1\)](#)) is amended by adding at the end the following new subparagraph:

"(C) Special rule for increased minimum rebate percentage.--

"(i) In general.-- In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of--

"(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

"(II) the amounts received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2501 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2501 of such Act. The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

"(ii) Manner of payment reduction.-- The amount of the payment reduction under clause (i) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State's regular quarterly draw for all Medicaid spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under section 1116(d)."

(b) Increase in Rebate for Other Drugs.-- Section 1927(c)(3)(B) of such Act ([42 U.S.C. 1396r-8\(c\)\(3\)\(B\)](#)) is amended--

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii)--

(A) by inserting "and before January 1, 2010," after "December 31, 1993,"; and

[*308] (B) by striking the period and inserting "; and"; and

(3) by adding at the end the following new clause:

"(iii) after December 31, 2009, is 13 percent."

(c) Extension of Prescription Drug Discounts to Enrollees of Medicaid Managed Care Organizations.--

(1) In general.-- Section 1903(m)(2)(A) of such Act ([42 U.S.C. 1396b](#)(m)(2)(A)) is amended--

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

(B) in clause (xii), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection."

(2) Conforming amendments.-- Section 1927 ([42 U.S.C. 1396r-8](#)) is amended--

(A) in subsection (b)--

(i) in paragraph (1)(A), in the first sentence, by inserting ", including such drugs dispensed to individuals enrolled with a Medicaid managed care organization if the organization is responsible for coverage of such drugs" before the period; and

(ii) in paragraph (2)(A), by inserting "including such information reported by each Medicaid managed care organization," after "for which payment was made under the plan during the period,"; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

"(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are--

"(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

"(B) subject to discounts under section 340B of the Public Health Service Act."

[*309] (d) Additional Rebate for New Formulations of Existing Drugs.--

(1) In general.-- Section 1927(c)(2) of the Social Security Act ([42 U.S.C. 1396r-8](#)(c)(2)) is amended by adding at the end the following new subparagraph:

"(C) Treatment of new formulations.--

"(i) In general.-- Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of--

"(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

"(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of the original single source drug or innovator multiple source drug; and

"(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

"(ii) **No application to new formulations of orphan drugs.**-- Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act ([21 U.S.C. 360bb](#)) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug."

(2) [Notes](#)

Effective date.-- The amendment made by paragraph (1) shall apply to drugs that are paid for by a State after December 31, 2009.

(e) **Maximum Rebate Amount.**-- Section 1927(c)(2) of such Act ([42 U.S.C. 1396r-8\(c\)\(2\)](#)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

"(D) **Maximum rebate amount.**-- In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug."

(f) **Conforming Amendments.**--

(1) **In general.**-- Section 340B of the Public Health Service Act ([42 U.S.C. 256b](#)) is amended--

(A) in subsection (a)(2)(B)(i), by striking "1927(c)(4)" and inserting "1927(c)(3)"; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

[*310] (2) [Notes](#)

Effective date.-- The amendments made by this subsection take effect on January 1, 2010.

Sec. 2502.

ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) **In General.**-- Section 1927(d) of the Social Security Act (42 U.S.C. 1397r-8(d)) is amended--

(1) in paragraph (2)--

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

"(7) **Non-excludable drugs.**-- The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

"(A) Agents when used to promote smoking cessation, including agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

"(B) Barbiturates.

"(C) Benzodiazepines."

(b) <<Notes>>

Effective Date.--The amendments made by this section shall apply to services furnished on or after January 1, 2014.

Sec. 2503.

PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) Pharmacy Reimbursement Limits.--

(1) **In general.**-- Section 1927(e) of the Social Security Act ([42 U.S.C. 1396r-8\(e\)](#)) is amended--

(A) in paragraph (4), by striking "(or, effective January 1, 2007, two or more)"; and

(B) by striking paragraph (5) and inserting the following:

"(5) Use of amp in upper payment limits.-- The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A."

(2) **Definition of amp.**-- Section 1927(k)(1) of such Act ([42 U.S.C. 1396r-8\(k\)\(1\)](#)) is amended--

(A) in subparagraph (A), by striking "by" and all that follows through the period and inserting "by--

"(i) wholesalers for drugs distributed to retail community pharmacies; and

"(ii) retail community pharmacies that purchase drugs directly from the manufacturer."; and

(B) by striking subparagraph (B) and inserting the following:

[*311] "(B) Exclusion of customary prompt pay discounts and other payments.--

"(i) In general.-- The average manufacturer price for a covered outpatient drug shall exclude--

"(I) customary prompt pay discounts extended to wholesalers;

"(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

"(III) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

"(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

"(ii) Inclusion of other discounts and payments.-- Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug."; and

(C) in subparagraph (C), by striking "the retail pharmacy class of trade" and inserting "retail community pharmacies".

(3) Definition of multiple source drug.-- Section 1927(k)(7) of such Act ([42 U.S.C. 1396r-8\(k\)\(7\)](#)) is amended--

(A) in subparagraph (A)(i)(III), by striking "the State" and inserting "the United States"; and

(B) in subparagraph (C)--

(i) in clause (i), by inserting "and" after the semicolon;

(ii) in clause (ii), by striking "; and" and inserting a period; and

(iii) by striking clause (iii).

(4) Definitions of retail community pharmacy; wholesaler.-- Section 1927(k) of such Act ([42 U.S.C. 1396r-8\(k\)](#)) is amended by adding at the end the following new paragraphs:

"(10) Retail community pharmacy.-- The term 'retail community pharmacy' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail [*312] prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

"(11) Wholesaler.-- The term 'wholesaler' means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer's and distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions."

(b) Disclosure of Price Information to the Public.-- Section 1927(b)(3) of such Act ([42 U.S.C. 1396r-8\(b\)\(3\)](#)) is amended--

(1) in subparagraph (A)--

(A) in the first sentence, by inserting after clause (iii) the following:

"(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer's total number of units that are used to calculate the monthly average manufacturer price for each covered outpatient drug;"; and

(B) in the second sentence, by inserting "(relating to the weighted average of the most recently reported monthly average manufacturer prices)" after "(D)(v)"; and

(2) in subparagraph (D)(v), by striking "average manufacturer prices" and inserting "the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)".

(c) Clarification of Application of Survey of Retail Prices.-- Section 1927(f)(1) of such Act ([42 U.S.C. 1396r-8\(b\)\(1\)](#)) is amended--

(1) in subparagraph (A)(i), by inserting "with respect to a retail community pharmacy," before "the determination"; and

(2) in subparagraph (C)(ii), by striking "retail pharmacies" and inserting "retail community pharmacies".

(d) <<Notes>>

Effective Date.--The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Subtitle G--

Medicaid Disproportionate Share Hospital (DSH) Payments

Sec. 2551.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) **In General.**-- Section 1923(f) of the Social Security Act ([42 U.S.C. 1396r-4\(f\)](#)) is amended--

- (1) in paragraph (1), by striking "and (3)" and inserting ", (3), and (7)";
- (2) in paragraph (3)(A), by striking "paragraph (6)" and inserting "paragraphs (6) and (7)";
- [*313] (3) by redesignating paragraph (7) as paragraph (8); and
- (4) by inserting after paragraph (6) the following new paragraph:

"(7) Reduction of state DSH allotments once reduction in uninsured threshold reached.--

"(A) In general.-- Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to--

"(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(i); and

"(ii) in the case of any subsequent fiscal year with respect to the State, the DSH allotment determined under this paragraph for the State for the preceding fiscal year, reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B)(ii).

"(B) Applicable percentage.-- For purposes of subparagraph (A), the applicable percentage for a State for a fiscal year is the following:

"(i) Uninsured reduction threshold fiscal year.-- In the case of the first fiscal year described in subparagraph (C) with respect to the State--

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

"(II) if the State is any other State, the applicable percentage is 50 percent.

"(ii) Subsequent fiscal years in which the percentage of uninsured decreases.-- In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year--

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent; and

"(II) if the State is any other State, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 50 percent.

"(C) Fiscal year described.-- For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that [*314] occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is at least 45 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

"(D) Exclusion of portions diverted for coverage expansions.-- For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

"(E) Minimum allotment.-- In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

"(F) Uncovered individuals.-- In this paragraph, the term 'uncovered individuals' means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).".

(b) <<Notes>>

Effective Date.--The amendments made by subsection (a) take effect on October 1, 2011.

Subtitle H--

Improved Coordination for Dual Eligible Beneficiaries

Sec. 2601.

5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) In General.-- Section 1915(h) of the Social Security Act ([42 U.S.C. 1396n](#)(h)) is amended--

- (1) by inserting "(1)" after "(h)";
- (2) by inserting ", or a waiver described in paragraph (2)" after "(e)"; and
- (3) by adding at the end the following new paragraph:

"(2)

(A) Notwithstanding subsections (c)(3) and (d) (3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the

request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

[*315] "(B) In this paragraph, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan."

(b) Conforming Amendments.--

(1) Section 1915 of such Act ([42 U.S.C. 1396n](#)) is amended--

(A) in subsection (b), by adding at the end the following new sentence: "Subsection (h)(2) shall apply to a waiver under this subsection.";

(B) in subsection (c)(3), in the second sentence, by inserting "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection";

(C) in subsection (d)(3), in the second sentence, by inserting "(other than a waiver described in subsection (h)(2))" after "A waiver under this subsection".

(2) Section 1115 of such Act ([42 U.S.C. 1315](#)) is amended--

(A) in subsection (e)(2), by inserting "(5 years, in the case of a waiver described in section 1915(h)(2))" after "3 years"; and

(B) in subsection (f)(6), by inserting "(5 years, in the case of a waiver described in section 1915(h)(2))" after "3 years".

Sec. 2602.

[<<Notes>>](#)

PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES.

(a) Establishment of Federal Coordinated Health Care Office.--

(1) In general.-- Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a Federal Coordinated Health Care Office.

(2) Establishment and reporting to CMS administrator.-- The Federal Coordinated Health Care Office--

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) Purpose.-- The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to--

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) Goals.-- The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

[*316] (2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) Specific Responsibilities.-- The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act ([42 U.S.C. 1395w-28\(b\)\(6\)](#))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act ([42 U.S.C. 1395b-6](#)) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act ([42 U.S.C. 1396](#)) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act ([42 U.S.C. 1396u-5\(c\)\(6\)](#))), as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(e) Report.-- The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) Dual Eligible Defined.-- In this section, the term "dual eligible individual" means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII **[*317]** of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

Subtitle I--

Improving the Quality of Medicaid for Patients and Providers

Sec. 2701.**ADULT HEALTH QUALITY MEASURES.**

Title XI of the Social Security Act ([42 U.S.C. 1301](#) et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

"Sec. 1139B.

[<<Notes>>](#)

ADULT HEALTH QUALITY MEASURES.

"(a) Development of Core Set of Health Care Quality Measures for Adults Eligible for Benefits Under Medicaid.-- The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

"(b) Deadlines.--

"(1) Recommended measures.-- Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

"(2) Dissemination.-- Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

"(3) Standardized reporting.-- Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

"(4) Reports to congress.-- Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

"(5) Establishment of Medicaid quality measurement program.--

"(A) In general.-- Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging **[*318]** and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)

"(B) Revising, strengthening, and improving initial core measures.-- Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

"(c) Construction.-- Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

"(d) Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid.--

"(1) Annual state reports.-- Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the--

"(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

"(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

"(2) Publication.-- Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

"(e) Appropriation.-- Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, \$ 60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended."

Sec. 2702.

[<<Notes>>](#)

PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) In General.-- The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines appropriate for application to the Medicaid program in regulations. Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations. The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.

(b) Health Care-Acquired Condition.-- In this section. the term "health care-acquired condition" means a medical condition for which an individual was diagnosed that could be identified **[*319]** by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act ([42 U.S.C. 1395ww\(d\)\(4\)\(D\)\(iv\)](#)).

(c) Medicare Provisions.-- In carrying out this section, the Secretary shall apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act ([42 U.S.C. 1395ww\(d\)\(4\)\(D\)](#)) relating to the prohibition of payments based on the presence of a secondary diagnosis code specified by the Secretary in such regulations, as appropriate for the Medicaid program. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

Sec. 2703.

STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) State Plan Amendment.-- Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

"Sec. 1945.

[<<Notes>>](#)

State Option To Provide Coordinated Care Through a Health Home for Individuals With Chronic Conditions.--

"(a) In General.-- Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

"(b) Health Home Qualification Standards.-- The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

"(c) Payments.--

"(1) In general.-- A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

"(2) Methodology.--

"(A) In general.-- The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment--

[*320] "(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

"(ii) shall be established consistent with section 1902(a)(30)(A).

"(B) Alternate models of payment.-- The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

"(3) Planning grants.--

"(A) In general.-- Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

"(B) State contribution.-- A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111-5) for each fiscal year for which the grant is awarded.

"(C) Limitation.-- The total amount of payments made to States under this paragraph shall not exceed \$ 25,000,000.

"(d) Hospital Referrals.-- A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

"(e) Coordination.-- A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

"(f) Monitoring.-- A State shall include in the State plan amendment--

"(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

"(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

"(g) Report on Quality Measures.-- As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining [*321] the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

"(h) Definitions.-- In this section:

"(1) Eligible individual with chronic conditions.--

"(A) In general.-- Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who--

"(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

"(ii) has at least--

"(I) 2 chronic conditions;

"(II) 1 chronic condition and is at risk of having a second chronic condition;

or

"(III) 1 serious and persistent mental health condition.

"(B) Rule of construction.-- Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

"(2) Chronic condition.-- The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

"(A) A mental health condition.

"(B) Substance use disorder.

"(C) Asthma.

"(D) Diabetes.

"(E) Heart disease.

"(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

"(3) Health home.-- The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

"(4) Health home services.--

"(A) In general.-- The term 'health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

"(B) Services described.-- The services described in this subparagraph are--

"(i) comprehensive care management;

"(ii) care coordination and health promotion;

"(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

"(iv) patient and family support (including authorized representatives);

"(v) referral to community and social support services, if relevant; and

"(vi) use of health information technology to link services, as feasible and appropriate.

"(5) Designated provider.-- The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health [*322] center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic--

"(A) has the systems and infrastructure in place to provide health home services; and

"(B) satisfies the qualification standards established by the Secretary under subsection (b).

"(6) Team of health care professionals.-- The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may--

"(A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

"(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

"(7) Health team.-- The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act."

(b) Evaluation.--

(1) Independent evaluation.--

(A) In general.-- The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) Evaluation report.-- Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) <<Notes>>

Survey and interim report.--

(A) In general.-- Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to--

- (i) hospital admission rates;
- (ii) chronic disease management;
- (iii) coordination of care for individuals with chronic conditions;
- (iv) assessment of program implementation;
- (v) processes and lessons learned (as described in subparagraph (B));
- (vi) assessment of quality improvements and clinical outcomes under such option; and
- [*323]** (vii) estimates of cost savings.

(B) Implementation reporting.-- A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

Sec. 2704.**<<Notes>>****DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.****(a) Authority To Conduct Project.--**

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary--

- (A)** with respect to an episode of care that includes a hospitalization; and
- (B)** for concurrent physicians services provided during a hospitalization.

(2) Duration.-- The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) Requirements.-- The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses,

or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than **[*324]** if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(c) Waiver of Provisions.-- Notwithstanding section 1115(a) of the Social Security Act ([42 U.S.C. 1315\(a\)](#)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) Evaluation and Report.--

(1) Data.-- Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) Report.-- Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

Sec. 2705.

[<<Notes>>](#)

MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) In General.-- The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act, as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the

payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) Duration and Scope.-- The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) Eligible Safety Net Hospital System or Network.-- For purposes of this section, the term "eligible safety net hospital system or network" means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) Evaluation.--

(1) Testing.-- The Innovation Center shall test and evaluate the demonstration project conducted under this section [*325] to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) Budget neutrality.-- During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as so added) shall not be applicable.

(3) Modification.-- During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) Report.-- Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(f) Authorization of Appropriations.-- There are authorized to be appropriated such sums as are necessary to carry out this section.

Sec. 2706.

[<<Notes>>](#)

PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) Authority To Conduct Demonstration.--

(1) In general.-- The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) Duration.-- The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) Application.-- A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) Requirements.--

(1) Performance guidelines.-- The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) Savings requirement.-- A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) Minimum participation period.-- A provider desiring to be recognized as an accountable care organization under [*326] the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) Incentive Payment.-- An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) Authorization of Appropriations.-- There are authorized to be appropriated such sums as are necessary to carry out this section.

Sec. 2707.

<<Notes>>

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) Authority To Conduct Demonstration Project.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act ([42 U.S.C. 1395dd](#)) for the provision of medical assistance available under such plan to individuals who--

- (1)** have attained age 21, but have not attained age 65;
- (2)** are eligible for medical assistance under such plan; and
- (3)** require such medical assistance to stabilize an emergency medical condition.

(b) Stabilization Review.-- A State shall specify in its application described in subsection (c)(1) establish a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) Eligible State Defined.--

(1) In general.-- An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

(2) Application.-- A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

(3) Selection.-- A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of [*327] paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

(d) Length of Demonstration Project.-- The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) Limitations on Federal Funding.--

(1) Appropriation.--

(A) In general.-- Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, \$ 75,000,000 for fiscal year 2011.

(B) Budget authority.-- Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 5-year availability.-- Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(3) Limitation on payments.-- In no case may--

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed \$ 75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2015.

(4) Funds allocated to states.-- Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

(5) Payments to states.-- The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

(f) Evaluation and Report to Congress.--

(1) Evaluation.-- The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

(B) An assessment of discharge planning by participating hospitals.

(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to [*328] those admitted to these same facilities through other means.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(2) Report.-- Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

(g) Waiver Authority.--

(1) In general.-- The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act ([42 U.S.C. 1396d\(a\)](#)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) Limited other waiver authority.-- The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

(h) Definitions.-- In this section:

(1) Emergency medical condition.-- The term "emergency medical condition" means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) Federal medical assistance percentage.-- The term "Federal medical assistance percentage" has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act ([42 U.S.C. 1396d\(b\)](#)).

(3) Institution for mental diseases.-- The term "institution for mental diseases" has the meaning given to that term in section 1905(i) of the Social Security Act ([42 U.S.C. 1396d\(i\)](#)).

(4) Medical assistance.-- The term "medical assistance" has the meaning given that term in section 1905(a) of the Social Security Act ([42 U.S.C. 1396d\(a\)](#)).

(5) Stabilized.-- The term "stabilized" means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) State.-- The term "State" has the meaning given that term for purposes of title XIX of the Social Security Act ([42 U.S.C. 1396](#) et seq.).

Subtitle J--

Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 2801.

MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) In General.-- Section 1900 of the Social Security Act ([42 U.S.C. 1396](#)) is amended--

(1) in subsection (b)--

[*329] (A) in paragraph (1)--

(i) in the paragraph heading, by inserting "for all states" before "and annual"; and

(ii) in subparagraph (A), by striking "children's";

(iii) in subparagraph (B), by inserting ", the Secretary, and States" after "Congress";

(iv) in subparagraph (C), by striking "March 1" and inserting "March 15"; and

(v) in subparagraph (D), by striking "June 1" and inserting "June 15";

(B) in paragraph (2)--

(i) in subparagraph (A)--

(I) in clause (i)--

(aa) by inserting "the efficient provision of" after "expenditures for"; and

(bb) by striking "hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees" and inserting "payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services,

Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services"; and

(II) in clause (iii), by inserting "(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations)" after "beneficiaries";

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

"(B) Eligibility policies.-- Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

"(C) Enrollment and retention processes.-- Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

"(D) Coverage policies.-- Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

"(E) Quality of care.-- Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and [*330] interact with similar goals established by other purchasers of health care services.";

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

"(G) Interactions with Medicare and Medicaid.-- Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals." and

(v) in subparagraph (H) (as so redesignated), by inserting "and preventive, acute, and long-term services and supports" after "barriers";

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

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

"(3) Recommendations and reports of state-specific data.-- MACPAC shall-

"(A) review national and State-specific Medicaid and CHIP data; and

"(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.";

(E) in paragraph (4), as redesignated by subparagraph (C), by striking "or any other problems" and all that follows through the period and inserting ", as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.";

(F) in paragraph (5), as so redesignated,--

(i) in the paragraph heading, by inserting "and regulations" after "reports"; and

(ii) by striking "If" and inserting the following:

"(A) Certain secretarial reports.-- If"; and

(iii) in the second sentence, by inserting "and the Secretary" after "appropriate committees of Congress"; and

(iv) by adding at the end the following:

"(B) Regulations.-- MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.";

(G) in paragraph (10), as so redesignated, by inserting ", and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations" before the period; and

(H) by adding at the end the following:

"(11) Consultation and coordination with MedPAC.--

"(A) In general.-- MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in [*331] paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

"(B) Information sharing.-- MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

"(12) Consultation with states.-- MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

"(13) Coordinate and consult with the federal coordinated health care office.-- MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

"(14) Programmatic oversight vested in the secretary.-- MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.";

(2) in subsection (c)(2)--

(A) by striking subparagraphs (A) and (B) and inserting the following:

"(A) In general.-- The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

"(B) Inclusion.-- The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP."

[*332] (3) in subsection (d)(2), by inserting "and State" after "Federal";

(4) in subsection (e)(1), in the first sentence, by inserting "and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP," after "United States"; and

(5) in subsection (f)--

(A) in the subsection heading, by striking " Authorization of Appropriations" and inserting " Funding";

(B) in paragraph (1), by inserting "(other than for fiscal year 2010)" before "in the same manner"; and

(C) by adding at the end the following:

"(3) Funding for fiscal year 2010.--

"(A) In general.-- Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, \$ 9,000,000.

"(B) Transfer of funds.-- Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, \$ 2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

"(4) Availability.-- Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended."

(b) Conforming MedPAC Amendments.-- Section 1805(b) of the Social Security Act ([42 U.S.C. 1395b-6\(b\)](#)), is amended--

(1) in paragraph (1)(C), by striking "March 1 of each year (beginning with 1998)" and inserting "March 15";

(2) in paragraph (1)(D), by inserting ", and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible" before the period; and

(3) by adding at the end the following:

"(9) Review and annual report on Medicaid and commercial trends.-- The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate national basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 (in this section referred to as 'MACPAC').

"(10) Coordinate and consult with the federal coordinated health care office.-- The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

"(11) Interaction of Medicaid and Medicare.-- The Commission shall consult with MACPAC in carrying out its duties under this section, as appropriate. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, **[*333]** shall rest with the Commission. Responsibility for analysis of and recommendations to change Medicaid policy regarding Medicaid beneficiaries, including Medicaid beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC."

Subtitle K--

Protections for American Indians and Alaska Natives

Sec. 2901.

SPECIAL RULES RELATING TO INDIANS.

(a) <<Notes>>

No Cost-sharing for Indians With Income at or Below 300 Percent of Poverty Enrolled in Coverage Through a State Exchange.--For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) <<Notes>>

Payer of Last Resort.--Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act ([25 U.S.C. 1603](#))) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) Facilitating Enrollment of Indians Under the Express Lane Option.-- Section 1902(e)(13)(F)(ii) of the Social Security Act ([42 U.S.C. 1396a\(e\)\(13\)\(F\)\(ii\)](#)) is amended--

(1) in the clause heading, by inserting "and Indian tribes and tribal organizations" after "agencies"; and

(2) by adding at the end the following:

"(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c))."

(d) Technical Corrections.-- Section 1139(c) of the Social Security Act ([42 U.S.C. 1320b-9\(c\)](#)) is amended by striking "In this section" and inserting "For purposes of this section, title XIX, and title XXI".

Sec. 2902.

ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) Reimbursement for All Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics.-- Section 1880(e)(1)(A) of the Social Security Act ([42 U.S.C. 1395gg](#)(e)(1)(A)) is amended by striking "during the 5-year period beginning on" and inserting "on or after".

(b) <<Notes>>

Effective Date.--The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

[*334] Subtitle L--Maternal and Child Health Services

Sec. 2951.

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act ([42 U.S.C. 701](#) et seq.) is amended by adding at the end the following new section:

"Sec. 511.

<<Notes>>

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

"(a) Purposes.-- The purposes of this section are--

"(1) to strengthen and improve the programs and activities carried out under this title;

"(2) to improve coordination of services for at risk communities; and

"(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

"(b) Requirement for All States To Assess Statewide Needs and Identify at Risk Communities.--

"(1) In general.-- Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies--

"(A) communities with concentrations of--

"(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

"(ii) poverty;

"(iii) crime;

"(iv) domestic violence;

"(v) high rates of high-school drop-outs;

"(vi) substance abuse;

"(vii) unemployment; or

"(viii) child maltreatment;

"(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including--

"(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

"(ii) the gaps in early childhood home visitation in the State; and

"(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

"(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

"(2) Coordination with other assessments.-- In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by [*335] the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

"(3) Submission to the secretary.-- Each State shall submit to the Secretary, in such form and manner as the Secretary shall require--

"(A) the results of the statewide needs assessment required under paragraph (1); and

"(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

"(c) Grants for Early Childhood Home Visitation Programs.--

"(1) Authority to make grants.-- In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

"(2) Authority to use initial grant funds for planning or implementation.-- An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

"(3) Grant duration.-- The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

"(4) Technical assistance.-- The Secretary shall provide an eligible entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds.

"(d) Requirements.-- The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

"(1) Quantifiable, measurable improvement in benchmark areas.--

"(A) In general.-- The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the [*336] program results in improvements for the eligible families participating in the program in each of the following areas:

"(i) Improved maternal and newborn health.

"(ii) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits.

"(iii) Improvement in school readiness and achievement.

"(iv) Reduction in crime or domestic violence.

"(v) Improvements in family economic self-sufficiency.

"(vi) Improvements in the coordination and referrals for other community resources and supports.

"(B) Demonstration of improvements after 3 years.--

"(i) Report to the secretary.-- Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

"(ii) Corrective action plan.-- If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

"(iii) Technical assistance.--

"(I) In general.-- The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

"(II) Advisory panel.-- The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

"(iv) No improvement or failure to submit report.-- If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

[*337] "(C) Final report.--Not later than December 31, 2015, the eligible entity shall submit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

"(2) Improvements in outcomes for individual families.--

"(A) In general.-- The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

"(B) Participant outcomes.-- The participant outcomes described in this subparagraph are the following:

"(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes

"(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

"(iii) Improvements in parenting skills.

"(iv) Improvements in school readiness and child academic achievement.

"(v) Reductions in crime or domestic violence.

"(vi) Improvements in family economic self-sufficiency.

"(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

"(3) Core components.-- The program includes the following core components:

"(A) Service delivery model or models.--

"(i) In general.-- Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

"(I) The model conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous--

[*338] "(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

"(bb) quasi-experimental research designs.

"(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

"(ii) Majority of grant funds used for evidence-based models.-- An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II).

"(iii) Criteria for evidence of effectiveness of models.-- The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

"(B) Additional requirements.--

"(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

"(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

"(iii) The program maintains high quality supervision to establish home visitor competencies.

"(iv) The program demonstrates strong organizational capacity to implement the activities involved.

"(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

"(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

"(4) Priority for serving high-risk populations.-- The eligible entity gives priority to providing services under the program to the following:

"(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

"(B) Low-income eligible families.

"(C) Eligible families who are pregnant women who have not attained age 21.

[*339] "(D) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.

"(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

"(F) Eligible families that have users of tobacco products in the home.

"(G) Eligible families that are or have children with low student achievement.

"(H) Eligible families with children with developmental delays or disabilities.

"(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

"(e) Application Requirements.-- An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

"(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

"(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

"(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

"(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

"(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

"(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

"(7) Assurances that the entity will establish procedures to ensure that--

"(A) the participation of each eligible family in the program is voluntary; and

"(B) services are provided to an eligible family in accordance with the individual assessment for that family.

"(8) Assurances that the entity will--

"(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

"(B) participate in, and cooperate with, data and information collection necessary for the evaluation required [*340] under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

"(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

"(10) Other information as required by the Secretary.

"(f) **Maintenance of Effort.**-- Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

"(g) **Evaluation.**--

"(1) **Independent, expert advisory panel.**-- The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development--

"(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

"(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

"(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

"(2) **Authority to conduct evaluation.**-- On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include--

"(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

"(B) an assessment of--

"(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

"(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and

"(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

[*341] "(3) Report.-- Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

"(h) Other Provisions.--

"(1) Intra-agency collaboration.-- The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to--

"(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

"(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

"(2) Grants to eligible entities that are not states.--

"(A) Indian tribes, tribal organizations, or urban Indian organizations.-- The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to--

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(B) Nonprofit organizations.-- If, as of the beginning of fiscal year 2012, a State has not applied or been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under

paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable [*342] to eligible entities that are States and shall require the organization to--

"(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(3) Research and other evaluation activities.--

"(A) In general.-- The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

"(B) Requirements.-- The Secretary shall ensure that--

"(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

"(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

"(4) Report and recommendation.-- Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include--

"(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

"(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

"(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

"(i) Application of Other Provisions of Title.--

"(1) In general.-- Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

"(2) Exceptions.-- The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(C) Section 504(d) (relating to a limitation on administrative expenditures).

"(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

[*343] **"(E)** Section 507 (relating to penalties for false statements).

"(F) Section 508 (relating to nondiscrimination).

"(G) Section 509(a) (relating to the administration of the grant program).

"(j) Appropriations.--

"(1) In general.-- Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section--

"(A) \$ 100,000,000 for fiscal year 2010;

"(B) \$ 250,000,000 for fiscal year 2011;

"(C) \$ 350,000,000 for fiscal year 2012;

"(D) \$ 400,000,000 for fiscal year 2013; and

"(E) \$ 400,000,000 for fiscal year 2014.

"(2) Reservations.-- Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve--

"(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

"(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

"(3) Availability.-- Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

"(k) Definitions.-- In this section:

"(1) Eligible entity.--

"(A) **In general.--** The term 'eligible entity' means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

"(B) **Nonprofit organizations.--** Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State or several States.

"(2) Eligible family.-- The term 'eligible family' means--

"(A) a woman who is pregnant, and the father of the child if the father is available; or

"(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

"(3) Indian tribe; tribal organization.-- The terms 'Indian Tribe' and 'Tribal Organization', and 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act."

[*344] Sec. 2952. <<Notes>>

SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) Research on Postpartum Conditions.--

(1) Expansion and intensification of activities.-- The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the "Secretary") is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as "postpartum conditions"), including research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under this paragraph shall include conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic techniques.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may--

(i) include public service announcements through television, radio, and other means; and

(ii) focus on--

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(2) Sense of congress regarding longitudinal study of relative mental health consequences for women of resolving a pregnancy.--

(A) Sense of congress.-- It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) Report.-- Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enactment of this Act, and periodically [*345] thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(b) Grants To Provide Services to Individuals With a Postpartum Condition and Their Families.-- Title V of the Social Security Act ([42 U.S.C. 701](#) et seq.), as amended by section 2951, is amended by adding at the end the following new section:

"Sec. 512.

[<<Notes>>](#)

SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

"(a) In General.-- In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination

of effective and cost-efficient systems for the delivery of essential services to individuals with or at risk for postpartum conditions and their families.

"(b) Certain Activities.-- To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

"(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services.

"(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

"(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

"(4) Providing education about postpartum conditions to promote earlier diagnosis and treatment. Such education may include--

"(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

"(B) in the case of a grantee that is a State, hospital, or birthing facility--

"(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

"(ii) ensuring that training programs regarding such education are carried out at the health facility.

"(c) Integration With Other Programs.-- To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

"(d) Requirements.-- The Secretary shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for [*346] each grant period, a report to the Secretary that describes how grant funds were used during such period.

"(e) Technical Assistance.-- The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

"(f) Application of Other Provisions of Title.--

"(1) In general.-- Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

"(2) Exceptions.-- The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(C) Section 504(d) (relating to a limitation on administrative expenditures).

"(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

"(E) Section 507 (relating to penalties for false statements).

"(F) Section 508 (relating to nondiscrimination).

"(G) Section 509(a) (relating to the administration of the grant program).

"(g) **Definitions.--** In this section:

"(1) The term 'eligible entity'--

"(A) means a public or nonprofit private entity; and

"(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

"(2) The term 'postpartum condition' means postpartum depression or postpartum psychosis."

(c) General Provisions.--

(1) Authorization of appropriations.-- To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose--

(A) \$ 3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) Report by the secretary.--

(A) Study.-- The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) Report.-- Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

[*347] Sec. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act ([42 U.S.C. 701](#) et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

"Sec. 513.

[<<Notes>>](#)

PERSONAL RESPONSIBILITY EDUCATION.

"(a) Allotments to States.--

"(1) Amount.--

"(A) In general.-- For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of--

"(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

"(ii) the State youth population percentage determined under paragraph (2).

"(B) Minimum allotment.--

"(i) In general.-- Each State allotment under this paragraph for a fiscal year shall be at least \$ 250,000.

"(ii) Pro rata adjustments.-- The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

"(C) Application required to access allotments.--

"(i) In general.-- A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

"(ii) Requirements.-- The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following as well as such additional information as the Secretary may require:

"(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

"(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

"(III) A description of the State's plan for using the State allotments provided under this section to achieve such goals, especially among youth [*348] populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

"(2) State youth population percentage.--

"(A) In general.-- For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of--

"(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

"(ii) the number of such individuals in all States.

"(B) Determination of number of youth.-- The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

"(3) Availability of state allotments.-- Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

"(4) Authority to award grants from state allotments to local organizations and entities in nonparticipating states.--

"(A) Grants from unexpended allotments.-- If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

"(B) 3-year grants.--

"(i) In general.-- The Secretary shall solicit applications to award 3-year grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

"(ii) Faith-based organizations or consortia.-- The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia.

"(C) Evaluation.-- An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

"(5) Maintenance of effort.-- No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded [*349] a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

"(6) Data collection and reporting.-- A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

"(b) Purpose.--

"(1) In general.-- The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education programs consistent with this subsection.

"(2) Personal responsibility education programs.--

"(A) In general.-- In this section, the term 'personal responsibility education program' means a program that is designed to educate adolescents on--

"(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

"(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

"(B) Requirements.-- The requirements of this subparagraph are the following:

"(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

"(ii) The program is medically-accurate and complete.

"(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

"(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

"(v) The program provides age-appropriate information and activities.

"(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

"(C) Adulthood preparation subjects.-- The adulthood preparation subjects described in this subparagraph are the following:

[*350] **"(i)** Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

"(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

"(iii) Financial literacy.

"(iv) Parent-child communication.

"(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

"(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

"(c) Reservations of Funds.--

"(1) Grants to implement innovative strategies.-- From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve \$ 10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

"(2) Other reservations.-- From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

"(A) Grants for Indian tribes or tribal organizations.-- The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

"(B) Secretarial responsibilities.--

"(i) Reservation of funds.-- The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

"(ii) Program support.-- The Secretary shall provide, directly or through a competitive grant process, research, training and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other State, tribal, and community organizations working [*351] to reduce teen pregnancy. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

"(iii) Evaluation.-- The Secretary shall evaluate the programs and activities carried out with funds made available through allotments or grants under this section.

"(d) Administration.--

"(1) In general.-- The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

"(2) Application of other provisions of title.--

"(A) In general.-- Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

"(B) Exceptions.-- The following provisions of this title shall apply to allotments and grants made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(iii) Section 504(d) (relating to a limitation on administrative expenditures).

"(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

"(v) Section 507 (relating to penalties for false statements).

"(vi) Section 508 (relating to nondiscrimination).

"(e) **Definitions.**-- In this section:

"(1) **Age-appropriate.**-- The term 'age-appropriate', with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

"(2) **Medically accurate and complete.**-- The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and--

"(A) published in peer-reviewed journals, where applicable; or

"(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

"(3) **Indian tribes; tribal organizations.**-- The terms 'Indian tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act ([25 U.S.C. 1603](#)).

[*352] "(4) **Youth.**-- The term 'youth' means an individual who has attained age 10 but has not attained age 20.

"(f) **Appropriation.**-- For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, \$ 75,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this subsection shall remain available until expended."

Sec. 2954.

RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act ([42 U.S.C. 710](#)) is amended--

(1) in subsection (a), by striking "fiscal year 1998 and each subsequent fiscal year" and inserting "each of fiscal years 2010 through 2014"; and

(2) in subsection (d)--

(A) in the first sentence, by striking "1998 through 2003" and inserting "2010 through 2014"; and

(B) in the second sentence, by inserting "(except that such appropriation shall be made on the date of enactment of the Patient Protection and Affordable Care Act in the case of fiscal year 2010)" before the period.

Sec. 2955.

INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) **Transition Planning.**-- Section 475(5)(H) of the Social Security Act ([42 U.S.C. 675](#)(5)(H)) is amended by inserting "includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State

law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law," after "employment services,".

(b) Independent Living Education.-- Section 477(b)(3) of such Act ([42 U.S.C. 677\(b\)\(3\)](#)) is amended by adding at the end the following:

"(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so."

(c) Health Oversight and Coordination Plan.-- Section 422(b)(15)(A) of such Act ([42 U.S.C. 622\(b\)\(15\)\(A\)](#)) is amended--

(1) in clause (v), by striking "and" at the end; and

(2) by adding at the end the following:

"(vii) steps to ensure that the components of the transition plan development process required under [*353] section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and".

(d) [<<Notes>>](#)

Effective Date.--The amendments made by this section take effect on October 1, 2010.

TITLE III--

IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A--

Transforming the Health Care Delivery System

PART I--

LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

Sec. 3001.

HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) Program.--

(1) In general.-- Section 1886 of the Social Security Act ([42 U.S.C. 1395www](#)), as amended by section 4102(a) of the HITECH Act (Public Law 111-5), is amended by adding at the end the following new subsection:

"(o) Hospital Value-Based Purchasing Program.--

"(1) Establishment.--

"(A) In general.-- Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the 'Program') under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

"(B) Program to begin in fiscal year 2013.-- The Program shall apply to payments for discharges occurring on or after October 1, 2012.

"(C) Applicability of program to hospitals.--

"(i) In general.-- For purposes of this subsection, subject to clause (ii), the term 'hospital' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

"(ii) Exclusions.-- The term 'hospital' shall not include, with respect to a fiscal year, a hospital--

"(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

"(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

[*354] "(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

"(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

"(iii) Independent analysis.-- For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

"(iv) Exemption.-- In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

"(2) Measures.--

"(A) In general.-- The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

"(B) Requirements.--

"(i) For fiscal year 2013.-- For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

"(I) Conditions or procedures.-- Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

"(aa) Acute myocardial infarction (AMI).

"(bb) Heart failure.

"(cc) Pneumonia.

"(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

"(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

"(II) HCAHPS.-- Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

"(ii) Inclusion of efficiency measures.-- For value-based incentive payments made with respect to [*355] discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of 'Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

"(C) Limitations.--

"(i) Time requirement for prior reporting and notice.-- The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

"(ii) Measure not applicable unless hospital furnishes services appropriate to the measure.-- A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

"(D) Replacing measures.-- Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

"(3) Performance standards.--

"(A) Establishment.-- The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

"(B) Achievement and improvement.-- The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

"(C) Timing.-- The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

"(D) Considerations in establishing standards.-- In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as--

"(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

"(ii) historical performance standards;

"(iii) improvement rates; and

"(iv) the opportunity for continued improvement.

"(4) Performance period.-- For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

"(5) Hospital performance score.--

"(A) In general.-- Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the [*356] total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital performance score') for each hospital for each performance period.

"(B) Application.--

"(i) Appropriate distribution.-- The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments.

"(ii) Higher of achievement or improvement.-- The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

"(iii) Weights.-- The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

"(iv) No minimum performance standard.-- The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

"(v) Reflection of measures applicable to the hospital.-- The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

"(6) Calculation of value-based incentive payments.--

"(A) In general.-- In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

"(B) Value-based incentive payment amount.-- The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of--

"(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

"(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

"(C) Value-based incentive payment percentage.-- [*357] **"(i)** In general.--The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

"(ii) Requirements.-- In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that--

"(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

"(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

"(7) Funding for value-based incentive payments.--

"(A) Amount.-- The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

"(B) Adjustment to payments.--

"(i) In general.-- The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

"(ii) No effect on other payments.-- Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

"(C) Applicable percent defined.-- For purposes of subparagraph (B), the term 'applicable percent' means--

"(i) with respect to fiscal year 2013, 1.0 percent;

"(ii) with respect to fiscal year 2014, 1.25 percent;

"(iii) with respect to fiscal year 2015, 1.5 percent;

"(iv) with respect to fiscal year 2016, 1.75 percent; and

"(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

"(D) Base operating DRG payment amount defined.--

"(i) In general.-- Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year--

"(I) the payment amount that would otherwise be made under subsection (d) (determined without [*358] regard to subsection (q)) for a discharge if this subsection did not apply; reduced by

"(II) any portion of such payment amount that is attributable to--

"(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

"(bb) such other payments under subsection (d) determined appropriate by the Secretary.

"(ii) Special rules for certain hospitals.--

"(I) Sole community hospitals and Medicare-dependent, small rural hospitals.-- In the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(II) Hospitals paid under section 1814.-- In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

"(8) Announcement of net result of adjustments.-- Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

"(9) No effect in subsequent fiscal years.-- The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

"(10) Public reporting.--

"(A) Hospital specific information.--

"(i) In general.-- The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including--

"(I) the performance of the hospital with respect to each measure that applies to the hospital;

"(II) the performance of the hospital with respect to each condition or procedure; and

"(III) the hospital performance score assessing the total performance of the hospital.

"(ii) Opportunity to review and submit corrections.-- The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

[*359] "(iii) Website.--Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(B) Aggregate information.-- The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including--

"(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

"(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

"(11) Implementation.--

"(A) Appeals.-- The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

"(B) Limitation on review.-- Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

"(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

"(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

"(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

"(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

"(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

"(C) Consultation with small hospitals.-- The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

"(12) Promulgation of regulations.-- The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6)."

(2) Amendments for reporting of hospital quality information.-- Section 1886(b)(3)(B)(viii) of the Social Security Act ([42 U.S.C. 1395ww](#)(b)(3)(B)(viii)) is amended--

[*360] (A) in subclause (II), by adding at the end the following sentence: "The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under subsection (o).";

(B) in subclause (V), by striking "beginning with fiscal year 2008" and inserting "for fiscal years 2008 through 2012";

(C) in subclause (VII), in the first sentence, by striking "data submitted" and inserting "information regarding measures submitted"; and

(D) by adding at the end the following new subclauses:

"(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

"(IX)

(aa) Subject to item (bb), effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a).

"(bb) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stakeholders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to--

"(aa) physicians under section 1848(k); and

"(bb) other providers of services and suppliers under this title.

"(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital."

(3) Website improvements.-- Section 1886(b)(3)(B) of the Social Security Act ([42 U.S.C. 1395ww](#)(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111-5), is amended by adding at the end the following new clause:

"(x)

(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

"(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it."

(4) GAO study and report.--

(A) Study.-- The Comptroller General of the United States shall conduct a study on the performance of the **[*361]** hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on--

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) Reports.--

(i) Interim report.-- Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) Final report.-- Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(5) HHS study and report.--

(A) Study.-- The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis--

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

[*362] (B) Report.--Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) <<Notes>>

Value-Based Purchasing Demonstration Programs.--

(1) Value-based purchasing demonstration program for inpatient critical access hospitals.--**(A) Establishment.--**

(i) In general.-- Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act ([42 U.S.C. 1395x\(mm\)](#))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) Duration.-- The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) Sites.-- The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) Waiver authority.-- The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) Budget neutrality requirement.-- In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) Report.-- Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with--

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

[*363] (2) Value-based purchasing demonstration program for hospitals excluded from hospital value-based purchasing program as a result of insufficient numbers of measures and cases.--

(A) Establishment.--

(i) **In general.--** Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act ([42 U.S.C. 1395x\(b\)](#))) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(ii) **Applicable hospital defined.--** For purposes of this paragraph, the term "applicable hospital" means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) **Duration.--** The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) **Sites.--** The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) Waiver authority.-- The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) Budget neutrality requirement.-- In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(D) Report.-- Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with--

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

Sec. 3002.**IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.**

(a) Extension.-- Section 1848(m) of the Social Security Act ([42 U.S.C. 1395w-4](#)(m)) is amended--

[*364] (1) in paragraph (1)--

(A) in subparagraph (A), in the matter preceding clause (i), by striking "2010" and inserting "2014"; and

(B) in subparagraph (B)--

(i) in clause (i), by striking "and" at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

"(iii) for 2011, 1.0 percent; and

"(iv) for 2012, 2013, and 2014, 0.5 percent.";

(2) in paragraph (3)--

(A) in subparagraph (A), in the matter preceding clause (i), by inserting "(or, for purposes of subsection (a)(8), for the quality reporting period for the year)" after "reporting period"; and

(B) in subparagraph (C)(i), by inserting ", or, for purposes of subsection (a)(8), for a quality reporting period for the year" after "(a)(5), for a reporting period for a year";

(3) in paragraph (5)(E)(iv), by striking "subsection (a)(5)(A)" and inserting "paragraphs (5)(A) and (8)(A) of subsection (a)"; and

(4) in paragraph (6)(C)--

(A) in clause (i)(II), by striking ", 2009, 2010, and 2011" and inserting "and subsequent years"; and

(B) in clause (iii)--

(i) by inserting "(a)(8)" after "(a)(5)"; and

(ii) by striking "under subparagraph (D)(iii) of such subsection" and inserting "under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively".

(b) Incentive Payment Adjustment for Quality Reporting.-- Section 1848(a) of the Social Security Act ([42 U.S.C. 1395w-4](#)(a)) is amended by adding at the end the following new paragraph:

"(8) Incentives for quality reporting.--

"(A) Adjustment.--

"(i) In general.-- With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

"(ii) Applicable percent.-- For purposes of clause (i), the term 'applicable percent' means--

"(I) for 2015, 98.5 percent; and

"(II) for 2016 and each subsequent year, 98 percent.

[*365] "(B) Application.--

"(i) Physician reporting system rules.-- Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

"(ii) Incentive payment validation rules.-- Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

"(C) Definitions.-- For purposes of this paragraph:

"(i) Eligible professional; covered professional services.-- The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

"(ii) Physician reporting system.-- The term 'physician reporting system' means the system established under subsection (k).

"(iii) Quality reporting period.-- The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary."

(c) Maintenance of Certification Programs.--

(1) In general.-- Section 1848(k)(4) of the Social Security Act ([42 U.S.C. 1395w-4\(k\)\(4\)](#)) is amended by inserting "or through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties that meets the criteria for such a registry" after "Database)".

(2) <<Notes>>

Effective date.-- The amendment made by paragraph (1) shall apply for years after 2010.

(d) Integration of Physician Quality Reporting and EHR Reporting.-- Section 1848(m) of the Social Security Act ([42 U.S.C. 1395w-4\(m\)](#)) is amended by adding at the end the following new paragraph:

"(7) Integration of physician quality reporting and EHR reporting.-- Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

"(A) The selection of measures, the reporting of which would both demonstrate--

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(B) Such other activities as specified by the Secretary."

(e) Feedback.-- Section 1848(m)(5) of the Social Security Act ([42 U.S.C. 1395w-4\(m\)\(5\)](#)) is amended by adding at the end the following new subparagraph:

"(H) Feedback.-- The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection."

(f) Appeals.-- Such section is further amended--

(1) in subparagraph (E), by striking "There shall" and inserting "Except as provided in subparagraph (I), there shall"; and

[*366] (2) by adding at the end the following new subparagraph:

"(l) Informal appeals process.-- The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection."

Sec. 3003.

IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) In General.-- Section 1848(n) of the Social Security Act ([42 U.S.C. 1395w-4\(n\)](#)) is amended--

(1) in paragraph (1)--

(A) in subparagraph (A)--

(i) by striking "general.--The Secretary" and inserting "general.--

"(i) Establishment.-- The Secretary";

(ii) in clause (i), as added by clause (i), by striking "the 'Program')" and all that follows through the period at the end of the second sentence and inserting "the 'Program')."; and

(iii) by adding at the end the following new clauses:

"(ii) Reports on resources.-- The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title.

"(iii) Inclusion of certain information.-- If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports."; and

(B) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraph (A)(ii)";

(2) in paragraph (4)--

(A) in the heading, by inserting "initial" after "focus"; and

(B) in the matter preceding subparagraph (A), by inserting "initial" after "focus the";

(3) in paragraph (6), by adding at the end the following new sentence: "For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph."; and

(4) by adding at the end the following new paragraphs:

"(9) Reports on utilization.--

"(A) Development of episode grouper.--

"(i) In general.-- The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

"(ii) Timeline for development.-- The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

"(iii) Public availability.-- The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

"(iv) Endorsement.-- The Secretary shall seek endorsement of the episode grouper described in [*367] subparagraph (A) by the entity with a contract under section 1890(a).

"(B) Reports on utilization.-- Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(C) Analysis of data.-- The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to--

"(i) attribute episodes of care, in whole or in part, to physicians;

"(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

"(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

"(D) Data adjustment.-- In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments--

"(i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

"(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

"(E) Public availability of methodology.-- The Secretary shall make available to the public--

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) Definition of physician.-- In this paragraph:

"(i) In general.-- The term 'physician' has the meaning given that term in section 1861(r)(1).

"(ii) Treatment of groups.-- Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of an episode of care under such methodology.

"(10) Coordination with other value-based purchasing reforms.-- The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title."

(b) Conforming Amendment.-- Section 1890(b) of the Social Security Act ([42 U.S.C. 1395aaa](#)(b)) is amended by adding at the end the following new paragraph:

"(6) Review and endorsement of episode grouper under the physician feedback program.-

- The entity shall provide for the review and, as appropriate, the endorsement of the [*368]

episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis."

Sec. 3004.

QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) Long-term Care Hospitals.-- Section 1886(m) of the Social Security Act ([42 U.S.C. 1395ww\(m\)](#)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

"(5) Quality reporting.--

"(A) Reduction in update for failure to report.--

"(i) In general.-- Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

"(ii) Special rule.-- The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

"(B) Noncumulative application.-- Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

"(C) Submission of quality data.-- For rate year 2014 and each subsequent rate year, each long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) Quality measures.--

"(i) In general.-- Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

"(ii) Exception.-- In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) Time frame.-- Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

[*369] "(E) Public availability of data submitted.--The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services."

(b) Inpatient Rehabilitation Hospitals.-- Section 1886(j) of the Social Security Act ([42 U.S.C. 1395ww\(j\)](#)) is amended--

- (1) by redesignating paragraph (7) as paragraph (8); and
- (2) by inserting after paragraph (6) the following new paragraph:

"(7) Quality reporting.--

"(A) Reduction in update for failure to report.--

"(i) In general.-- For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), and after application of paragraph (3)(D), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

"(ii) Special rule.-- The application of this subparagraph may result in the increase factor described in paragraph (3)(C) being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(B) Noncumulative application.-- Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

"(C) Submission of quality data.-- For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) Quality measures.--

"(i) In general.-- Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

"(ii) Exception.-- In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or [*370] adopted by a consensus organization identified by the Secretary.

"(iii) Time frame.-- Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

"(E) Public availability of data submitted.-- The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services."

(c) Hospice Programs.-- Section 1814(i) of the Social Security Act ([42 U.S.C. 1395f\(i\)](#)) is amended--

- (1) by redesignating paragraph (5) as paragraph (6); and
- (2) by inserting after paragraph (4) the following new paragraph:

"(5) Quality reporting.--

"(A) Reduction in update for failure to report.--

"(i) In general.-- For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

"(ii) Special rule.-- The application of this subparagraph may result in the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

"(B) Noncumulative application.-- Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

"(C) Submission of quality data.-- For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(D) Quality measures.--

"(i) In general.-- Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

[*371] "(ii) Exception.--In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(iii) Time frame.-- Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

"(E) Public availability of data submitted.-- The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services."

Sec. 3005.

QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act ([42 U.S.C. 1395cc](#)) is amended--

(1) in subsection (a)(1)--

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

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

(C) by adding at the end the following new subparagraph:

"(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k)."; and

(2) by adding at the end the following new subsection:

"(k) Quality Reporting by Cancer Hospitals.--

"(1) In general.-- For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

"(2) Submission of quality data.-- For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

"(3) Quality measures.--

"(A) In general.-- Subject to subparagraph (B), any measure specified by the Secretary under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

"(B) Exception.-- In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been [*372] endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) Time frame.-- Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

"(4) Public availability of data submitted.-- The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services."

Sec. 3006.

PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) Skilled Nursing Facilities.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act ([42 U.S.C. 1395i-3\(a\)](#))).

(2) Details.-- In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act ([42 U.S.C. 1395aaa](#)) and section 1890A such Act, as

added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in skilled nursing facilities.

(i) In general.-- Subject to clause (ii), any measure specified by the Secretary under subparagraph (A)(iii) must have been endorsed by the entity with a contract under section 1890(a).

(ii) Exception.-- In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, **[*373]** the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(E) Any other issues determined appropriate by the Secretary.

(3) Consultation.-- In developing the plan under paragraph (1), the Secretary shall--

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) Report to congress.-- Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) Home Health Agencies.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act ([42 U.S.C. 1395x\(o\)](#))).

(2) Details.-- In developing the plan under paragraph (1), the Secretary shall consider the following issues:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act ([42 U.S.C. 1395aaa](#)) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) Consultation.-- In developing the plan under paragraph (1), the Secretary shall--

(A) consult with relevant affected parties; and

(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

(4) Report to congress.-- Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

Sec. 3007.

VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act ([42 U.S.C. 1395w-4](#)) is amended--

(1) in subsection (b)(1), by inserting "subject to subsection (p)," after "1998,"; and

[*374] (2) by adding at the end the following new subsection:

"(p) Establishment of Value-based Payment Modifier.--

"(1) In general.-- The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

"(2) Quality.--

"(A) In general.-- For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as established by the Secretary under subparagraph (B)).

"(B) Measures.--

"(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

"(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

"(3) Costs.-- For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

"(4) Implementation.--

"(A) Publication of measures, dates of implementation, performance period.-- Not later than January 1, 2012, the Secretary shall publish the following:

"(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

"(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

"(iii) The initial performance period (as specified under subparagraph (B)(ii)).

"(B) Deadlines for implementation.--

"(i) Initial implementation.-- Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physician fee schedule established under subsection (b).

"(ii) Initial performance period.--

"(I) In general.-- The Secretary shall specify an initial performance period for application of [*375] the payment modifier established under this subsection with respect to 2015.

"(II) Provision of information during initial performance period.-- During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

"(iii) Application.-- The Secretary shall apply the payment modifier established under this subsection for items and services furnished--

"(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

"(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

"(C) Budget neutrality.-- The payment modifier established under this subsection shall be implemented in a budget neutral manner.

"(5) Systems-based care.-- The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

"(6) Consideration of special circumstances of certain providers.-- In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

"(7) Application.-- For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

"(8) Definitions.-- For purposes of this subsection:

"(A) Costs.-- The term 'costs' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

"(B) Performance period.-- The term 'performance period' means a period specified by the Secretary.

"(9) Coordination with other value-based purchasing reforms.-- The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

[*376] "(10) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of--

- "(A) the establishment of the value-based payment modifier under this subsection;
- "(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);
- "(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;
- "(D) the dates for implementation of the value-based payment modifier;
- "(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;
- "(F) the application of the value-based payment modifier under paragraph (7); and
- "(G) the determination of costs under paragraph (8)(A)."

Sec. 3008.

PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) In General.-- Section 1886 of the Social Security Act ([42 U.S.C. 1395ww](#)), as amended by section 3001, is amended by adding at the end the following new subsection:

"(p) Adjustment to Hospital Payments for Hospital Acquired Conditions.--

"(1) In general.-- In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (o) and (q) and section 1814(l)(4) but without regard to this subsection).

"(2) Applicable hospitals.--

"(A) In general.-- For purposes of this subsection, the term 'applicable hospital' means a subsection (d) hospital that meets the criteria described in subparagraph (B).

"(B) Criteria described.--

"(i) In general.-- The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

"(ii) Risk adjustment.-- In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

"(C) Exemption.-- In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an [*377] annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

"(3) Hospital acquired conditions.-- For purposes of this subsection, the term 'hospital acquired condition' means a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

"(4) Applicable period.-- In this subsection, the term 'applicable period' means, with respect to a fiscal year, a period specified by the Secretary.

"(5) Reporting to hospitals.-- Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

"(6) Reporting hospital specific information.--

"(A) In general.-- The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

"(B) Opportunity to review and submit corrections.-- The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) Website.-- Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(7) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The criteria described in paragraph (2)(A).

"(B) The specification of hospital acquired conditions under paragraph (3).

"(C) The specification of the applicable period under paragraph (4).

"(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6)."

(b) Study and Report on Expansion of Healthcare Acquired Conditions Policy to Other Providers.--

(1) Study.-- The Secretary of Health and Human Services shall conduct a study on expanding the healthcare acquired conditions policy under subsection (d)(4)(D) of section 1886 of the Social Security Act ([42 U.S.C. 1395ww](#)) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities, long-term care hospitals (as described in subsection(d)(1)(B)(iv) of such section), hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of **[*378]** how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

(2) Report.-- Not later than January 1, 2012, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II--

NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

Sec. 3011.

NATIONAL STRATEGY.

Title III of the Public Health Service Act ([42 U.S.C. 241](#) et seq.) is amended by adding at the end the following:

"PART S--

HEALTH CARE QUALITY PROGRAMS

"Subpart I-- National Strategy for Quality Improvement in Health Care

"Sec. 399HH.

[<<Notes>>](#)

NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE.

"(a) Establishment of National Strategy and Priorities.--

"(1) National strategy.-- The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

"(2) Identification of priorities.--

"(A) In general.-- The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

"(B) Requirements.-- The Secretary shall ensure that priorities identified under subparagraph (A) will--

"(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care for all populations, including children and vulnerable populations;

"(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

"(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

"(iv) improve Federal payment policy to emphasize quality and efficiency;

"(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

"(vi) address the health care provided to patients with high-cost chronic diseases;

"(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

"(viii) reduce health disparities across health disparity populations (as defined in section 485E) and geographic areas; and

[*379] **"(ix)** address other areas as determined appropriate by the Secretary.

"(C) Considerations.-- In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders.

"(D) Coordination with state agencies.-- The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children's Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under subparagraph (A).

"(b) Strategic Plan.--

"(1) In general.-- The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

"(2) Requirements.-- The strategic plan shall include provisions for addressing, at a minimum, the following:

"(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

"(B) Agency-specific strategic plans to achieve national priorities.

"(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

"(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

"(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

"(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

"(c) Periodic Update of National Strategy.-- The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

"(d) Submission and Availability of National Strategy and Updates.--

"(1) Deadline for initial submission of national strategy.-- Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

"(2) Updates.--

"(A) In general.-- The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

"(B) Information submitted.-- Each update submitted under subparagraph (A) shall include--

[*380] "(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

"(ii) an analysis of the progress, or lack of progress, in meeting such goals and any barriers to such progress;

"(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

"(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

"(C) Satisfaction of other reporting requirements.-- Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements under sections 1139A(a)(6) and 1139B(b)(4), respectively, of the Social Security Act.

"(e) Health Care Quality Internet Website.-- Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding--

"(1) the national priorities for health care quality improvement established under subsection (a)(2);

"(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

"(3) other information, as the Secretary determines to be appropriate."

Sec. 3012.[<<Notes>>](#)**INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.**

(a) In General.-- The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the "Working Group").

(b) Goals.-- The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2) of the Public Health Service Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

(c) Composition.--

(1) In general.-- The Working Group shall be composed of senior level representatives of--

- (A)** the Department of Health and Human Services;
- (B)** the Centers for Medicare & Medicaid Services;
- (C)** the National Institutes of Health;
- (D)** the Centers for Disease Control and Prevention;
- (E)** the Food and Drug Administration;
- (F)** the Health Resources and Services Administration;
- (G)** the Agency for Healthcare Research and Quality;
- [*381]** **(H)** the Office of the National Coordinator for Health Information Technology;
- (I)** the Substance Abuse and Mental Health Services Administration;
- (J)** the Administration for Children and Families;
- (K)** the Department of Commerce;
- (L)** the Office of Management and Budget;
- (M)** the United States Coast Guard;
- (N)** the Federal Bureau of Prisons;
- (O)** the National Highway Traffic Safety Administration;
- (P)** the Federal Trade Commission;
- (Q)** the Social Security Administration;
- (R)** the Department of Labor;
- (S)** the United States Office of Personnel Management;
- (T)** the Department of Defense;
- (U)** the Department of Education;
- (V)** the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) Chair and vice-chair.--

(A) Chair.-- The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) Vice chair.-- Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) Report to Congress.-- Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

Sec. 3013.

QUALITY MEASURE DEVELOPMENT.

(a) Public Health Service Act.-- Title IX of the Public Health Service Act ([42 U.S.C. 299](#) et seq.) is amended--

(1) by redesignating part D as part E;

(2) [<<Notes>>](#)

by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking "931" and inserting "941"; and

(4) by inserting after section 926 the following:

"PART D--

HEALTH CARE QUALITY IMPROVEMENT

"Subpart I-- Quality Measure Development

"Sec. 931.

[<<Notes>>](#)

QUALITY MEASURE DEVELOPMENT.

"(a) Quality Measure.-- In this subpart, the term 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

[*382] "(b) Identification of Quality Measures.--

"(1) Identification.-- The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration--

"(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

"(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act; and

"(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

"(2) Publication.-- The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

"(c) Grants or Contracts for Quality Measure Development.--

"(1) In general.-- The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

"(2) Prioritization in the development of quality measures.-- In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of--

"(A) health outcomes and functional status of patients;

"(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

"(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 936);

"(D) the meaningful use of health information technology;

"(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

"(F) the efficiency of care;

"(G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

"(H) patient experience and satisfaction;

"(I) the use of innovative strategies and methodologies identified under section 933; and

[*383] "(J) other areas determined appropriate by the Secretary.

"(3) Eligible entities.-- To be eligible for a grant or contract under this subsection, an entity shall--

"(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

"(B) have adopted procedures to include in the quality measure development process--

"(i) the views of those providers or payers whose performance will be assessed by the measure; and

"(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

"(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality

measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

"(D) have transparent policies regarding governance and conflicts of interest; and

"(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

"(4) Use of funds.-- An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

"(A) Such measures support measures required to be reported under the Social Security Act, where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

"(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

"(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

"(D) Each quality measure is free of charge to users of such measure.

"(E) Each quality measure is publicly available on an Internet website.

"(d) Other Activities by the Secretary.-- The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act or adopted by the Secretary.

"(e) Coordination of Grants.-- The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5) and 1139B(4)(A) of the Social Security Act."

(b) Social Security Act.-- Section 1890A of the Social Security Act, as added by section 3014(b), is amended by adding at the end the following new subsection:

"(e) Development of Quality Measures.-- The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined appropriate by [*384] the Administrator) for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality."

(c) Funding.-- There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, \$ 75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be used pursuant to subsection (e) of section 1890A of the Social Security Act, as added by subsection (b), with respect to programs under such Act. Amounts appropriated under this subsection for a fiscal year shall remain available until expended.

Sec. 3014.

QUALITY MEASUREMENT.

(a) New Duties for Consensus-based Entity.--

(1) Multi-stakeholder group input.-- Section 1890(b) of the Social Security Act ([42 U.S.C. 1395aaa](#)(b)), as amended by section 3003, is amended by adding at the end the following new paragraphs:

"(7) Convening multi-stakeholder groups.--

"(A) In general.-- The entity shall convene multi-stakeholder groups to provide input on--

"(i) the selection of quality measures described in subparagraph (B), from among--

"(I) such measures that have been endorsed by the entity; and

"(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

"(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

"(B) Quality measures.--

"(i) In general.-- Subject to clause (ii), the quality measures described in this subparagraph are quality measures--

"(I) for use pursuant to sections 1814(i)(5)(D), 1833(i)(7), 1833(t)(17), 1848(k)(2)(C), 1866(k)(3), 1881(h)(2)(A)(iii), 1886(b)(3)(B)(viii), 1886(j)(7)(D), 1886(m)(5)(D), 1886(o)(2), and 1895(b)(3)(B)(v);

"(II) for use in reporting performance information to the public; and

"(III) for use in health care programs other than for use under this Act.

"(ii) Exclusion.-- Data sets (such as the outcome and assessment information set for home health services and the minimum data set for skilled nursing facility services) that are used for purposes of classification systems used in establishing payment rates under this title shall not be quality measures described in this subparagraph.

"(C) Requirement for transparency in process.-- [*385] **"(i) In general.--**In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

"(ii) Selection of organizations participating in multi-stakeholder groups.-- The process described in clause (i) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

"(D) Multi-stakeholder group defined.-- In this paragraph, the term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure.

"(8) Transmission of multi-stakeholder input.-- Not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups provided under paragraph (7)."

(2) Annual report.-- Section 1890(b)(5)(A) of the Social Security Act ([42 U.S.C. 1395aaa](#)(b)(5)(A)) is amended--

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

(B) in clause (iii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new clauses:

"(iv) gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section

399HH of the Public Health Service Act, and where quality measures are unavailable or inadequate to identify or address such gaps;

"(v) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

"(vi) the matters described in clauses (i) and (ii) of paragraph (7)(A).".

(b) Multi-stakeholder Group Input Into Selection of Quality Measures.-- Title XVIII of the Social Security Act ([42 U.S.C. 1395](#) et seq.) is amended by inserting after section 1890 the following:

" Quality Measurement

"Sec. 1890A.

[<<Notes>>](#)

(a) Multi-stakeholder Group Input Into Selection of Quality Measures.--The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

"(1) Input.-- Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

[*386] "(2) Public availability of measures considered for selection.-- Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

"(3) Transmission of multi-stakeholder input.-- Pursuant to section 1890(b)(8), not later than February 1 of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

"(4) Consideration of multi-stakeholder input.-- The Secretary shall take into consideration the input from multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

"(5) Rationale for use of quality measures.-- The Secretary shall publish in the Federal Register the rationale for the use of any quality measure described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.

"(6) Assessment of impact.-- Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall--

"(A) conduct an assessment of the quality impact of the use of endorsed measures described in section 1890(b)(7)(B); and

"(B) make such assessment available to the public.

"(b) Process for Dissemination of Measures Used by the Secretary.--

"(1) In general.-- The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

"(A) The incorporation of such measures, where applicable, in workforce programs, training curricula, and any other means of dissemination determined appropriate by the Secretary.

"(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

"(2) Existing methods.-- To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process established under paragraph (1).

"(c) Review of Quality Measures Used by the Secretary.--

"(1) In general.-- The Secretary shall--

"(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1890(b)(7)(B); and

"(B) with respect to each such measure, determine whether to--

"(i) maintain the use of such measure; or

"(ii) phase out such measure.

"(2) Considerations.-- In conducting the review under paragraph (1), the Secretary shall take steps to--

"(A) seek to avoid duplication of measures used; and

[*387] **"(B)** take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

"(d) Rule of Construction.-- Nothing in this section shall preclude a State from using the quality measures identified under sections 1139A and 1139B."

(c) Funding.-- For purposes of carrying out the amendments made by this section, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act ([42 U.S.C. 1395j](#)) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act ([42 U.S.C. 1395t](#)), in such proportion as the Secretary determines appropriate, of \$ 20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.

Sec. 3015.

DATA COLLECTION; PUBLIC REPORTING.

Title III of the Public Health Service Act ([42 U.S.C. 241](#) et seq.), as amended by section 3011, is further amended by adding at the end the following:

"Sec. 399II.

[<<Notes>>](#)

COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

"(a) In General.-- The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

"(b) Grants or Contracts for Data Collection.--

"(1) In general.-- The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

"(2) Eligible entities.-- To be eligible for a grant or contract under this subsection, an entity shall--

"(A) be--

"(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

"(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

"(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

"(B) promote the use of the systems that provide data to improve and coordinate patient care;

[*388] "(C) support the provision of timely, consistent quality and resource use information to health care providers, and other groups and organizations as appropriate, with an opportunity for providers to correct inaccurate measures; and

"(D) agree to report, as determined by the Secretary, measures on quality and resource use to the public in accordance with the public reporting process established under section 399JJ.

"(c) Consistent Data Aggregation.-- The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

"(d) Matching Funds.-- The Secretary may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to \$ 1 for each \$ 5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

"(e) Authorization of Appropriations.-- To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

"Sec. 399JJ.

[<<Notes>>](#)

PUBLIC REPORTING OF PERFORMANCE INFORMATION.

"(a) Development of Performance Websites.-- The Secretary shall make available to the public, through standardized Internet websites, performance information summarizing data on quality measures. Such information shall be tailored to respond to the differing needs of hospitals and other institutional health care providers, physicians and other clinicians, patients, consumers, researchers, policymakers, States, and other stakeholders, as the Secretary may specify.

"(b) Information on Conditions.-- The performance information made publicly available on an Internet website, as described in subsection (a), shall include information regarding clinical conditions to the extent such information is available, and the information shall, where appropriate, be provider-

specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

"(c) Consultation.--

"(1) In general.-- In carrying out this section, the Secretary shall consult with the entity with a contract under section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

"(2) Consultation with stakeholders.-- The entity with a contract under section 1890(a) of the Social Security Act shall convene multi-stakeholder groups, as described in such section, to review the design and format of each Internet website made available under subsection (a) and shall transmit [*389] to the Secretary the views of such multi-stakeholder groups with respect to each such design and format.

"(d) Coordination.-- Where appropriate, the Secretary shall coordinate the manner in which data are presented through Internet websites described in subsection (a) and for public reporting of other quality measures by the Secretary, including such quality measures under title XVIII of the Social Security Act.

"(e) Authorization of Appropriations.-- To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014."

PART III--

ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

Sec. 3021.

ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) In General.-- Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

" Center for Medicare and Medicaid Innovation

"Sec. 1115A.

[<<Notes>>](#)

(a) Center for Medicare and Medicaid Innovation Established.--

"(1) In general.-- There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

"(2) Deadline.-- The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

"(3) Consultation.-- In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

"(4) Definitions.-- In this section:

"(A) Applicable individual.-- The term 'applicable individual' means--

"(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

"(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

"(iii) an individual who meets the criteria of both clauses (i) and (ii).

"(B) Applicable title.-- The term 'applicable title' means title XVIII, title XIX, or both.

[*390] "(b) Testing of Models (Phase I).--

"(1) In general.-- The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

"(2) Selection of models to be tested.--

"(A) In general.-- The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

"(B) Opportunities.-- The models described in this subparagraph are the following models:

"(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

"(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

"(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

"(I) An inability to perform 2 or more activities of daily living.

"(II) Cognitive impairment, including dementia.

"(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

"(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

"(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

[*391] "(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

"(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

"(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

"(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

"(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

"(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

"(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

"(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

"(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for-

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"(I) developing, documenting, and disseminating best practices and proven care methods;

"(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

"(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

"(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

[*392] "(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

"(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

"(C) Additional factors for consideration.-- In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

"(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

"(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

"(iii) Whether the model provides for in-person contact with applicable individuals.

"(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

"(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

"(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

"(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

"(3) Budget neutrality.--

"(A) Initial period.-- The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

"(B) Termination or modification.-- The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, [*393] with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

"(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

"(ii) reduce spending under the applicable title without reducing the quality of care; or

"(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

"(4) Evaluation.--

"(A) In general.-- The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of--

"(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

"(ii) the changes in spending under the applicable titles by reason of the model.

"(B) Information.-- The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

"(c) Expansion of Models (Phase II).-- Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if--

"(1) the Secretary determines that such expansion is expected to--

"(A) reduce spending under applicable title without reducing the quality of care; or

"(B) improve the quality of care and reduce spending; and

"(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

"(d) Implementation.--

"(1) Waiver authority.-- The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

"(2) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of--

"(A) the selection of models for testing or expansion under this section;

[*394] "(B) the selection of organizations, sites, or participants to test those models selected;

"(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

"(D) determinations regarding budget neutrality under subsection (b)(3);

"(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

"(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

"(3) Administration.-- Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

"(e) Application to CHIP.-- The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

"(f) Funding.--

"(1) In general.-- There are appropriated, from amounts in the Treasury not otherwise appropriated--

"(A) \$ 5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

"(B) \$ 10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

"(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

"(2) Use of certain funds.-- Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than \$ 25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

"(g) Report to Congress.-- Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models."

(b) Medicaid Conforming Amendment.-- Section 1902(a) of the Social Security Act (*42 U.S.C. 1396a(a)*), as amended by section 8002(b), is amended--

(1) in paragraph (81), by striking "and" at the end;

[*395] **(2)** in paragraph (82), by striking the period at the end and inserting "; and"; and

(3) by inserting after paragraph (82) the following new paragraph:

"(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State."

(c) Revisions to Health Care Quality Demonstration Program.-- Subsections (b) and (f) of section 1866C of the Social Security Act ([42 U.S.C. 1395cc-3](#)) are amended by striking "5-year" each place it appears.

Sec. 3022.

MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act ([42 U.S.C. 1395](#) et seq.) is amended by adding at the end the following new section:

" Shared Savings Program

"Sec. 1899.

[<<Notes>>](#)

(a) Establishment.--

"(1) In general.-- Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program--

"(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

"(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

"(b) Eligible ACOs.--

"(1) In general.-- Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

"(A) ACO professionals in group practice arrangements.

"(B) Networks of individual practices of ACO professionals.

"(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

"(D) Hospitals employing ACO professionals.

"(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

"(2) Requirements.-- An ACO shall meet the following requirements:

"(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

[*396] "(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

"(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

"(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

"(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

"(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

"(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

"(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

"(3) Quality and other reporting requirements.--

"(A) In general.-- The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of--

"(i) clinical processes and outcomes;

"(ii) patient and, where practicable, caregiver experience of care; and

"(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

"(B) Reporting requirements.-- An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

"(C) Quality performance standards.-- The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by [*397] ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

"(D) Other reporting requirements.-- The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

"(4) No duplication in participation in shared savings programs.-- A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

"(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice pilot program under section 1866E.

"(c) Assignment of Medicare Fee-for-service Beneficiaries to ACOs.-- The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

"(d) Payments and Treatment of Savings.--

"(1) Payments.--

"(A) In general.-- Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if--

"(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

"(ii) the ACO meets the requirement under subparagraph (B)(i).

"(B) Savings requirement and benchmark.--

"(i) Determining savings.-- In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under [*398] this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(ii) Establish and update benchmark.-- The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

"(2) Payments for shared savings.-- Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

"(3) Monitoring avoidance of at-risk patients.-- If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

"(4) Termination.-- The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

"(e) Administration.-- Chapter 35 of title 44, United States Code, shall not apply to the program.

"(f) Waiver Authority.-- The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

"(g) Limitations on Review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of--

"(1) the specification of criteria under subsection (a)(1)(B);

"(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

"(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

"(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

[*399] **"(5)** the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

"(6) the termination of an ACO under subsection (d)(4).

"(h) Definitions.-- In this section:

"(1) ACO professional.-- The term 'ACO professional' means--

"(A) a physician (as defined in section 1861(r)(1)); and

"(B) a practitioner described in section 1842(b)(18)(C)(i).

"(2) Hospital.-- The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

"(3) Medicare fee-for-service beneficiary.-- The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894."

Sec. 3023.

NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

" National Pilot Program On Payment Bundling

"Sec. 1866D.

[<<Notes>>](#)

(a) Implementation.--

"(1) In general.-- The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

"(2) Definitions.-- In this section:

"(A) Applicable beneficiary.-- The term 'applicable beneficiary' means an individual who--

"(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and

"(ii) is admitted to a hospital for an applicable condition.

"(B) Applicable condition.-- The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

"(i) Whether the conditions selected include a mix of chronic and acute conditions.

"(ii) Whether the conditions selected include a mix of surgical and medical conditions.

"(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

"(iv) Whether a condition has significant variation in--

"(I) the number of readmissions; and

[*400] "(II) the amount of expenditures for post-acute care spending under this title.

"(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

"(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

"(C) Applicable services.-- The term 'applicable services' means the following:

"(i) Acute care inpatient services.

"(ii) Physicians' services delivered in and outside of an acute care hospital setting.

"(iii) Outpatient hospital services, including emergency department services.

"(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

"(v) Other services the Secretary determines appropriate.

"(D) Episode of care.--

"(i) In general.-- Subject to clause (ii), the term 'episode of care' means, with respect to an applicable condition and an applicable beneficiary, the period that includes--

"(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

"(II) the length of stay of the applicable beneficiary in such hospital; and

"(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

"(ii) Establishment of period by the secretary.-- The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

"(E) Physicians' services.-- The term 'physicians' services' has the meaning given such term in section 1861(q).

"(F) Pilot program.-- The term 'pilot program' means the pilot program under this section.

"(G) Provider of services.-- The term 'provider of services' has the meaning given such term in section 1861(u).

"(H) Readmission.-- The term 'readmission' has the meaning given such term in section 1886(q)(5)(E).

"(l) Supplier.-- The term 'supplier' has the meaning given such term in section 1861(d).

"(3) Deadline for implementation.-- The Secretary shall establish the pilot program not later than January 1, 2013.

"(b) Developmental Phase.--

"(1) Determination of patient assessment instrument.-- The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most [*401] clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

"(2) Development of quality measures for an episode of care and for post-acute care.--

"(A) In general.-- The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program--

"(i) for episodes of care; and

"(ii) for post-acute care.

"(B) Site-neutral post-acute care quality measures.-- Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

"(C) Coordination with quality measure development and endorsement procedures.-- The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all post-acute care settings.

"(c) Details.--

"(1) Duration.--

"(A) In general.-- Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

"(B) Extension.-- The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(2) Participating providers of services and suppliers.--

"(A) In general.-- An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

"(B) Requirements.-- The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

"(3) Payment methodology.--

"(A) In general.--

"(i) Establishment of payment methods.-- The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes

of care. The Secretary shall make payments to the entity for services covered under this section.

"(ii) No additional program expenditures.-- Payments under this section for applicable items and [*402] services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

"(B) Inclusion of certain services.-- A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

"(C) Bundled payments.--

"(i) In general.-- A bundled payment under the pilot program shall--

"(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

"(II) be made to the entity which is participating in the pilot program.

"(ii) Requirement for provision of applicable services and other appropriate services.-- Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

"(D) Payment for post-acute care services after the episode of care.-- The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

"(4) Quality measures.--

"(A) In general.-- The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

"(i) Functional status improvement.

"(ii) Reducing rates of avoidable hospital readmissions.

"(iii) Rates of discharge to the community.

"(iv) Rates of admission to an emergency room after a hospitalization.

"(v) Incidence of health care acquired infections.

"(vi) Efficiency measures.

"(vii) Measures of patient-centeredness of care.

"(viii) Measures of patient perception of care.

"(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

"(B) Reporting on quality measures.-- [*403] "(i) In general.--A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each

year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

"(ii) Submission of data through electronic health record.-- To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act ([42 U.S.C. 300jj-11](#)(13)) in a manner specified by the Secretary.

"(d) Waiver.-- The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

"(e) Independent Evaluation and Reports on Pilot Program.--

"(1) Independent evaluation.-- The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has--

"(A) improved quality measures established under subsection (c)(4)(A);

"(B) improved health outcomes;

"(C) improved applicable beneficiary access to care; and

"(D) reduced spending under this title.

"(2) Reports.--

"(A) Interim report.-- Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

"(B) Final report.-- Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

"(f) Consultation.-- The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

"(g) Implementation Plan.--

"(1) In general.-- Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(h) Administration.-- Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section."

[*404] Sec. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

" Independence At Home Medical Practice Demonstration Program

"Sec. 1866D.

[<<Notes>>](#)

(a) Establishment.--

"(1) In general.-- The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

"(2) Requirement.-- The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in--

- "(A)** reducing preventable hospitalizations;
- "(B)** preventing hospital readmissions;
- "(C)** reducing emergency room visits;
- "(D)** improving health outcomes commensurate with the beneficiaries' stage of chronic illness;
- "(E)** improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;
- "(F)** reducing the cost of health care services covered under this title; and
- "(G)** achieving beneficiary and family caregiver satisfaction.

"(b) Independence at Home Medical Practice.--

"(1) Independence at home medical practice defined.-- In this section:

"(A) In general.-- The term 'independence at home medical practice' means a legal entity that--

"(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

"(ii) is organized at least in part for the purpose of providing physicians' services;

"(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

[*405] "(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

"(v) has entered into an agreement with the Secretary;

"(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

"(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

"(B) Physician.-- The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

"(2) Participation of nurse practitioners and physician assistants.-- Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if--

"(A) all the requirements of this section are met;

"(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

"(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

"(3) Inclusion of providers and practitioners.-- Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

"(4) Quality and performance standards.-- The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

"(c) Payment Methodology.--

"(1) Establishment of target spending level.-- The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services [*406] covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

"(2) Incentive payments.-- Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

"(d) Applicable Beneficiaries.--

"(1) Definition.-- In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined--

"(A) is entitled to benefits under part A and enrolled for benefits under part B;

"(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

"(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

"(D) within the past 12 months has had a nonelective hospital admission;

"(E) within the past 12 months has received acute or subacute rehabilitation services;

"(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

"(G) meets such other criteria as the Secretary determines appropriate.

"(2) Patient election to participate.-- The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

"(3) Beneficiary access to services.-- Nothing in this section shall be construed as encouraging physicians or nurse [*407] practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

"(e) Implementation.--

"(1) Starting date.-- The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

"(2) No physician duplication in demonstration participation.-- The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

"(3) No beneficiary duplication in demonstration participation.-- The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

"(4) Preference.-- In approving an independence at home medical practice, the Secretary shall give preference to practices that are--

"(A) located in high-cost areas of the country;

"(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

"(C) use electronic medical records, health information technology, and individualized plans of care.

"(5) Limitation on number of practices.-- In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

"(6) Waiver.-- The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

"(7) Administration.-- Chapter 35 of title 44, United States Code, shall not apply to this section.

"(f) Evaluation and Monitoring.--

"(1) In general.-- The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

"(2) Monitoring applicable beneficiaries.-- The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

"(g) Reports to Congress.-- The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

"(h) Funding.-- For purposes of administering and carrying out the demonstration program, other than for payments for items [*408] and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) \$ 5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

"(i) Termination.--

"(1) Mandatory termination.-- The Secretary shall terminate an agreement with an independence at home medical practice if--

"(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or

"(B) such practice fails to meet quality standards during any year of the demonstration program.

"(2) Permissive termination.-- The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary."

Sec. 3025.

HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) In General.-- Section 1886 of the Social Security Act ([42 U.S.C. 1395ww](#)), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

"(q) Hospital Readmissions Reduction Program.--

"(1) In general.-- With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to

account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of--

"(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and

"(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

"(2) Base operating DRG payment amount defined.--

"(A) In general.-- Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year--

"(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by

"(ii) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).

"(B) Special rules for certain hospitals.--

"(i) Sole community hospitals and Medicare-dependent, small rural hospitals.-- In the case of [*409] a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(ii) Hospitals paid under section 1814.-- In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

"(3) Adjustment factor.--

"(A) In general.-- For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of--

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in subparagraph (C).

"(B) Ratio.-- The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of--

"(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and

"(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.

"(C) Floor adjustment factor.-- For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for--

"(i) fiscal year 2013 is 0.99;

"(ii) fiscal year 2014 is 0.98; or

"(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

"(4) Aggregate payments, excess readmission ratio defined.-- For purposes of this subsection:

"(A) Aggregate payments for excess readmissions.-- The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of--

"(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

"(ii) the number of admissions for such condition for such hospital for such applicable period; and

"(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.

[*410] "(B) Aggregate payments for all discharges.--The term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

"(C) Excess readmission ratio.--

"(i) In general.-- Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of--

"(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

"(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

"(ii) Exclusion of certain readmissions.-- For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

"(5) Definitions.-- For purposes of this subsection:

"(A) Applicable condition.-- The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which--

"(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions--

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

"(B) Expansion of applicable conditions.-- Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as

of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by [*411] the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) Applicable hospital.-- The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

"(D) Applicable period.-- The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.

"(E) Readmission.-- The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

"(6) Reporting hospital specific information.--

"(A) In general.-- The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

"(B) Opportunity to review and submit corrections.-- The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) Website.-- Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(7) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The determination of base operating DRG payment amounts.

"(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).

"(C) The measures of readmissions as described in paragraph (5)(A)(ii).

"(8) Readmission rates for all patients.--

"(A) Calculation of readmission.-- The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with [*412] respect to this title and posted on the CMS Hospital Compare website.

"(B) Posting of hospital specific all patient readmission rates.-- The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the

Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

"(C) Hospital submission of all patient data.--

"(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

"(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

"(D) Definitions.-- For purposes of this paragraph:

"(i) The term 'all patients' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

"(ii) The term 'specified hospital' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph."

(b) Quality Improvement.-- Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

"Sec. 399KK.

[<<Notes>>](#)

QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.

"(a) Establishment.--

"(1) In general.-- Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).

"(2) Eligible hospital defined.-- In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

"(3) Risk adjustment.-- The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.

"(b) Report to the Secretary.-- As determined appropriate by the Secretary, eligible hospitals and patient safety organizations **[*413]** working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates."

Sec. 3026.

[<<Notes>>](#)

COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) In General.-- The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) Definitions.-- In this section:

(1) Eligible entity.-- The term "eligible entity" means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act ([42 U.S.C. 1395ww](#)(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as under section 1886(q) of the Social Security Act, as added by section 3025.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers).

(2) High-risk Medicare beneficiary.-- The term "high-risk Medicare beneficiary" means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) Medicare beneficiary.-- The term "Medicare beneficiary" means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act ([42 U.S.C. 1395](#) et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) Program.-- The term "program" means the program conducted under this section.

(5) Readmission.-- The term "readmission" has the meaning given such term in section 1886(q)(5)(E) of the Social Security Act, as added by section 3025.

(6) Secretary.-- The term "Secretary" means the Secretary of Health and Human Services.

(c) Requirements.--

(1) Duration.--

(A) In general.-- The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) Expansion.-- The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this [*414] title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) Application; participation.--

(A) In general.--

(i) Application.-- An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) Partnership.-- If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) Intervention proposal.-- Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

(C) Limitation.-- A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act ([42 U.S.C. 1395x](#)(ee)).

(3) Selection.-- In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that--

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospitals and practitioners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(d) Implementation.-- Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

[*415] (e) Waiver Authority.--The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) Funding.-- For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act ([42 U.S.C. 1395i](#)) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act ([42 U.S.C. 1395t](#)), in such proportion as the Secretary determines appropriate, of \$ 500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

Sec. 3027.

EXTENSION OF GAINSHARING DEMONSTRATION.

(a) In General.-- Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109-171) [<<Notes>>](#)

is amended by inserting "(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)" after "December 31, 2009".

(b) Funding.--

(1) In general.-- Subsection (f)(1) of such section is amended by inserting "and for fiscal year 2010, \$ 1,600,000," after "\$ 6,000,000,".

(2) Availability.-- Subsection (f)(2) of such section is amended by striking "2010" and inserting "2014 or until expended".

(c) Reports.--

(1) Quality improvement and savings.-- Subsection (e)(3) of such section is amended by striking "December 1, 2008" and inserting "March 31, 2011".

(2) Final report.-- Subsection (e)(4) of such section is amended by striking "May 1, 2010" and inserting "March 31, 2013".

Subtitle B--

Improving Medicare for Patients and Providers

PART I--

ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

Sec. 3101.

INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act ([42 U.S.C. 1395w-4](#)(d)) is amended by adding at the end the following new paragraph:

"(10) Update for 2010.--

"(A) In general.-- Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

"(B) No effect on computation of conversion factor for 2011 and subsequent years.-- The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied."

[*416] Sec. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) Extension of Work GPCI Floor.-- Section 1848(e)(1)(E) of the Social Security Act ([42 U.S.C. 1395w-4](#)(e)(1)(E)) is amended by striking "before January 1, 2010" and inserting "before January 1, 2011".

(b) <<Notes>>

Practice Expense Geographic Adjustment for 2010 and Subsequent Years.--Section 1848(e)(1) of the Social Security Act ([42 U.S.C. 1395w-4](#)(e)(1)) is amended--

(1) in subparagraph (A), by striking "and (G)" and inserting "(G), and (H)"; and

(2) by adding at the end the following new subparagraph:

"(H) Practice expense geographic adjustment for 2010 and subsequent years.--

"(i) For 2010.-- Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 3/4 of the difference between the relative costs of employee wages and rents in

each of the different fee schedule areas and the national average of such employee wages and rents.

"(ii) For 2011.-- Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

"(iii) Hold harmless.-- The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

"(iv) Analysis.-- The Secretary shall analyze current methods of establishing practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

"(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

"(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which [*417] types of office expenses are determined in local markets instead of national markets.

"(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

"(v) Revision for 2012 and subsequent years.-- As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including--

"(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

"(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments. Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner."

Sec. 3103.

EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act ([42 U.S.C. 1395l\(g\)\(5\)](#)) is amended by striking "December 31, 2009" and inserting "December 31, 2010".

Sec. 3104.

EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106-554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ([42 U.S.C. 1395w-4](#) note), section 104 of division B of the Tax Relief and Health Care Act of 2006 ([42 U.S.C. 1395w-4](#) note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking "and 2009" and inserting "2009, and 2010".

Sec. 3105.

EXTENSION OF AMBULANCE ADD-ONS.

(a) Ground Ambulance.-- Section 1834(l)(13)(A) of the Social Security Act ([42 U.S.C. 1395m](#)(l)(13)(A)) is amended--

(1) in the matter preceding clause (i)--

(A) by striking "2007, and for" and inserting "2007, for"; and

(B) by striking "2010" and inserting "2010, and for such services furnished on or after April 1, 2010, and before January 1, 2011,"; and

(2) in each of clauses (i) and (ii), by inserting ", and on or after April 1, 2010, and before January 1, 2011" after "January 1, 2010" each place it appears.

(b) [<<Notes>>](#)

Air Ambulance.--Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law [*418] 110-275) is amended by striking "December 31, 2009" and inserting "December 31, 2009, and during the period beginning on April 1, 2010, and ending on January 1, 2011".

(c) Super Rural Ambulance.-- Section 1834(l)(12)(A) of the Social Security Act ([42 U.S.C. 1395m](#)(l)(12)(A)) is amended by striking "2010" and inserting "2010, and on or after April 1, 2010, and before January 1, 2011".

Sec. 3106.

EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) Extension of Certain Payment Rules.-- Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ([42 U.S.C. 1395www](#) note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111-5), is further amended by striking "3-year period" each place it appears and inserting "4-year period".

(b) Extension of Moratorium.-- Section 114(d)(1) of such Act ([42 U.S.C. 1395www](#) note), in the matter preceding subparagraph (A), is amended by striking "3-year period" and inserting "4-year period".

Sec. 3107.

EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) [<<Notes>>](#)

is amended by striking "December 31, 2009" and inserting "December 31, 2010".

Sec. 3108.

PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) Ordering Post-Hospital Extended Care Services.--

(1) In general.-- Section 1814(a)(2) of the Social Security Act ([42 U.S.C. 1395f](#)(a)(2)), in the matter preceding subparagraph (A), is amended by striking "or clinical nurse specialist" and inserting ", a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))" after "nurse practitioner".

(2) Conforming amendment.-- Section 1814(a) of the Social Security Act ([42 U.S.C. 1395f](#)(a)) is amended, in the second sentence, by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or physician assistant" after "nurse practitioner,".

(b) <<Notes>>

Effective Date.--The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

Sec. 3109.

EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) In General.-- Section 1834(a)(20) of the Social Security Act ([42 U.S.C. 1395m](#)(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 100-275), is amended--

(1) in subparagraph (F)(i)--

(A) by inserting "and subparagraph (G)" after "clause (ii)"; and

(B) by inserting ", except that the Secretary shall not require a pharmacy to have submitted to the Secretary [***419**] such evidence of accreditation prior to January 1, 2011" before the semicolon at the end; and

(2) by adding at the end the following new subparagraph:**"(G) Application of accreditation requirement to certain pharmacies.--**

"(i) In general.-- With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph--

"(I) subject to subclause (II), in applying such standards and the accreditation requirement of subparagraph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

"(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

"(ii) Pharmacies described.-- A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

"(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

"(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse

action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

"(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

"(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary."

(b) [<<Notes>>](#)

Administration.--Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

[*420] (c) [<<Notes>>](#)

Rule of Construction.--Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act ([42 U.S.C. 1395w-3](#)).

Sec. 3110.

PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) In General.--

(1) In general.-- Section 1837 of the Social Security Act ([42 U.S.C. 1395p](#)) is amended by adding at the end the following new subsection:

"(I)

(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

"(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

"(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

"(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

"(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part,

including the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

"(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence."

(2) <<Notes>>

Effective date.-- The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) Waiver of Increase of Premium.-- Section 1839(b) of the Social Security Act ([42 U.S.C. 1395r\(b\)](#)) is amended by striking "section 1837(i)(4)" and inserting "subsection (i)(4) or (l) of section 1837".

[*421] Sec. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) Payment.--

(1) In general.-- Section 1848 of the Social Security Act ([42 U.S.C. 1395w-4](#)) is amended--

(A) in subsection (b)--

(i) in paragraph (4)(B), by inserting ", and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))" before the period at the end; and

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

"(6) Treatment of bone mass scans.-- For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of--

"(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

"(B) the conversion factor (established under subsection (d)) for 2006; and

"(C) the geographic adjustment factor (established under subsection (e)(2)) for the service for the fee schedule area for 2010 and 2011, respectively."; and

(B) in subsection (c)(2)(B)(iv)--

(i) in subclause (II), by striking "and" at the end;

(ii) in subclause (III), by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following new subclause:

"(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011."

(2) <<Notes>>

Implementation.-- Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) Study and Report by the Institute of Medicine.--

(1) In general.-- The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section 1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) Report.-- An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

Sec. 3112.

REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act ([42 U.S.C. 1395iii](#)) is amended by striking "\$ 22,290,000,000" and inserting "\$ 0".

[*422] Sec. 3113. [.<<Notes>>](#)

TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) Demonstration Project.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

(2) Covered complex diagnostic laboratory test defined.-- In this section, the term "complex diagnostic laboratory test" means a diagnostic laboratory test--

(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;

(C) which is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

(D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

(E) is described in section 1861(s)(3) of the Social Security Act ([42 U.S.C. 1395x\(s\)\(3\)](#)).

(3) Separate payment defined.-- In this section, the term "separate payment" means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social Security Act by reason of sections 1862(a)(14) and 1866(a)(1)(H)(i) of the such Act ([42 U.S.C. 1395y\(a\)\(14\)](#); [42 U.S.C. 1395cc\(a\)\(1\)\(H\)\(i\)](#)).

(b) Duration.-- Subject to subsection (c)(2), the Secretary shall conduct the demonstration project under this section for the 2-year period beginning on July 1, 2011.

(c) Payments and Limitation.-- Payments under the demonstration project under this section shall--

(1) be made from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act ([42 U.S.C. 1395t](#)); and

(2) may not exceed \$ 100,000,000.

(d) Report.-- Not later than 2 years after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project. Such report shall include--

(1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act (including any savings under such title); and

[*423] (2) such recommendations as the Secretary determines appropriate.

(e) Implementation Funding.-- For purposes of administering this section (including preparing and submitting the report under subsection (d)), the Secretary shall provide for the transfer, from the Federal Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act ([42 U.S.C. 1395t](#)), to the Centers for Medicare & Medicaid Services Program Management Account, of \$ 5,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

Sec. 3114.

IMPROVED ACCESS FOR CERTIFIED NURSE-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act ([42 U.S.C. 1395l\(a\)\(1\)\(K\)](#)) is amended by inserting "(or 100 percent for services furnished on or after January 1, 2011)" after "1992, 65 percent".

PART II--RURAL PROTECTIONS

Sec. 3121.

EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) In General.-- Section 1833(t)(7)(D)(i) of the Social Security Act ([42 U.S.C. 1395l\(t\)\(7\)\(D\)\(i\)](#)) is amended--

(1) in subclause (II)--

(A) in the first sentence, by striking "2010" and inserting "2011"; and

(B) in the second sentence, by striking "or 2009" and inserting ", 2009, or 2010"; and

(2) in subclause (III), by striking "January 1, 2010" and inserting "January 1, 2011".

(b) Permitting All Sole Community Hospitals To Be Eligible for Hold Harmless.-- Section 1833(t)(7)(D)(i)(III) of the Social Security Act ([42 U.S.C. 1395l\(t\)\(7\)\(D\)\(i\)\(III\)](#)) is amended by adding at the end the following new sentence: "In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the preceding sentence shall be applied without regard to the 100-bed limitation.".

Sec. 3122.

<<Notes>>

EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ([42 U.S.C. 1395l-4](#)), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 ([42 U.S.C. 1395l](#) note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ([42 U.S.C. 1395l](#) note), is amended by inserting "or during the 1-year period beginning on July 1, 2010" before the period at the end.

Sec. 3123.[<<Notes>>](#)**EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.**

(a) One-year Extension.-- Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

"(g) One-Year Extension of Demonstration Program.--

"(1) In general.-- Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration [*424] program under this section for an additional 1-year period (in this section referred to as the '1-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

"(2) Expansion of demonstration states.-- Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

"(3) Increase in maximum number of hospitals participating in the demonstration program.-- Notwithstanding subsection (a)(4), during the 1-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

"(4) No affect on hospitals in demonstration program on date of enactment.-- In the case of a rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary shall provide for the continued participation of such rural community hospital in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation."

(b) Conforming Amendments.-- Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272) is amended by inserting "(in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 1-year extension period" after "5-year period".

(c) Technical Amendments.--

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272) is amended--

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

(B) in paragraph (2), by inserting "cost" before "reporting period" the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2272) is amended--

(A) in subparagraph (A)(ii), by striking "paragraph (2)" and inserting "subparagraph (B)"; and

(B) in subparagraph (B), by striking "paragraph (1)(B)" and inserting "subparagraph (A)(ii)".

Sec. 3124.**EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.**

(a) Extension of Payment Methodology.-- Section 1886(d)(5)(G) of the Social Security Act ([42 U.S.C. 1395ww](#)(d)(5)(G)) is amended--

- (1) in clause (i), by striking "October 1, 2011" and inserting "October 1, 2012"; and
- [*425] (2) in clause (ii)(II), by striking "October 1, 2011" and inserting "October 1, 2012".

(b) Conforming Amendments.--

(1) Extension of target amount.-- Section 1886(b)(3)(D) of the Social Security Act ([42 U.S.C. 1395ww](#)(b)(3)(D)) is amended--

(A) in the matter preceding clause (i), by striking "October 1, 2011" and inserting "October 1, 2012"; and

(B) in clause (iv), by striking "through fiscal year 2011" and inserting "through fiscal year 2012".

(2) Permitting hospitals to decline reclassification.-- Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 ([42 U.S.C. 1395ww](#) note) is amended by striking "through fiscal year 2011" and inserting "through fiscal year 2012".

Sec. 3125.

TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act ([42 U.S.C. 1395ww](#)(d)(12)) is amended--

- (1) in subparagraph (A), by inserting "or (D)" after "subparagraph (B)";
- (2) in subparagraph (B), in the matter preceding clause (i), by striking "The Secretary" and inserting "For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary";
- (3) in subparagraph (C)(i)--
 - (A) by inserting "(or, with respect to fiscal years 2011 and 2012, 15 road miles)" after "25 road miles"; and
 - (B) by inserting "(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)" after "800 discharges"; and
- (4) by adding at the end the following new subparagraph:

"(D) Temporary applicable percentage increase.-- For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year."

Sec. 3126.

IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) Removal of Limitation on Number of Eligible Counties Selected.-- Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 ([42 U.S.C. 1395i-4](#) note) is amended by striking "not more than 6".

(b) Removal of References to Rural Health Clinic Services and Inclusion of Physicians' Services in Scope of Demonstration Project.-- Such section 123 is amended--

[*426] (1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)--

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

"(B) Physicians' services (as defined in section 1861(q) of the Social Security Act ([42 U.S.C. 1395x\(q\)](#))).";

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

Sec. 3127.

MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) Study.-- The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act ([42 U.S.C. 1395](#) et seq.). Such study shall include an analysis of--

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) Report.-- Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

Sec. 3128.

TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) In General.-- Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act ([42 U.S.C. 1395m](#)) are each amended by inserting "101 percent of" before "the reasonable costs".

(b) <<Notes>>

Effective Date.--The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; *117 Stat. 2266*).

Sec. 3129.

EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) Authorization.-- Section 1820(j) of the Social Security Act ([42 U.S.C. 1395i-4\(j\)](#)) is amended--

(1) by striking "2010, and for" and inserting "2010, for"; and

(2) by inserting "and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended" before the period at the end.

(b) Use of Funds.-- Section 1820(g)(3) of the Social Security Act ([42 U.S.C. 1395i-4\(g\)\(3\)](#)) is amended--

[*427] (1) in subparagraph (A), by inserting "and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary" before the period at the end; and

(2) in subparagraph (E)--

(A) by striking ", and to offset" and inserting ", to offset"; and

(B) by inserting "and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary" before the period at the end.

(c) [<<Notes>>](#)

Effective Date.--The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III--IMPROVING PAYMENT ACCURACY

Sec. 3131.

PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) Rebasing Home Health Prospective Payment Amount.--

(1) In general.-- Section 1895(b)(3)(A) of the Social Security Act ([42 U.S.C. 1395fff\(b\)\(3\)\(A\)](#)) is amended--

(A) in clause (i)(III), by striking "For periods" and inserting "Subject to clause (iii), for periods"; and

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

"(iii) Adjustment for 2013 and subsequent years.--

"(I) In general.-- Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

"(II) Transition.-- The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any **[*428]** adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or

amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act."

(2) MedPAC study and report.--

(A) Study.-- The Medicare Payment Advisory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on--

- (i) access to care;
- (ii) quality outcomes;
- (iii) the number of home health agencies; and
- (iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) Report.-- Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) Program-specific Outlier Cap.-- Section 1895(b) of the Social Security Act ([42 U.S.C. 1395fff\(b\)](#)) is amended--

(1) in paragraph (3)(C), by striking "the aggregate" and all that follows through the period at the end and inserting "5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period."; and

(2) in paragraph (5)--

(A) by striking "Outliers.-- The Secretary" and inserting the following: "Outliers.--

"**(A) In general.--** Subject to subparagraph (B), the Secretary";

(B) in subparagraph (A), as added by subparagraph (A), by striking "5 percent" and inserting "2.5 percent"; and

(C) by adding at the end the following new subparagraph:

"(B) Program specific outlier cap.-- The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year."

(c) Application of the Medicare Rural Home Health Add-on Policy.-- Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; *117 Stat. 2283*), [<<Notes>>](#)

as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109-171; *120 Stat. 46*), is amended--

(1) in the section heading, by striking "one-year" and inserting "temporary"; and

(2) in subsection (a)--

[*429] (A) by striking ", and episodes" and inserting ", episodes";

(B) by inserting "and episodes and visits ending on or after April 1, 2010, and before January 1, 2016," after "January 1, 2007,"; and

(C) by inserting "(or, in the case of episodes and visits ending on or after April 1, 2010, and before January 1, 2016, 3 percent)" before the period at the end.

(d) [<<Notes>>](#)

Study and Report on the Development of Home Health Payment Reforms in Order To Ensure Access to Care and Quality Services.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act ([42 U.S.C. 1395fff](#)) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including--

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) Considerations.-- In conducting the study under paragraph (1), the Secretary shall consider whether certain factors [*430] should be used to measure patient severity of illness and access to care, such as--

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

(D) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) Report.-- Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) Consultations.-- In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with--

- (A) stakeholders representing home health agencies;
- (B) groups representing Medicare beneficiaries;
- (C) the Medicare Payment Advisory Commission;
- (D) the Inspector General of the Department of Health and Human Services; and
- (E) the Comptroller General of the United States.

Sec. 3132.

HOSPICE REFORM.

(a) Hospice Care Payment Reforms.--

(1) In general.-- Section 1814(i) of the Social Security Act ([42 U.S.C. 1395f\(i\)](#)), as amended by section 3004(c), is amended--

- (A) by redesignating paragraph (6) as paragraph (7); and
- (B) by inserting after paragraph (5) the following new paragraph:

"(6)

(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

"(B) The additional data and information to be collected under subparagraph (A) may include data and information on--

"(i) charges and payments;

"(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

"(iii) with respect to each type of service included in hospice care--

[*431] "(I) the number of days of hospice care attributable to the type of service;

"(II) the cost of the type of service; and

"(III) the amount of payment for the type of service;

"(iv) charitable contributions and other revenue of the hospice program;

"(v) the number of hospice visits;

"(vi) the type of practitioner providing the visit; and

"(vii) the length of the visit and other basic information with respect to the visit.

"(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

"(D)

(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

"(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

"(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).".

(2) Conforming amendments.-- Section 1814(i)(1)(C) of the Social Security Act ([42 U.S.C. 1395f\(i\)\(1\)\(C\)](#)) is amended--

(A) in clause (ii)--

(i) in the matter preceding subclause (I), by inserting "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)" after "subsequent fiscal year"; and

(ii) in subclause (VII), by inserting "(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv)," after "subsequent fiscal year"; and

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

"(iii) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase [*432] (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year."

(b) Adoption of MedPAC Hospice Program Eligibility Recertification Recommendations.-- Section 1814(a)(7) of the Social Security Act ([42 U.S.C. 1395f\(a\)\(7\)](#)) is amended--

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

(2) by adding at the end the following new subparagraph:

"(D) on and after January 1, 2011--

"(i) a hospice physician or nurse practitioner has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary); and

"(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and"

Sec. 3133.**IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

Section 1886 of the Social Security Act ([42 U.S.C. 1395ww](#)), as amended by sections 3001, 3008, and 3025, is amended--

- (1)** in subsection (d)(5)(F)(i), by striking "For" and inserting "Subject to subsection (r), for"; and
- (2)** by adding at the end the following new subsection:

"(r) Adjustments to Medicare DSH Payments.--

"(1) Empirically justified DSH payments.-- For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

"(2) Additional payment.-- In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

"(A) Factor one.-- A factor equal to the difference between--

"(i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

"(ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

"(B) Factor two.-- [*433] "(i) Fiscal years 2015, 2016, and 2017.--For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals--

"(I) who are uninsured in 2012, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on such Act that, if determined in the affirmative, would clear such Act for enrollment); and

"(II) who are uninsured in the most recent period for which data is available (as so calculated).

"(ii) 2018 and subsequent years.-- For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals--

"(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

"(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

"(C) Factor three.-- A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of--

"(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

"(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

"(3) Limitations on review.-- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

"(B) Any period selected by the Secretary for such purposes."

[*434] Sec. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) In General.-- Section 1848(c)(2) of the Social Security Act ([42 U.S.C. 1395w-4\(c\)\(2\)](#)) is amended by adding at the end the following new subparagraphs:

"(K) Potentially misvalued codes.--

"(i) In general.-- The Secretary shall--

"(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

"(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

"(ii) Identification of potentially misvalued codes.-- For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

"(iii) Review and adjustments.--

"(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

"(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

"(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

"(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

"(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes [***435**] for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (b).

"(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

"(L) Validating relative value units.--

"(i) In general.-- The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

"(ii) Components and elements of work.-- The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

"(iii) Scope of codes.-- The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

"(iv) Methods.-- The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

"(v) Adjustments.-- The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II)."

(b) <<Notes>>

Implementation.--

(1) Administration.--

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) Focusing CMS resources on potentially overvalued codes.-- Section 1868(a) of the Social Security Act ([42 U.S.C. 1395ee](#)(a)) is repealed.

[*436] Sec. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) Adjustment in Practice Expense To Reflect Higher Presumed Utilization.-- Section 1848 of the Social Security Act ([42 U.S.C. 1395w-4](#)) is amended--

(1) in subsection (b)(4)--

(A) in subparagraph (B), by striking "subparagraph (A)" and inserting "this paragraph"; and

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

"(C) Adjustment in practice expense to reflect higher presumed utilization.-- Consistent with the methodology for computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) furnished on or after January 1, 2010, the Secretary shall adjust such number of units so it reflects--

"(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 percent (rather than 50 percent) presumed rate of utilization of imaging equipment;

"(ii) in the case of services furnished on or after January 1, 2013, and before January 1, 2014, a 70 percent (rather than 50 percent) presumed rate of utilization of imaging equipment; and

"(iii) in the case of services furnished on or after January 1, 2014, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclauses:

"(III) Change in presumed utilization level of certain advanced diagnostic imaging services for 2010 through 2012.-- Effective for fee schedules established beginning with 2010 and ending with 2012, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 65 percent under subsection (b)(4)(C)(i) instead of a presumed rate of utilization of such equipment of 50 percent.

"(IV) Change in presumed utilization level of certain advanced diagnostic imaging services for 2013.-- Effective for fee schedules established for 2013, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 70 percent under subsection (b)(4)(C)(ii) instead of a presumed rate of utilization of such equipment of 50 percent.

"(V) Change in presumed utilization level of certain advanced diagnostic imaging services for 2014 and subsequent years.-- Effective for fee schedules established beginning with 2014, reduced expenditures attributable to the presumed [***437**] rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of a presumed rate of utilization of such equipment of 50 percent."

(b) Adjustment in Technical Component "discount" on Single-session Imaging to Consecutive Body Parts.-- Section 1848 of the Social Security Act ([42 U.S.C. 1395w-4](#)), as amended by subsection (a), is amended--

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

"(D) Adjustment in technical component discount on single-session imaging involving consecutive body parts.-- For services furnished on or after July 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent."; and

(2) in subsection (c)(2)(B)(v), by adding at the end the following new subclause:

"(VI) Additional reduced payment for multiple imaging procedures.-

- Effective for fee schedules established beginning with 2010 (but not applied for services furnished prior to July 1, 2010), reduced expenditures attributable to the increase in the multiple procedure payment reduction from 25 to 50 percent (as described in subsection (b)(4)(D)).".

(c) Analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services.—

Not later than January 1, 2013, the Chief Actuary of the Centers for Medicare & Medicaid Services shall make publicly available an analysis of whether, for the period of 2010 through 2019, the cumulative expenditure reductions under title XVIII of the Social Security Act that are attributable to the adjustments under the amendments made by this section are projected to exceed \$ 3,000,000,000.

Sec. 3136.

REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) In General.-- Section 1834(a)(7)(A) of the Social Security Act ([42 U.S.C. 1395m](#)(a)(7)(A)) is amended--

(1) in clause (i)--

(A) in subclause (II), by inserting "subclause (III) and" after "Subject to"; and

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

"(III) Special rule for power-driven wheelchairs.-- For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively."; and

(2) in clause (iii)--

(A) in the heading, by inserting "complex, rehabilitative" before "power-driven"; and

(B) by inserting "complex, rehabilitative" before "power-driven".

[*438] (b) Technical Amendment.--Section 1834(a)(7)(C)(ii)(II) of the Social Security Act ([42 U.S.C. 1395m](#)(a)(7)(C)(ii)(II)) is amended by striking "(A)(ii) or".

(c) <<Notes>>

Effective Date.--

(1) In general.-- Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) Application to competitive bidding.-- The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act ([42 U.S.C. 1395w-3](#)) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

Sec. 3137.

HOSPITAL WAGE INDEX IMPROVEMENT.

(a) Extension of Section 508 Hospital Reclassifications.--

(1) In general.-- Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 ([42 U.S.C. 1395](#) note), [<<Notes>>](#)

as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking "September 30, 2009" and inserting "September 30, 2010".

(2) <<Notes>>

Use of particular wage index in fiscal year 2010.-- For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 ([74 Fed. Reg. 43754](#)), and any subsequent corrections.

(b) <<Notes>>

Plan for Reforming the Medicare Hospital Wage Index System.--

(1) In general.-- Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) Details.-- In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled "Report to Congress: Promoting Greater Efficiency in Medicare", including establishing a new hospital compensation index system that--

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

[*439] **(E)** addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) Consultation.-- In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) Use of Particular Criteria for Determining Reclassifications.-- Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital (as defined in paragraph (1)(B) of section 1886(d) of the Social Security Act ([42 U.S.C. 1395www](#)(d)) for the purposes described in paragraph (10)(D)(v) of such section for fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b)), the Geographic Classification Review Board established under paragraph (10) of such section shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

Sec. 3138.

TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act ([42 U.S.C. 1395](#)(t)) is amended by adding at the end the following new paragraph:

"(18) Authorization of adjustment for cancer hospitals.--

"(A) Study.-- The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

"(B) Authorization of adjustment.-- Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011."

Sec. 3139.

PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) In General.-- Section 1847A of the Social Security Act ([42 U.S.C. 1395w-3a](#)) is amended--

(1) in subsection (b)--

(A) in paragraph (1)--

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

(ii) in subparagraph (B), by striking the period at the end and inserting "; or"; and

(iii) by adding at the end the following new subparagraph:

[*440] "(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8)."; and

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

"(8) Biosimilar biological product.-- The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of--

"(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

"(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I))."; and

(2) in subsection (c)(6), by adding at the end the following new subparagraph:

"(H) Biosimilar biological product.-- The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in

an application for another biological product licensed under section 351 of the Public Health Service Act.

"(l) Reference biological product.-- The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product."

(b) <<Notes>>

Effective Date.--The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

Sec. 3140.

<<Notes>>

MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) Establishment.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act ([42 U.S.C. 1395](#) et seq.) from funds otherwise paid under such title to such hospice programs.

(2) Duration.-- The demonstration program under this section shall be conducted for a 3-year period.

(3) Sites.-- The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall be conducted. Such hospice programs shall be located in urban and rural areas.

(b) Independent Evaluation and Reports.--

(1) Independent evaluation.-- The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program [***441**] has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) Reports.-- The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) Budget Neutrality.-- With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

Sec. 3141.

<<Notes>>

APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 ([42 U.S.C. 1395ww](#) note) and paragraph (h)(4) of section 412.64 of title 42, Code of

Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

Sec. 3142.

HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) Study.--

(1) In general.-- The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act ([42 U.S.C. 1395ww](#)). Such study shall include an analysis of--

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to Medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) Urban Medicare-dependent hospital defined.-- For purposes of this section, the term "urban Medicare-dependent hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that--

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act ([42 U.S.C. 1395f\(l\)](#)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a Medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

[*442] (B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) Report.-- Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Sec. 3143.

[<<Notes>>](#)

PROTECTING HOME HEALTH BENEFITS.

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.

Subtitle C--Provisions Relating to Part C

Sec. 3201.

MEDICARE ADVANTAGE PAYMENT.

(a) MA Benchmark Based on Plan's Competitive Bids.--

(1) In general.-- Section 1853(j) of the Social Security Act ([42 U.S.C. 1395w-23\(j\)](#)) is amended--

(A) by striking " Amounts.--For purposes" and inserting " Amounts.--

"(1) In general.-- For purposes";

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)--

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking "an amount equal to" and all that follows through the end and inserting "an amount equal to--

"(I) for years before 2007, 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

"(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

"(III) for 2012, the sum of--

"(aa) 2/3 of the quotient of--

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

"(IV) for 2013, the sum of--

"(aa) 1/3 of the quotient of--

[*443] **"(AA)** the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

"(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

"(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or";

(iii) in clause (ii), as redesignated by clause (i), by striking "subparagraph (A)" and inserting "clause (i)";

(D) by adding at the end the following new paragraphs:

"(2) Computation of ma competitive benchmark amount.--

"(A) In general.-- Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA

plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

"(B) Weighting rules.--

"(i) Single plan rule.-- In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

"(ii) Use of simple average among multiple plans if no plans offered in previous year.-- In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

"(3) Cap on ma competitive benchmark amount.-- In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount [*444] that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year."; and

(E) in subsection (k)(2)(B)(ii)(III), by striking "(j)(1)(A)" and inserting "(j)(1)(A)(i)".

(2) Conforming amendments.--

(A) Section 1853(k)(2) of the Social Security Act ([42 U.S.C. 1395w-23](#)(k)(2)) is amended--

(i) in subparagraph (A), by striking "through 2010" and inserting "and subsequent years"; and

(ii) in subparagraph (C)--

(I) in clause (iii), by striking "and" at the end;

(II) in clause (iv), by striking the period at the end and inserting "; and"; and

(III) by adding at the end the following new clause:

"(v) for 2011 and subsequent years, 0.00."

(B) Section 1854(b) of the Social Security Act ([42 U.S.C. 1395w-24](#)(b)) is amended--

(i) in paragraph (3)(B)(i), by striking "1853(j)(1)" and inserting "1853(j)(1)(A)"; and

(ii) in paragraph (4)(B)(i), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)".

(C) [Notes](#)

Section 1858(f) of the Social Security Act ([42 U.S.C. 1395w-27](#)(f)) is amended--

(i) in paragraph (1), by striking "1853(j)(2)" and inserting "1853(j)(1)(B)"; and

(ii) in paragraph (3)(A), by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(D) Section 1860C-1(d)(1)(A) of the Social Security Act ([42 U.S.C. 1395w-29](#)(d)(1)(A)) is amended by striking "1853(j)(1)(A)" and inserting "1853(j)(1)(A)(i)".

(b) Reduction of National Per Capita Growth Percentage for 2011.-- Section 1853(c)(6) of the Social Security Act ([42 U.S.C. 1395w-23](#)(c)(6)) is amended--

(1) in clause (v), by striking "and" at the end;

(2) in clause (vi)--

- (A) by striking "for a year after 2002" and inserting "for 2003 through 2010"; and
- (B) by striking the period at the end and inserting a comma; and
- (C) by adding at the end the following new clauses:
 - "(vii) for 2011, 3 percentage points; and
 - "(viii) for a year after 2011, 0 percentage points."

(c) Enhancement of Beneficiary Rebates.-- Section 1854(b)(1)(C)(i) of the Social Security Act ([42 U.S.C. 1395w-24\(b\)\(1\)\(C\)\(i\)](#)) is amended by inserting "(or 100 percent in the case of plan years beginning on or after January 1, 2014)" after "75 percent".

(d) Bidding Rules.--

(1) Requirements for information submitted.-- Section 1854(a)(6)(A) of the Social Security Act ([42 U.S.C. 1395w-24\(a\)\(6\)\(A\)](#)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: "Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries [***445**] and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v)."

(2) Establishment of actuarial guidelines.-- Section 1854(a)(6)(B) of the Social Security Act ([42 U.S.C. 1395w-24\(a\)\(6\)\(B\)](#)) is amended--

- (A) in clause (i), by striking "(iii) and (iv)" and inserting "(iii), (iv), and (v)"; and
- (B) by adding at the end the following new clause:

"(v) Establishment of actuarial guidelines.--

"(I) In general.-- In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish--

"(aa) actuarial guidelines for the submission of bid information under this paragraph; and

"(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

"(II) Denial of bid amounts.-- The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (I).

"(III) Refusal to accept certain bids due to misrepresentations and failures to adequately meet requirements.-- In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline."

(3) <<Notes>>

Effective date.-- The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA Local Plan Service Areas.--

(1) In general.-- Section 1853(d) of the Social Security Act ([42 U.S.C. 1395w-23\(d\)](#)) is amended--

(A) in the subsection heading, by striking " MA Region" and inserting " MA Region; MA Local Plan Service Area";

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

"(A) with respect to an MA local plan--

"(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

[*446] "(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and"; and

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

"(5) **MA local plan service area.--** For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

"(A) **Urban areas.--**

"(i) **In general.--** Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

"(ii) **CBSA covering more than one state.--** In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

"(B) **Rural areas.--** Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

"(C) **Refinements to service areas.--** For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

"(D) **Additional authority to make limited exceptions to service area requirements for ma local plans.--** The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the Patient Protection and Affordable Care Act)--

"(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

"(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan."

(2) **Conforming amendments.--**

(A) **In general.--**

(i) Section 1851(b)(1) of the Social Security Act ([42 U.S.C. 1395w-21\(b\)\(1\)](#)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act ([42 U.S.C. 1395w-23\(b\)\(1\)\(B\)\(i\)](#))--

[*447] (I) in the matter preceding subclause (I), by striking "MA payment area" and inserting "MA local area (as defined in subsection (d)(2))"; and

(II) in subclause (I), by striking "MA payment area" and inserting "MA local area (as so defined)".

(iii) Section 1853(b)(4) of such Act ([42 U.S.C. 1395w-23](#)(b)(4)) is amended by striking "Medicare Advantage payment area" and inserting "MA local area (as so defined)".

(iv) Section 1853(c)(1) of such Act ([42 U.S.C. 1395w-23](#)(c)(1)) is amended--

(I) in the matter preceding subparagraph (A), by striking "a Medicare Advantage payment area that is"; and

(II) in subparagraph (D)(i), by striking "MA payment area" and inserting "MA local area (as defined in subsection (d)(2))".

(v) Section 1854 of such Act ([42 U.S.C. 1395w-24](#)) is amended by striking subsection (h).

(B) [Notes](#)

Effective date.--The amendments made by this paragraph shall take effect on January 1, 2012.

(f) Performance Bonuses.--

(1) MA plans.--

(A) In general.-- Section 1853 of the Social Security Act ([42 U.S.C. 1395w-23](#)) is amended by adding at the end the following new subsection:

"(n) Performance Bonuses.--

"(1) Care coordination and management performance bonus.--

"(A) In general.-- For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of--

"(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year; and

"(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

"(B) Limitation.-- In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

"(C) Programs described.-- The following programs are described in this paragraph:

"(i) Care management programs that--

"(I) target individuals with 1 or more chronic conditions;

[*448] **"(II)** identify gaps in care; and

"(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

"(ii) Programs that focus on patient education and self-management of health conditions, including interventions that--

"(I) help manage chronic conditions;

"(II) reduce declines in health status; and

"(III) foster patient and provider collaboration.

"(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

"(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

"(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

"(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

"(vii) Medication therapy management programs that are more extensive than is required under section 1860D-4(c) (as determined by the Secretary).

"(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

"(ix) Such other care management and coordination programs as the Secretary determines appropriate.

"(D) Conduct of program in urban and rural areas.-- An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

"(E) Reporting of data.-- Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

"(F) Periodic auditing.-- The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

"(2) Quality performance bonuses.--

"(A) Quality bonus.-- For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or [*449] comparable rating) on a rating system described in subparagraph (C) in an amount equal to--

"(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year; and

"(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year.

"(B) Improved quality bonus.-- For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

"(C) Use of rating system.-- For purposes of subparagraph (A), a rating system described in this paragraph is--

"(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

"(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

"(D) Data used in determining score.--

"(i) In general.-- The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

"(ii) Plans that fail to report data.-- An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

"(3) Quality bonus for new and low enrollment ma plans.--

"(A) New ma plans.-- For years beginning with 2014, in the case of an MA plan that first submits a bid undersection 1854(a)(1)(A) for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1851(e), and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for [*450] individuals enrolled under the original Medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

"(B) Low enrollment plans.-- For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

"(4) Risk adjustment.-- The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

"(5) Notification.-- The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services."

(B) Conforming amendment.-- Section 1853(a)(1)(B) of the Social Security Act ([42 U.S.C. 1395w-23](#)(a)(1)(B)) is amended--

(i) in clause (i), by inserting "and any performance bonus under subsection (n)" before the period at the end; and

(ii) in clause (ii), by striking "(G)" and inserting "(G), plus the amount (if any) of any performance bonus under subsection (n)".

(2) Application of performance bonuses to ma regional plans.-- Section 1858 of the Social Security Act ([42 U.S.C. 1395w-27a](#)) is amended--

(A) in subsection (f)(1), by striking "subsection (e)" and inserting "subsections (e) and (i)"; and

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

"(i) Application of Performance Bonuses to MA Regional Plans.-- For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection."

(g) Grandfathering Supplemental Benefits for Current Enrollees After Implementation of Competitive Bidding.-- [*451] Section 1853 of the Social Security Act ([42 U.S.C. 1395w-23](#)), as amended by subsection (f), is amended by adding at the end the following new subsection:

"(o) Grandfathering Supplemental Benefits for Current Enrollees After Implementation of Competitive Bidding.--

"(1) Identification of areas.-- The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(2) Election to provide rebates to grandfathered enrollees.--

"(A) In general.-- For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

"(B) Applicable amount.-- For purposes of this subsection, the term 'applicable amount' means--

"(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

"(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

"(3) Special rules for plans in identified areas.-- Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

"(A) Payments.-- The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to--

"(i) for 2012 and 2013, the sum of--

"(I) the bid amount under section 1854(a) for the MA local plan; and

"(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

"(ii) for 2014 and subsequent years, the sum of--

"(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

[*452] "(II) the applicable amount (as so defined) for the MA local plan for the year.

"(B) Requirement to submit bids under competitive bidding.-- The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

"(C) Nonapplication of bonus payments and any other rebates.-- The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

"(D) Nonapplication of uniform bid and premium amounts to grandfathered enrollees.-- Section 1854(c) shall not apply with respect to the MA local plan.

"(E) Nonapplication of limitation on application of plan rebates toward payment of part b premium.-- Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

"(F) Risk adjustment.-- The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

"(4) Definition of grandfathered enrollee.-- In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1)."

(h) Transitional Extra Benefits.-- Section 1853 of the Social Security Act ([42 U.S.C. 1395w-23](#)), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

"(p) Transitional Extra Benefits.--

"(1) In general.-- For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

"(2) Enrollees described.-- An enrollee described in this paragraph is an individual who--

"(A) enrolls in an MA local plan in an applicable area; and

"(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

"(3) Applicable areas.-- In this subsection, the term 'applicable area' means the following:

"(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than \$ 100.

"(B) A county where--

[*453] **"(i)** the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

"(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

"(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

"(4) Review of plan bids.-- In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

"(5) Funding.-- The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of an amount not to exceed \$ 5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection."

(i) Nonapplication of Competitive Bidding and Related Provisions and Clarification of MA Payment Area for PACE Programs.--

(1) Nonapplication of competitive bidding and related provisions for pace programs.-- Section 1894 of the Social Security Act ([42 U.S.C. 1395eee](#)) is amended--

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

"(h) Nonapplication of Competitive Bidding and Related Provisions Under Part C.-- With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

"(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

"(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

"(3) Section 1853(n), relating to the payment of performance bonuses.

[*454] **"(4)** Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

"(5) Section 1853(p), relating to transitional extra benefits."

(2) Special rule for ma payment area for pace programs.-- Section 1853(d) of the Social Security Act ([42 U.S.C. 1395w-23](#)(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

"(6) Special rule for ma payment area for pace programs.-- For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2))."

Sec. 3202.

BENEFIT PROTECTION AND SIMPLIFICATION.

(a) Limitation on Variation of Cost Sharing for Certain Benefits.--

(1) In general.-- Section 1852(a)(1)(B) of the Social Security Act ([42 U.S.C. 1395w-22](#)(a)(1)(B)) is amended--

(A) in clause (i), by inserting ", subject to clause (iii)," after "and B or"; and

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

"(iii) Limitation on variation of cost sharing for certain benefits.-- Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

"(iv) Services described.-- The following services are described in this clause:

"(I) Chemotherapy administration services.

"(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

"(III) Skilled nursing care.

"(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

"(v) Exception.-- In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i)."

(2) <<Notes>>

Effective date.-- The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) Application of Rebates, Performance Bonuses, and Premiums.--

(1) Application of rebates.-- Section 1854(b)(1)(C) of the Social Security Act ([42 U.S.C. 1395w-24\(b\)\(1\)\(C\)](#)) is amended--

(A) in clause (ii), by striking "rebate.--A rebate" and inserting "rebate for plan years before 2012.-- For plan years before 2012, a rebate";

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

"(iii) Form of rebate for plan year 2012 and subsequent plan years.-- For plan years beginning on or after January 1, 2012, a rebate required under **[*455]** this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

"(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original Medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original Medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

"(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original Medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

"(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original Medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).".

(2) Application of performance bonuses.-- Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

"(6) Application of performance bonuses.-- For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).".

(3) Application of ma monthly supplementary beneficiary premium.-- Section 1854(b)(2)(C) of the Social Security Act ([42 U.S.C. 1395w-24\(b\)\(2\)\(C\)](#)) is amended--

(A) by striking "Premium.--The term" and inserting"premium.--

"(i) In general.-- The term"; and

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

"(ii) Application of ma monthly supplementary beneficiary premium.-- For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).".

[*456] Sec. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act ([42 U.S.C. 1395w-23\(a\)\(1\)\(C\)](#)) is amended by adding at the end the following new clause:

"(iii) Application of coding intensity adjustment for 2011 and subsequent years.--

"(I) Requirement to apply in 2011 through 2013.-- In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

"(II) Authority to apply in 2014 and subsequent years.-- The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years."

Sec. 3204.

SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) Annual 45-day Period for Disenrollment From MA Plans To Elect To Receive Benefits Under the Original Medicare Fee-for-service Program.--

(1) <<Notes>>

In general.-- Section 1851(e)(2)(C) of the Social Security Act ([42 U.S.C. 1395w-1](#)(e)(2)(C)) is amended to read as follows:

"(C) Annual 45-day period for disenrollment from MA plans to elect to receive benefits under the original Medicare fee-for-service program.-- Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original Medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D-1."

(2) <<Notes>>

Effective date.-- The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) Timing of the Annual, Coordinated Election Period Under Parts C and D.-- Section 1851(e)(3)(B) of the Social Security Act ([42 U.S.C. 1395w-1](#)(e)(3)(B)) is amended--

(1) <<Notes>>

in clause (iii), by striking "and" at the end;

(2) in clause (iv)--

(A) by striking "and succeeding years" and inserting ", 2008, 2009, and 2010"; and

(B) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new clause:

"(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year."

[*457] Sec. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) Extension of SNP Authority.-- Section 1859(f)(1) of the Social Security Act ([42 U.S.C. 1395w-28](#)(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is amended by striking "2011" and inserting "2014".

(b) Authority To Apply Frailty Adjustment Under PACE Payment Rules.-- Section 1853(a)(1)(B) of the Social Security Act ([42 U.S.C. 1395w-23](#)(a)(1)(B)) is amended by adding at the end the following new clause:

"(iv) Authority to apply frailty adjustment under pace payment rules for certain specialized ma plans for special needs individuals.--

"(I) In general.-- Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

"(II) Plan described.-- A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program."

(c) Transition and Exception Regarding Restriction on Enrollment.-- Section 1859(f) of the Social Security Act ([42 U.S.C. 1395w-28](#)(f)) is amended by adding at the end the following new paragraph:

"(6) Transition and exception regarding restriction on enrollment.--

"(A) In general.-- Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to--

"(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

"(ii) the original Medicare fee-for-service program under parts A and B.

"(B) Applicable individuals.-- For purposes of clause (i), the term 'applicable individual' means an individual who--

"(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

"(C) Exception.-- The Secretary shall provide for an exception to the transition described in subparagraph (A) [***458**] for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

"(D) Timeline for initial transition.-- The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013."

(d) Temporary Extension of Authority To Operate but No Service Area Expansion for Dual Special Needs Plans That Do Not Meet Certain Requirements.-- Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) [<<Notes>>](#) is amended by striking "December 31, 2010" and inserting "December 31, 2012".

(e) Authority To Require Special Needs Plans Be NCQA Approved.-- Section 1859(f) of the Social Security Act ([42 U.S.C. 1395w-28](#)(f)), as amended by subsections (a) and (c), is amended--

(1) in paragraph (2), by adding at the end the following new subparagraph:

"(C) If applicable, the plan meets the requirement described in paragraph (7).";

(2) in paragraph (3), by adding at the end the following new subparagraph:

"(E) If applicable, the plan meets the requirement described in paragraph (7).";

(3) in paragraph (4), by adding at the end the following new subparagraph:

"(C) If applicable, the plan meets the requirement described in paragraph (7).";
and

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

"(7) Authority to require special needs plans be NCQA approved.-- For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).".

(f) Risk Adjustment.-- Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i-23(a)(1)(C)) [<<Notes>>](#)

is amended by adding at the end the following new clause:

"(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions.--

"(I) In general.-- For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6)).

"(II) Individuals described.-- An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who **[*459]** enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

"(III) Evaluation.-- For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

"(IV) Publication of evaluation and revisions.-- The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.".

(g) Technical Correction.-- Section 1859(f)(5) of the Social Security Act ([42 U.S.C. 1395w-28\(f\)\(5\)](#)) is amended, in the matter preceding subparagraph (A), by striking "described in subsection (b)(6)(B)(i)".

Sec. 3206.

EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act ([42 U.S.C. 1395mm\(h\)\(5\)\(C\)\(ii\)](#)) is amended, in the matter preceding subclause (I), by striking "January 1, 2010" and inserting "January 1, 2013".

Sec. 3207.

[<<Notes>>](#)

TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject "2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans") to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act ([42 U.S.C. 1395w-27](#)(i)(2)) and that had enrollment as of October 1, 2009.

Sec. 3208.

MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) In General.-- Section 1859 of the Social Security Act ([42 U.S.C. 1395w-28](#)) is amended by adding at the end the following new subsection:

"(g) Special Rules for Senior Housing Facility Plans.--

"(1) In general.-- In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

[*460] "(2) Medicare advantage senior housing facility plan described.-- For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that--

"(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

"(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

"(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

"(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year."

(b) <<Notes>>

Effective Date.--The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

Sec. 3209.

AUTHORITY TO DENY PLAN BIDS.

(a) In General.-- Section 1854(a)(5) of the Social Security Act ([42 U.S.C. 1395w-24](#)(a)(5)) is amended by adding at the end the following new subparagraph:

"(C) Rejection of bids.--

"(i) In general.-- Nothing in this section shall be construed as requiring the Secretary to accept any or every bid submitted by an MA organization under this subsection.

"(ii) Authority to deny bids that propose significant increases in cost sharing or decreases in benefits.-- The Secretary may deny a bid submitted by an MA organization for an

MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under the plan."

(b) Application Under Part D.-- Section 1860D-11(d) of such Act ([42 U.S.C. 1395w-111\(d\)](#)) is amended by adding at the end the following new paragraph:

"(3) Rejection of bids.-- Paragraph (5)(C) of section 1854(a) shall apply with respect to bids submitted by a PDP sponsor under subsection (b) in the same manner as such paragraph applies to bids submitted by an MA organization under such section 1854(a)."

(c) <<Notes>>

Effective Date.--The amendments made by this section shall apply to bids submitted for contract years beginning on or after January 1, 2011.

Sec. 3210.

DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) In General.-- Section 1882 of the Social Security Act ([42 U.S.C. 1395ss](#)) is amended by adding at the end the following new subsection:

"(y) Development of New Standards for Certain Medicare Supplemental Policies.--

"(1) In general.-- The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage [*461] the use of appropriate physicians' services under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

"(2) Benefit packages described.-- The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'."

(b) Conforming Amendment.-- Section 1882(o)(1) of the Social Security Act ([42 U.S.C. 1395ss\(o\)\(1\)](#)) is amended by striking ", and (w)" and inserting "(w), and (y)".

Subtitle D--

Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans

Sec. 3301.

MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) Condition for Coverage of Drugs Under Part D.-- Part D of Title XVIII of the Social Security Act ([42 U.S.C. 1395w-101 et seq.](#)), is amended by adding at the end the following new section:

" Condition for Coverage of Drugs Under This Part

"Sec. 1860D-43.

[<<Notes>>](#)

(a) In General.--In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D-2(e)) of a manufacturer, the manufacturer must--

"(1) participate in the Medicare coverage gap discount program under section 1860D-14A;

"(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

"(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

"(b) **Effective Date.**-- Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

"(c) **Authorizing Coverage for Drugs Not Covered Under Agreements.**-- Subsection (a) shall not apply to the dispensing of a covered part D drug if--

"(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

[*462] "(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

"(d) **Definition of Manufacturer.**-- In this section, the term 'manufacturer' has the meaning given such term in section 1860D-14A(g)(5).".

(b) Medicare Coverage Gap Discount Program.-- Part D of title XVIII of the Social Security Act ([42 U.S.C. 1395w-101](#)) is amended by inserting after section 1860D-14 the following new section:

" Medicare Coverage Gap Discount Program

"**Sec. 1860D-14A.**

[<<Notes>>](#)

(a) Establishment.--The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the 'program') by not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1). The Secretary shall establish a model agreement for use under the program by not later than April 1, 2010, in consultation with manufacturers, and allow for comment on such model agreement.

"(b) **Terms of Agreement.**--

"(1) **In general.**--

"(A) **Agreement.**-- An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

"(B) **Provision of discounted prices at the point-of-sale.**-- Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

"(C) **Timing of agreement.**--

"(i) **Special rule for 2010 and 2011.**-- In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than May 1, 2010.

"(ii) **2012 and subsequent years.**-- In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a

subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(2) Provision of appropriate data.-- Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements under the program.

"(3) Compliance with requirements for administration of program.-- Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the [*463] program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

"(4) Length of agreement.--

"(A) In general.-- An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) Termination.--

"(i) By the secretary.-- The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice to the manufacturer of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, and such hearing shall take place prior to the effective date of the termination with sufficient time for such effective date to be repealed if the Secretary determines appropriate.

"(ii) By a manufacturer.-- A manufacturer may terminate an agreement under this section for any reason. Any such termination shall be effective, with respect to a plan year--

"(I) if the termination occurs before January 30 of a plan year, as of the day after the end of the plan year; and

"(II) if the termination occurs on or after January 30 of a plan year, as of the day after the end of the succeeding plan year.

"(iii) Effectiveness of termination.-- Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

"(iv) Notice to third party.-- The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

"(c) Duties Described and Special Rule for Supplemental Benefits.--

"(1) Duties described.-- The duties described in this subsection are the following:

"(A) Administration of program.-- Administering the program, including--

"(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

"(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

"(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, [*464] it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

"(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between--

"(I) the negotiated price of the applicable drug; and

"(II) the discounted price of the applicable drug;

"(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify;

"(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2); and

"(vii) providing a reasonable dispute resolution mechanism to resolve disagreements between manufacturers, applicable beneficiaries, and the third party with a contract under subsection (d)(3).

"(B) Monitoring compliance.--

"(i) **In general.--** The Secretary shall monitor compliance by a manufacturer with the terms of an agreement under this section.

"(ii) **Notification.--** If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

"(C) Collection of data from prescription drug plans and ma-pd plans.-- The Secretary may collect appropriate data from prescription drug plans and MA-PD plans in a timeframe that allows for discounted prices to be provided for applicable drugs under this section.

"(2) Special rule for supplemental benefits.-- For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

"(d) Administration.--

"(1) In general.-- Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

[*465] **"(2) Limitation.--**

"(A) In general.-- Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

"(B) Exception.-- The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and

ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

"(3) Contract with third parties.-- The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party--

"(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

"(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

"(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

"(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

"(4) Performance requirements.-- The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

"(5) Implementation.-- The Secretary may implement the program under this section by program instruction or otherwise.

"(6) Administration.-- Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

"(e) Enforcement.--

"(1) Audits.-- Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

"(2) Civil money penalty.--

"(A) In general.-- The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of--

[*466] **"(i)** the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer had failed to provide; and

"(ii) 25 percent of such amount.

"(B) Application.-- The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(f) Clarification Regarding Availability of Other Covered Part D Drugs.-- Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in).

"(g) Definitions.-- In this section:

"(1) Applicable beneficiary.-- The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug--

"(A) is enrolled in a prescription drug plan or an MA-PD plan;

"(B) is not enrolled in a qualified retiree prescription drug plan;

"(C) is not entitled to an income-related subsidy under section 1860D-14(a);

"(D) is not subject to a reduction in premium subsidy under section 1839(i); and

"(E) who--

"(i) has reached or exceeded the initial coverage limit under section 1860D-2(b)(3) during the year; and

"(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B).

"(2) Applicable drug.-- The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug--

"(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (other than a product licensed under subsection (k) of such section 351); and**"(B)**

(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan uses a formulary, which is on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in;

"(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA-PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in; or

"(iii) is provided through an exception or appeal.

"(3) Applicable number of calendar days.-- The term 'applicable number of calendar days' means--

[*467] "(A) with respect to claims for reimbursement submitted electronically, 14 days; and

"(B) with respect to claims for reimbursement submitted otherwise, 30 days.

"(4) Discounted price.--

"(A) In general.-- The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

"(B) Clarification.-- Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

"(C) Special case for certain claims.-- In the case where the entire amount of the negotiated price of an individual claim for an applicable drug with respect to an applicable beneficiary does not fall at or above the initial coverage limit under section 1860D-2(b)(3) and below the annual out-of-pocket threshold specified in section 1860D-2(b)(4)(B) for the year, the manufacturer of the applicable drug shall provide the discounted price under this section on only the portion of the negotiated price of the applicable drug that falls at or above such initial coverage limit and below such annual out-of-pocket threshold.

"(5) Manufacturer.-- The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

"(6) Negotiated price.-- The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

"(7) Qualified retiree prescription drug plan.-- The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D-22(a)(2).".

(c) Inclusion in Incurred Costs.--

(1) In general.-- Section 1860D-2(b)(4) of the Social Security Act ([42 U.S.C. 1395w](#)-102(b)(4)) is amended--

(A) in subparagraph (C), in the matter preceding clause (i), by striking "In applying" and inserting "Except as provided in subparagraph (E), in applying"; and

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

"(E) Inclusion of costs of applicable drugs under Medicare coverage gap discount program.-- In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D-14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare coverage gap discount [***468**] program under section 1860D-14A, regardless of whether part of such costs were paid by a manufacturer under such program."

(2) <<Notes>>

Effective date.-- The amendments made by this subsection shall apply to costs incurred on or after July 1, 2010.

(d) Conforming Amendment Permitting Prescription Drug Discounts.--

(1) In general.-- Section 1128B(b)(3) of the Social Security Act ([42 U.S.C. 1320a-7b](#)(b)(3)) is amended--

(A) by striking "and" at the end of subparagraph (G);

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; *117 Stat. 2213*)--

(i) by moving such subparagraph 2 EMS to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (*117 Stat. 2287*)--

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 EMS to the left; and

(iii) by striking the period at the end and inserting "; and"; and

(D) by adding at the end the following new subparagraph:

"(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D-14A(g)) of a manufacturer that is furnished to an applicable beneficiary (as defined in

paragraph (1) of such section) under the Medicare coverage gap discount program under section 1860D-14A."

(2) Conforming amendment to definition of best price under Medicaid.-- Section 1927(c)(1)(C)(i)(VI) of the Social Security Act ([42 U.S.C. 1396r-8\(c\)\(1\)\(C\)\(i\)\(VI\)](#)) is amended by inserting ", or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D-14A" before the period at the end.

(3) <<Notes>>

Effective date.-- The amendments made by this subsection shall apply to drugs dispensed on or after July 1, 2010.

Sec. 3302.

IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) In General.-- Section 1860D-14(b)(2)(B)(iii) of the Social Security Act ([42 U.S.C. 1395w-114\(b\)\(2\)\(B\)\(iii\)](#)) is amended by inserting ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)" before the period at the end.

(b) <<Notes>>

Effective Date.--The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

[*469] Sec. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

(a) In General.-- Section 1860D-14(a) of the Social Security Act ([42 U.S.C. 1395w-114\(a\)](#)) is amended by adding at the end the following new paragraph:

"(5) Waiver of de minimis premiums.-- The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimis. If such premium is waived under the plan, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount."

(b) Authorizing the Secretary To Auto-enroll Subsidy Eligible Individuals in Plans That Waive De Minimis Premiums.-- Section 1860D-1(b)(1) of the Social Security Act ([42 U.S.C. 1395w-101\(b\)\(1\)](#)) is amended--

(1) in subparagraph (C), by inserting "except as provided in subparagraph (D)," after "shall include,"

(2) by adding at the end the following new subparagraph:

"(D) Special rule for plans that waive de minimis premiums.-- The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D-14(a)(3)) who has failed to enroll in a prescription drug plan or an MA-PD plan, for the enrollment in a prescription drug plan or MA-PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D-14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment."

(c) <<Notes>>

Effective Date.--The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

Sec. 3304.

SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) In General.-- Section 1860D-14(a)(3)(B) of the Social Security Act ([42 U.S.C. 1395w-114\(a\)\(3\)\(B\)](#)) is amended by adding at the end the following new clause:

"(vi) Special rule for widows and widowers.-- Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective."

[*470] (b) [<<Notes>>](#)

Effective Date.--The amendment made by subsection (a) shall take effect on January 1, 2011.

Sec. 3305.

IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA-PD PLANS.

Section 1860D-14 of the Social Security Act ([42 U.S.C. 1395w-114](#)) is amended--

- (1)** by redesignating subsection (d) as subsection (e); and
- (2)** by inserting after subsection (c) the following new subsection:

"(d) Facilitation of Reassignments.-- Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with--

"(1) information on formulary differences between the individual's former plan and the plan to which the individual is reassigned with respect to the individual's drug regimens; and

"(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D-4(g), bring an appeal under section 1860D-4(h), or resolve a grievance under section 1860D-4(f)."

Sec. 3306.

FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) Additional Funding for State Health Insurance Programs.-- Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 ([42 U.S.C. 1395b-3](#) note) is amended by striking "[42 U.S.C. 1395w-23\(f\)](#)" and all that follows through the period at the end and inserting "[42 U.S.C. 1395w-23\(f\)](#)", to the Centers for Medicare & Medicaid Services Program Management Account--

"(i) for fiscal year 2009, of \$ 7,500,000; and

"(ii) for the period of fiscal years 2010 through 2012, of \$ 15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended."

(b) Additional Funding for Area Agencies on Aging.-- Subsection (b)(1)(B) of such section 119 is amended by striking "[\(42 U.S.C. 1395w-23\(f\)\)](#)" and all that follows through the period at the end and inserting "[\(42 U.S.C. 1395w-23\(f\)\)](#), to the Administration on Aging--

"(i) for fiscal year 2009, of \$ 7,500,000; and

"(ii) for the period of fiscal years 2010 through 2012, of \$ 15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended."

(c) Additional Funding for Aging and Disability Resource Centers.-- Subsection (c)(1)(B) of such section 119 is amended by striking "[\(42 U.S.C. 1395w-23\(f\)\)](#)" and all that follows through the period at the end and inserting "[\(42 U.S.C. 1395w-23\(f\)\)](#), to the Administration on Aging--

"(i) for fiscal year 2009, of \$ 5,000,000; and

"(ii) for the period of fiscal years 2010 through 2012, of \$ 10,000,000.

[*471] Amounts appropriated under this subparagraph shall remain available until expended."

(d) Additional Funding for Contract With the National Center for Benefits and Outreach Enrollment.-
- Subsection (d)(2) of such section 119 is amended by striking "[\(42 U.S.C. 1395w-23\(f\)\)](#)" and all that follows through the period at the end and inserting "[\(42 U.S.C. 1395w-23\(f\)\)](#), to the Administration on Aging--

"(i) for fiscal year 2009, of \$ 5,000,000; and

"(ii) for the period of fiscal years 2010 through 2012, of \$ 5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended."

(e) Secretarial Authority To Enlist Support in Conducting Certain Outreach Activities.-- Such section 119 is amended by adding at the end the following new subsection:

"(g) Secretarial Authority To Enlist Support in Conducting Certain Outreach Activities.-- The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence."

Sec. 3307.

IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) [<<Notes>>](#)

Improving Formulary Requirements.--Section 1860D-4(b)(3)(G) of the Social Security Act is amended to read as follows:

"(G) Required inclusion of drugs in certain categories and classes.--

"(i) Formulary requirements.--

"(I) In general.-- Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I).

"(II) Exceptions.-- The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

"(ii) Identification of drugs in certain categories and classes.--

"(I) In general.-- Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

"(II) Criteria.-- The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

[*472] "(iii) Implementation.--The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

"(iv) Requirement for certain categories and classes until criteria established.-- Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and classes of drugs shall be identified under clause (ii)(I):

"(I) Anticonvulsants.

"(II) Antidepressants.

"(III) Antineoplastics.

"(IV) Antipsychotics.

"(V) Antiretrovirals.

"(VI) Immunosuppressants for the treatment of transplant rejection."

(b) <<Notes>>

Effective Date.--The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

Sec. 3308.

REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) Income-Related Increase in Part D Premium.--

(1) In general.-- Section 1860D-13(a) of the Social Security Act ([42 U.S.C. 1395w-113\(a\)](#)) is amended by adding at the end the following new paragraph:

"(7) Increase in base beneficiary premium based on income.--

"(A) In general.-- In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) Monthly adjustment amount.-- The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of--

"(i) the quotient obtained by dividing--

"(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) Modified adjusted gross income.-- For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of

section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) Determination by commissioner of social security.-- The Commissioner of Social Security shall make any determination necessary to carry out the income-related [*473] increase in the base beneficiary premium under this paragraph.

"(E) Procedures to assure correct income-related increase in base beneficiary premium.--

"(i) Disclosure of base beneficiary premium.-- Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(ii) Additional disclosure.-- Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

"(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

"(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

"(III) The monthly adjustment amount specified in subparagraph (B).

"(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

"(F) Rule of construction.--

Descriptors

ABORTION; ADOPTION; AGED AND AGING; AMERICAN RECOVERY AND REINVESTMENT ACT; BALANCED BUDGET ACT; BIOLOGIC DRUG PRODUCTS; BIOLOGICS PRICE COMPETITION AND INNOVATION ACT; BLACK LUNG BENEFITS ACT; CANCER; CARDIOVASCULAR DISEASES; CATALYST TO BETTER DIABETES CARE ACT; CHILDREN; CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT; COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS ACT; CONGENITAL HEART FUTURES ACT; CURES ACCELERATION NETWORK ACT; DEFICIT REDUCTION ACT; DIABETES; DRUGS; EMPLOYEE RETIREMENT INCOME SECURITY ACT; EPIDEMIOLOGY; ESTABLISHING A NETWORK OF HEALTH-ADVANCING NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION ACT; EXCISE TAX; FAIR LABOR STANDARDS ACT; FEDERAL FOOD, DRUG, AND COSMETIC ACT; FEDERAL-STATE RELATIONS; HEALTH FACILITIES AND SERVICES; HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT; HEALTH INSURANCE; HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT; HIGHER EDUCATION ACT; INDIAN HEALTH CARE IMPROVEMENT ACT; INDIANS; INFORMATION SERVICES AND SYSTEMS; INSURANCE COMPANIES; MEDICAID; MEDICAL ECONOMICS; MEDICARE; MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT; MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT; MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT; MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT; MENTAL HEALTH AND ILLNESS; MINORITY GROUPS; NATIVE AMERICANS; NATIVE HAWAIIAN HEALTH CARE ACT; OMNIBUS BUDGET RECONCILIATION ACT; PATIENT PROTECTION AND AFFORDABLE CARE ACT ELDER JUSTICE ACT; PHYSICIANS; PUBLIC HEALTH SERVICE ACT; REHABILITATION ACT; SOCIAL SECURITY ACT; STATE LAWS; TAXATION; TAX INCENTIVES AND SHELTERS; TAX RELIEF AND HEALTH CARE ACT; WOMEN;

YOUNG WOMEN'S BREAST HEALTH EDUCATION AND AWARENESS REQUIRES LEARNING YOUNG ACT;
YOUTH; 111 PL 148

UNITED STATES PUBLIC LAWS

111th Congress 2nd Session© 2020, LEXIS-NEXIS, A DIVISION OF REED ELSEVIER INC. AND REED ELSEVIER PROPERTIES INC.

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- 2 NOTE: [42 USC 18033](#)
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- 4 NOTE: [42 USC 1395j-3a](#) note
- 5 NOTE: [42 USC 300gg-4](#)- 300gg-7, 300gg-25-300gg-28
- 6 NOTE: [42 USC 300gg-11](#)- 300gg-13, 300gg-9
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