

**O’DONOGHUE & O’DONOGHUE, LLP**

# **Patient Protection and Affordable Care Act**

**LEGISLATIVE PROVISIONS APPLICABLE TO SELF-INSURED MULTIEMPLOYER  
HEALTH AND WELFARE PLANS**

By: Ali Esfahani

*Summary created with the support and assistance of:  
Joyce A. Mader and  
Francis J. Martorana*

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NOTE:

HB3590 = ("HOUSE BILL" OR "HB")

YELLOW HIGHLIGHT = AMENDMENTS TO HOUSE BILL, AS FOUND IN HB3590, TITLE X

HR4872 = ("RECONCILIATION BILL" OR "RB")

## LIFETIME AND ANNUAL LIMITS

**HB 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—

(5) by inserting after section 2702, the following:

**“SEC. 2711. 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.

**HB SEC. 1004. 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.

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

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

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

“(a) PROHIBITION.—

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

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

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

“(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient H. R. 3590—766 Protection and Affordable Care Act, as determined by the Secretary. In defining the term ‘restricted annual limit’ for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

“(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.”

**RB SEC. 2301 INSURANCE REFORMS.**

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(4) APPLICATION OF CERTAIN PROVISIONS.—

“(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

“(i) PROVISIONS DESCRIBED.—Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.”

## DEPENDENT CARE COVERAGE

**HB 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 — (5) by inserting after section 2702, the following:

**“SEC. 2714. 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.

**HB SEC. 1004. 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.

**RB SEC. 2301. INSURANCE REFORMS.**

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(4) APPLICATION OF CERTAIN PROVISIONS.—

“(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) **shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:**

“(i) Section 2708 (relating to excessive waiting periods).

“(ii) Those provisions of section 2711 relating to lifetime limits.

“(iii) Section 2712 (relating to rescissions).

“(iv) Section 2714 (relating to extension of dependent coverage).

ii) ADULT CHILD COVERAGE.— For plan years beginning before January 1, 2014, the provisions of Section 2714 of the Public Health Service Act (as added by this subtitle) **shall apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan** (as defined in Section 5000A(f)(2) of the Internal Revenue Code of 1986) other than such grandfathered health plan.”.

(b) CLARIFICATION REGARDING DEPENDENT COVERAGE.—Section 2714(a) of the Public Health Service Act, as added by section 1001(5) of the Patient Protection and Affordable Care Act, is amended by striking ‘‘(who is not married)’’.

## APPEALS PROCESS

**HB 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— (5) by inserting after section 2702, the following:

### HB “SEC. 2719. 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;

“(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.”.

### HB SEC. 1004. 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.

### HB SEC. 10101. AMENDMENTS TO SUBTITLE A.

#### “SEC. 2719. APPEALS PROCESS.

“(a) INTERNAL CLAIMS APPEALS.—

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

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

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

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

“(2) ESTABLISHED PROCESSES.—To comply with paragraph

(1)—

“(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent

claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

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

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

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

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

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

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

“(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.”.

## REINSURANCE SUBSIDY FOR EARLY RETIREES

### HB SEC. 1102. 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, 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 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).

## NOTICE OF MATERIAL MODIFICATIONS OF PLAN DOCUMENTS

### TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

**HB 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—

(5) by inserting after section 2702, the following:

#### “SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

“(d) REQUIREMENT TO PROVIDE.—

“(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.

#### **HB SEC. 1004. 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.

#### **HB SEC. 10103(d):**

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

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

(2) by adding at the end the following:

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

## **REBATE TO ENROLLEES & OTHER REFORMS (n/a to self-insured)**

**HB 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—

(5) by inserting after section 2702, the following:

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

“(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with 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).

### **HB SEC. 1562. CONFORMING AMENDMENTS.**

(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. 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. 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.”.

**HB SEC. 10101(f):**

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

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

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

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

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

“(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees. The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

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

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

“(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the

amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

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

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

“(B) REBATE AMOUNT.—

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

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

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

“(ii) CALCULATION BASED ON AVERAGE RATIO.—

Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total H. R. 3590—769 premium revenue for each of the previous 3 years for the plan.

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

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

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

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

“(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.”.

## GRANDFATHERED PLANS + NO CHANGE IN COLLECTIVELY BARGAINED PLANS

### PART II—OTHER PROVISIONS

#### **HB SEC. 1251. 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).

**(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.

#### **HB SEC. 1253. EFFECTIVE DATES.**

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

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

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

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

(2) by adding at the end the following:

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

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

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

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

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

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

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

**RB SEC. 2301. INSURANCE REFORMS.**

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(4) APPLICATION OF CERTAIN PROVISIONS.—

“(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

“(i) Section 2708 (relating to excessive waiting periods).

“(ii) Those provisions of section 2711 relating to lifetime limits.

“(iii) Section 2712 (relating to rescissions).

“(iv) Section 2714 (relating to extension of dependent coverage).

## PROHIBITION ON RESCISSIONS

**HB 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—

(5) by inserting after section 2702, the following:

**“SEC. 2712. 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).

**HB SEC. 1004. 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.

**RB SEC. 2301. INSURANCE REFORMS.**

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(4) APPLICATION OF CERTAIN PROVISIONS.—

“(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

“(i) Section 2708 (relating to excessive waiting periods).

“(ii) Those provisions of section 2711 relating to lifetime limits.

“(iii) **Section 2712 (relating to rescissions).**

“(iv) Section 2714 (relating to extension of dependent coverage).

## EXCISE TAX

### TITLE IX—REVENUE PROVISIONS

#### Subtitle A—Revenue Offset Provisions

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

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

#### “SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

“(a) IMPOSITION OF TAX.—If—

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

“(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

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

“(1) IN GENERAL.—The term ‘excess benefit’ means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph

(2) for months during the taxable period.

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

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

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

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

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

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

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

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

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

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

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

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

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

“(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

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

“(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for ‘1992’ in subparagraph (B) thereof), increased by 1 percentage point. If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

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

“(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

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

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

“(c) LIABILITY TO PAY TAX.—

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

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

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

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

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

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

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

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

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

“(A) IN GENERAL.—Each employer shall—

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

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

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

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

“(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

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

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

“(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for longterm care, or

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

“(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.— Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

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

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

“(2) DETERMINATION OF COST.—

“(A) IN GENERAL.—The cost of applicable employer sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

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

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

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

“(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

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

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

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

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

“(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

“(2) LIMITATIONS ON PENALTY.—

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

“(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph

(1)(B) on any such failure if—

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

“(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

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

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

“(1) COVERAGE DETERMINATIONS.—

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

“(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

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

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

“(B) has attained age 55, and

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

“(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term ‘employees engaged in a high-risk profession’ means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee’s employment.

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

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

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

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

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

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

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

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

**HB SEC. 10901. MODIFICATIONS TO EXCISE TAX ON HIGH COST EMPLOYER SPONSORED HEALTH COVERAGE.**

(a) LONGSHORE WORKERS TREATED AS EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONS.—Paragraph (3) of section 4980I(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by inserting “individuals whose primary work is **longshore work** (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof),” before “and individuals engaged in the construction, mining”.

(b) EXEMPTION FROM HIGH-COST INSURANCE TAX INCLUDES CERTAIN ADDITIONAL EXCEPTED BENEFITS.—Clause (i) of section 4980I(d)(1)(B) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by striking “section 9832(c)(1)(A)” and inserting “section 9832(c)(1) (other than subparagraph (G) thereof)”.

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

**RB SEC. 1401. HIGH-COST PLAN EXCISE TAX.**

(a) IN GENERAL.—Section 4980I of the Internal Revenue Code of 1986, as added by section 9001 of the Patient Protection and Affordable Care Act and amended by section 10901 of such Act, is amended—

(1) in subsection (b)(3)(B)—

(A) by striking “The annual” and insert<sup>19</sup> in the following:

“(i) IN GENERAL.—Except as provided in clause (ii), the annual”; and

(B) by adding at the end the following new clause:

“(ii) **MULTIEMPLOYER PLAN COVERAGE.**—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.”;

(2) in subsection (b)(3)(C)—

(A) by striking “Except as provided in subparagraph (D)—”;

(B) in clause (i)—

(i) by striking “2013” each place it appears in the heading and the text and inserting “2018”;

(ii) by striking “\$8,500” in subclause (I) and inserting “\$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self only coverage)”;

(iii) by striking “\$23,000” in sub clause (II) and inserting “\$27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage)”;

(C) by redesignating clauses (ii) and (iii) as clauses (iv) and (v), respectively, and by inserting after clause (i) the following new clauses:

“(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

“(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/BlueShield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

“(II) 55 percent.

“(iii) AGE AND GENDER ADJUSTMENT.—

“(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

“(II) AMOUNT DETERMINED.—

The amount determined under this subclause is an amount equal to the excess (if any) of—

“(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual’s employer, over

“(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.”.

(D) in clause (iv), as redesignated by sub paragraph (C)—

(i) by inserting “covered by the plan” after “whose employees”; and

(ii) by striking subclauses (I) and (II) and inserting the following:

“(I) the dollar amount in clause

(i)(I) shall be increased by \$1,650, and

“(II) the dollar amount in clause

(i)(II) shall be increased by \$3,450,”

and

(E) in clause (v), as redesignated by sub paragraph (C)—

(i) by striking “2013” and inserting “2018”;

(ii) by striking “clauses (i) and (ii)” and inserting “clauses (i) (after the application of clause (ii)) and (iv)”;

(iii) by inserting “in the case of determinations for calendar years beginning before 2020” after “1 percentage point” in subclause (II) thereof;

(3) by striking subparagraph (D) of subsection (b)(3);

(4) in subsection (d)(1)(B), by redesignating clause (ii) as clause (iii) and by inserting after clause (i) the following new clause:

“(ii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or”; and

(5) in subsection (d), by adding at the end the following new paragraph:

“(3) EMPLOYEE.—The term ‘employee’ includes any former employee, surviving spouse, or other primary insured individual.”.

(b) EFFECTIVE DATES.—

(1) Section 9001(c) of the Patient Protection and Affordable Care Act is amended by striking “2012” and inserting “2017”.

(2) Section 10901(c) of the Patient Protection and Affordable Care Act is amended by striking “2012” and inserting “2017”.

## **INCREASE IN HSA TAXES FOR NON-MEDICAL DISTRIBUTIONS**

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

- (a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.
- (b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.
- (c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

## ANNUAL FEE ON INSURANCE PROVIDERS (n/a to self-insured)

### HB SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

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

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

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to \$6,700,000,000 as—

(A) the sum of—

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

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

(B) the sum of—

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

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

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

(1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table: With respect to a covered entity’s net premiums written during the calendar year that are:

The percentage of net premiums written that are taken into account is:

Not more than \$25,000,000 ..... 0 percent

More than \$25,000,000 but not more than \$50,000,000.

50 percent

More than \$50,000,000 ..... 100 percent.

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

With respect to a covered entity’s third party administration agreement fees during the calendar year that are:

The percentage of third party administration agreement fees that are taken into account is:

Not more than \$5,000,000 ..... 0 percent

More than \$5,000,000 but not more than \$10,000,000.

50 percent

More than \$10,000,000 ..... 100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

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

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

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

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

(3) CONTROLLED GROUPS.—

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

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

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

(1) a United States citizen,

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

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

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

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

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

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

(g) REPORTING REQUIREMENT.—

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

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph

(1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

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

- (II) the amount of the fee imposed by this section for which such report was required.
- (B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—
  - (i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,
  - (ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and
  - (iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.
- (h) ADDITIONAL DEFINITIONS.—For purposes of this section—
  - (1) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.
  - (2) UNITED STATES.—The term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.
  - (3) HEALTH INSURANCE.—The term “health insurance” shall not include insurance for long-term care or disability.
    - (i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section.
    - (j) APPLICATION OF SECTION.—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk, and any third party administration agreement fees received after such date.

**HB SEC. 10905. MODIFICATION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.**

(a) DETERMINATION OF FEE AMOUNT.—Subsection (b) of section 9010 of this Act is amended to read as follows:

“(b) DETERMINATION OF FEE AMOUNT.—

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

“(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

“(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

“(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

“With respect to a covered entity’s net premiums written during the calendar year that are:

The percentage of net premiums written that are taken into account is:

Not more than \$25,000,000 ..... 0 percent

More than \$25,000,000 but not more than \$50,000,000.

50 percent

More than \$50,000,000 ..... 100 percent.

“(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.”

(b) APPLICABLE AMOUNT.—Subsection (e) of section 9010 of this Act is amended to read as follows:

“(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1), the applicable amount shall be determined in accordance with the following table:

“**Calendar year Applicable amount**

2011 ..... \$2,000,000,000

2012 ..... \$4,000,000,000

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2013 .....	\$7,000,000,000
2014, 2015 and 2016 .....	\$9,000,000,000
2017 and thereafter .....	\$10,000,000,000.’’.

(c) EXEMPTION FROM ANNUAL FEE ON HEALTH INSURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section 9010(c)(2) of this Act is amended by striking “or” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting a comma, and by adding at the end the following new subparagraphs: “(C) any entity— “(i)(I) which is incorporated as, is a wholly owned subsidiary of, or is a wholly owned affiliate of, a nonprofit corporation under a State law, or “(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code), “(ii) the premium rate increases of which are regulated by a State authority, “(iii) which, as of the date of the enactment of this section, acts as the insurer of last resort in the State and is subject to State guarantee issue requirements, and “(iv) for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to the individual insurance market for such entity for the calendar year is not less than 100 percent, “(D) any entity— “(i)(I) which is incorporated as a nonprofit corporation under a State law, or “(II) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code), and “(ii) for which the medical loss ratio (as so determined)— “(I) with respect to each of the individual, small group, and large group insurance markets for such entity for the calendar year is not less than 90 percent, and “(II) with respect to all such markets for such entity for the calendar year is not less than 92 percent, or “(E) any entity— “(i) which is a mutual insurance company, “(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had— “(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and “(II) with respect to all markets described in subparagraph (D)(ii)(I), a medical loss ratio of not less than 90 percent, and “(iii) with respect to annual payment dates in calendar years after 2011, for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to all such markets for such entity for the preceding calendar year is not less than 89 percent (except that with respect to such annual payment date for 2012, the calculation under 2718(b)(1)(B)(ii) of such Act is determined by reference to the previous year, and with respect to such annual payment date for 2013, such calculation is determined by reference to the average for the previous 2 years).’’.

(d) CERTAIN INSURANCE EXEMPTED FROM FEE.—Paragraph (3) of section 9010(h) of this Act is amended to read as follows:

“(3) HEALTH INSURANCE.—The term ‘health insurance’ shall not include— “(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986, “(B) any insurance for long-term care, or “(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).’’.

(e) ANTI-AVOIDANCE GUIDANCE.—Subsection (i) of section 9010 of this Act is amended by inserting “and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of

this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2)” after “section”.

**(f) CONFORMING AMENDMENTS.—**

(1) Section 9010(a)(1) of this Act is amended by striking “2009” and inserting “2010”.

(2) Section 9010(c)(2)(B) of this Act is amended by striking “(except” and all that follows through “1323)”.

(3) Section 9010(c)(3) of this Act is amended by adding at the end the following new sentence: “If any entity described in subparagraph (C)(i)(I), (D)(i)(I), or (E)(i) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.”.

(4) Section 9010(g)(1) of this Act is amended by striking “and third party administration agreement fees”.

(5) Section 9010(j) of this Act is amended—

(A) by striking “2008” and inserting “2009”, and

(B) by striking “, and any third party administration agreement fees received after such date”.

**(g) EFFECTIVE DATE.—**The amendments made by this section shall take effect as if included in the enactment of section 9010.

**RB SEC 1406. HEALTH INSURANCE PROVIDERS.**

(a) IN GENERAL.—Section 9010 of the Patient Protection and Affordable Care Act, as amended by section 10905 of such Act, is amended—

(1) in subsection (a)(1), by striking “2010” and inserting “2013”;

(2) in subsection (b)(2)—

(A) by striking “For purposes of paragraph (1), the net premiums” and inserting “For purposes of paragraph (1)—

“(A) IN GENERAL.—The net premiums”;

(B) by adding at the end the following subparagraph:

“(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.”;

(3) in subsection (c)—

(A) by inserting “during the calendar year in which the fee under this section is due” in paragraph (1) after “risk”;

(B) in paragraph (2), by striking subparagraphs (C), (D), and (E) and inserting the following new subparagraphs:

“(C) any entity—

“(i) which is incorporated as a nonprofit corporation under a State law,

“(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which 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, and

“(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

“(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.”;

(C) in paragraph (3)(A), by striking “subparagraph (C)(i)(I), (D)(i)(I), or (E)(i)” and inserting “subparagraph (C) or (D)”;

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

“(4) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.”; (4) by striking subsection (e) and inserting the following:

“(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1)—

“(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

“Calendar year Applicable amount

2014 .....	\$8,000,000,000
2015 .....	\$11,300,000,000
2016 .....	\$11,300,000,000
2017 .....	\$13,900,000,000
2018 .....	\$14,300,000,000.

“(2) YEARS AFTER 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.”;

(5) in subsection (g), by adding at the end the following new paragraphs:

“(3) ACCURACY-RELATED PENALTY.—

“(A) IN GENERAL.—In the case of any understatement of a covered entity’s net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

“(i) the amount of the covered entity’s fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such under statement, over

“(ii) the amount of such fee the Secretary determined based on such under statement.

“(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity’s net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

4 “(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

“(4) TREATMENT OF INFORMATION.—Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.”; and

by striking subsection (j) and inserting the following new subsection:

“(j) EFFECTIVE DATE.—This section shall apply to calendar years beginning after December 31, 2013.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in section 9010 of the Patient Protection and Affordable Care Act.

## CAFETERIA PLANS FOR SMALL BUSINESSES

### HB SEC. 9022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

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

“(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

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

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

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

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

“(3) CONTRIBUTION REQUIREMENTS.—

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

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

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

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

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

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

“(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph

(B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

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

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

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

“(iii) HIGHLY COMPENSATED EMPLOYEE.—The term ‘highly compensated employee’ has the meaning given such term by section 414(q).

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

“(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

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

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

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

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

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

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

“(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

“(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States). A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

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

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

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

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

“(i) IN GENERAL.—If—

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

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

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

“(D) SPECIAL RULES.—

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

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

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

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

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

## FSA LIMITATIONS

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

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.”.

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

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

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

(d) EFFECTIVE DATES.—

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

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

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

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

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

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

“(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.”.

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

### **HB SEC. 10902. INFLATION ADJUSTMENT OF LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.**

(a) IN GENERAL.—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005 of this Act, is amended to read as follows:

“(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

“(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement.

“(2) ADJUSTMENT FOR INFLATION.—In the case of any taxable year beginning after December 31, 2011, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(A) such amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof. If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.”

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

**RB SEC. 1403. DELAY OF LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.**

(a) IN GENERAL.—Section 10902(b) of the Patient Protection and Affordable Care Act is amended by striking “December 31, 2010” and inserting “December 31, 2012”.

(b) INFLATION ADJUSTMENT.—Paragraph (2) of section 125(i) of the Internal Revenue Code of 1986, as added by section 9005 of the Patient Protection and Affordable Care Act and amended by section 10902 of such Act, is amended—

(1) in the matter preceding subparagraph (A), by striking “December 31, 2011” and inserting “December 31, 2013”; and

(2) in subparagraph (B), by striking “2010” and inserting “2012”

## PREEXISTING CONDITIONS

### Subtitle C—Quality Health Insurance Coverage for All Americans

#### PART I—HEALTH INSURANCE MARKET REFORMS

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:

#### **HB SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.**

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

(3)(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)—(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. 2705. 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.

**HB SEC. 1253. EFFECTIVE DATES.**

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

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

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

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

**RB SEC. 2301 INSURANCE REFORMS.**

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(B) PROVISIONS APPLICABLE ONLY TO GROUP HEALTH PLANS.—

“(i) PROVISIONS DESCRIBED.—Those provisions of section 2711 relating to annual limits and the provisions of section 2704 (relating to pre-existing condition exclusions) of the Public Health Service Act (as added by this subtitle) shall apply to grandfathered health plans that are group health plans for plan years beginning with the first plan year to which such provisions otherwise apply.

## WAITING PERIOD: For all Plans

### Subtitle C—Quality Health Insurance Coverage for All Americans PART I—HEALTH INSURANCE MARKET REFORMS

#### HB 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. 2708. 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.”

#### RB SEC. 2301. INSURANCE REFORMS.

(a) EXTENDING CERTAIN INSURANCE REFORMS TO GRANDFATHERED PLANS.—Section 1251(a) of the Patient Protection and Affordable Care Act, as added by section 10103(d) of such Act, is amended by adding at the end the following:

“(4) APPLICATION OF CERTAIN PROVISIONS.—

“(A) IN GENERAL.—The following provisions of the Public Health Service Act (as added by this title) shall apply to grandfathered health plans for plan years beginning with the first plan year to which such provisions would otherwise apply:

“(i) Section 2708 (relating to excessive waiting periods).

“(ii) Those provisions of section 2711 relating to lifetime limits.

“(iii) Section 2712 (relating to rescissions).

“(iv) Section 2714 (relating to extension of dependent coverage).

## **ADDITIONAL MARKET REFORMS**

### **HB SEC. 1562. CONFORMING AMENDMENTS.**

(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. 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. 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.”.

## MEDICAL CARE DEDUCTIONS ALLOWED FOR ADULT CHILDREN

### RB SEC. 1004. INCOME DEFINITIONS.

#### (d) ADULT DEPENDENTS.—

(1) EXCLUSION OF AMOUNTS EXPENDED FOR MEDICAL CARE.—The first sentence of **section 105(b) of the Internal Revenue Code** of 1986 (relating to amounts expended for medical care) is amended—

(A) by striking “and his dependents” and inserting “his dependents”; and

(B) by inserting before the period the following: “, and any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained **age 27**”.

(2) SELF-EMPLOYED HEALTH INSURANCE DEDUCTION.—Section 162(l)(1) of such Code is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for—

“(A) the taxpayer,

“(B) the taxpayer’s spouse,

“(C) the taxpayer’s dependents, and

“(D) any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27.”.

(3) COVERAGE UNDER SELF-EMPLOYED DEDUCTION.—Section 162(l)(2)(B) of such Code is amended by inserting “, or any dependent, or individual described in subparagraph (D) of paragraph (1) with respect to,” after “spouse of”.

(4) SICK AND ACCIDENT BENEFITS PROVIDED TO MEMBERS OF A **VOLUNTARY EMPLOYEES’ BENEFICIARY ASSOCIATION** AND THEIR DEPENDENTS.—Section 501(c)(9) of such Code is amended by adding at the end the following new sentence: “For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a member who as of the end of the calendar year has not attained age 27.”.

(5) MEDICAL AND OTHER BENEFITS FOR **RETIRED EMPLOYEES**.—Section 401(h) of such Code is amended by adding at the end the following: “For purposes of this subsection, the term ‘dependent’ shall include any individual who is a child (as defined in section 152(f)(1)) of a retired employee who as of the end of the calendar year has not attained age 27.”.

## PREVENTIVE CARE: Non-Grandfathered Plans Only

**HB 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—

(5) by inserting after section 2702, the following:

### “SEC. 2713. 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 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.

## PEDIATRIC COVERAGE + EMERGENCY SERVICES + OB-GYN

### Non-Grandfathered Plans Only

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

#### HB SEC. 10101. AMENDMENTS TO SUBTITLE A.

##### “SEC. 2719A. PATIENT PROTECTIONS.

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

“(b) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

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

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

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

“(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

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

“(2) DEFINITIONS.—In this subsection:

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

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

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

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

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

“(c) ACCESS TO PEDIATRIC CARE.—

“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

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

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

“(1) GENERAL RIGHTS.—

“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

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

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

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

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

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

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

## UNIFORM SUMMARY DOCUMENTS: For all Plans

### HB SEC. 10101. AMENDMENTS TO SUBTITLE A.

#### “SEC. 2715. 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:

“(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 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.

“(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).

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

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

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

(2) by adding at the end the following:

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

## W-2 REPORTING REQUIREMENT

### HB SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2.

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

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

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

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

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

## EMPLOYERS REQUIRED TO PROVIDE MINIMUM ESSENTIAL COVERAGE

### HB 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. 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 fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employersponsored 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 fulltime 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 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 fulltime 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.

“(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term ‘applicable premium tax credit and costsharing 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.”.

(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) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

#### **SEC. 10106. AMENDMENTS TO SUBTITLE F.**

(e) Section 4980H(b) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended to read as follows:

“(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 60 DAYS.—

“(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment of \$600 for each full-time employee of the employer to whom the extended waiting period applies.

“(2) EXTENDED WAITING PERIOD.—The term ‘extended waiting period’ means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 60 days.”.

(f)(1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting “, with respect to any month,” after “means”.

(2) Section 4980H(d)(2) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by adding at the end the following:

“(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

“(i) subparagraph (A) shall be applied by substituting ‘who employed an average of at least 5 fulltime employees on business days during the preceding calendar year and whose annual payroll expenses exceed \$250,000 for such preceding calendar year’ for ‘who employed an average of at least 50 full-time employees on business days during the preceding calendar year’, and

“(ii) subparagraph (B) shall be applied by substituting ‘5’ for ‘50’.”.

(3) The amendment made by paragraph (2) shall apply to months beginning after December 31, 2013.

(g) Section 6056(b) of the Internal Revenue Code of 1986, as added by section 1514(a) of the Act, is amended by adding at the end the following new flush sentence: “The Secretary shall have the authority to review the accuracy of the information provided under this subsection, including the applicable large employer’s share under paragraph (2)(C)(iv).”.

**HB SEC. 10108. FREE CHOICE VOUCHERS.**

(i) COORDINATION WITH EMPLOYER RESPONSIBILITIES.—

(1) SHARED RESPONSIBILITY PENALTY.—

(A) IN GENERAL.—Subsection (c) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:

“(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.”.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to months beginning after December 31, 2013.

**RB SEC. 1003. EMPLOYER RESPONSIBILITY.**

(a) PAYMENT CALCULATION.—Subparagraph (D) of subsection (d)(2) of section 4980H of the Internal Revenue Code of 1986, as added by section 1513 of the Patient Protection and Affordable Care Act and amended by section 10106 of such Act, is amended to read as follows:

“(D) APPLICATION OF EMPLOYER SIZE TO 12 ASSESSABLE PENALTIES.—

“(i) IN GENERAL.—The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating—

“(I) the assessable payment under subsection (a), or

“(II) the overall limitation under subsection (b)(2).

“(ii) AGGREGATION.—In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II) shall be allowed with respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of fulltime employees employed by each such person.”.

(b) APPLICABLE PAYMENT AMOUNT.—Section 4980H of such Code, as so added and amended, is amended

(1) in the flush text following subsection (c)(1)(B), by striking “400 percent of the applicable payment amount” and inserting “an amount equal to 1/12 of \$3,000”;

(2) in subsection (d)(1), by striking “\$750” and inserting “\$2,000”; and

(3) in subsection (d)(5)(A), in the matter preceding clause (i), by striking “subsection (b)(2) and (d)(1)” and inserting “subsection (b) and paragraph (1)”.

(c) COUNTING PART-TIME WORKERS IN SETTING THE THRESHOLD FOR EMPLOYER RESPONSIBILITY.—

Section 4980H(d)(2) of such Code, as so added and amended and as amended by subsection (a), is amended by adding at the end the following new subparagraph:

“(E) FULL-TIME EQUIVALENTS TREATED AS FULL-TIME EMPLOYEES.—Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.”.

**(d) ELIMINATING WAITING PERIOD ASSESSMENT.**— Section 4980H of such Code, as so added and amended and as amended by the preceding subsections, is amended by striking subsection (b) and redesignating subsections (c), (d), and (e) as subsections (b), (c), and (d), respectively.

## PPACA APPLICABLE TO ERISA & IRC

### HB SEC. 1562. CONFORMING AMENDMENTS.

**(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. 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. 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.”.

## MANDATORY RESEARCH TRUST FUND FEE

### HB SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

e) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND;  
FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(B) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

“Sec. 9511. Patient-centered outcomes research trust fund.”.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

#### “Subchapter B—Insured and Self-Insured Health Plans

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

#### “SEC. 4376. SELF-INSURED HEALTH PLANS.

“(a) IMPOSITION OF FEE.—In the case of any applicable self insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to \$2 (\$1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

“(b) LIABILITY FOR FEE.—

“(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

“(2) PLAN SPONSOR.—For purposes of paragraph (1) the term ‘plan sponsor’ means—

“(A) the employer in the case of a plan established or maintained by a single employer,

“(B) the employee organization in the case of a plan established or maintained by an employee organization,

“(C) in the case of—

“(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

“(ii) a multiple employer welfare arrangement, or

“(iii) a voluntary employees’ beneficiary association described in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

“(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

“(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

“(1) any portion of such coverage is provided other than through an insurance policy, and

“(2) such plan is established or maintained—

“(A) by 1 or more employers for the benefit of their employees or former employees,

“(B) by 1 or more employee organizations for the benefit of their members or former members,

“(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

“(D) by a voluntary employees’ beneficiary association described in section 501(c)(9),

“(E) by any organization described in section 501(c)(6), or

“(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

“(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

“(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

“(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

“(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

## COVERAGE OF CLINICAL TRIALS

### SEC. 10103. AMENDMENTS TO SUBTITLE C.

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

#### “SEC. 2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

“(a) COVERAGE.—

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

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

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

“(C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

“(2) ROUTINE PATIENT COSTS.—

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

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

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

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

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

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

“(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

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

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

“(2) Either—

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

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

“(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine

patient care services provided outside of the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

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

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

“(i) The National Institutes of Health.

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

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

“(iv) The Centers for Medicare & Medicaid Services.

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

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

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

“(I) The Department of Veterans Affairs.

“(II) The Department of Defense.

“(III) The Department of Energy.

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

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

“(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

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

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

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

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

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

“(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.”.

### **HB SEC. 1253. EFFECTIVE DATES.**

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

## ANNUAL REPORTS + WELLNESS PROGRAMS

**HB 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—

(5) by inserting after section 2702, the following:

### “SEC. 2717. 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.—

“(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.

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

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

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

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

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

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

“(1) WELLNESS AND PREVENTION PROGRAMS.—A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

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

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

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

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

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

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

“(3) LIMITATION ON DATABASES OR DATA BANKS.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

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

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

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

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

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

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

**HB SEC. 1253. EFFECTIVE DATES.**

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