

**Uniform Enrollment / Standard Definitions / Disclosure Subgroup:**

Relevant and Cross-Referenced Sections of PPACA:

- Section 1001 / Section 2715 of PHSa (as amended by Section 10101(a))
- Section 1251 (as amended by Section 10103(d))
- Section 1302(b)(1)
- Section 1311
- Section 1501/Sec. 5000A(f) of Internal Revenue Code
- Section 1562 / Sect. 715 of ERISA/Section 9815 of Internal Revenue Code

Outline of Relevant Sections of PPACA:

Title I – Quality and Affordable Health Care for All Americans

*Subtitle A – Immediate Improvements in Health Care Coverage for All Americans*

*Section 1001 – Amendments to the Public Health Service Act*

***Section 2715 of PHSa – Development and Utilization of Uniform  
Explanation of Coverage Documents and Standardized  
Definitions***

*Subtitle C – Quality Health Insurance Coverage for All Americans*

*Part II – Other Provisions*

***Section 1251 – Preservation of Right to Maintain Existing Coverage***

*Subtitle D – Available Coverage Choices for All Americans*

*Part I – Establishment of Qualified Health Plans*

***Section 1302 – Essential Health Benefits Requirements***

*Part II – Consumer Choices and Insurance Competition Through Health Benefit  
Exchanges*

***Section 1311 – Affordable Choices of Health Benefit Plans***

*Subtitle F – Shared Responsibility for Health Care*

*Part I – Individual Responsibility*

*Section 1501 – Requirement to Maintain Minimum Essential Coverage*

***Section 5000A of IRC – Requirement to Maintain Minimum  
Essential Coverage***

*Subtitle G – Miscellaneous Provisions*

***Section 1562 – Conforming Amendments***

Title X – Strengthening Quality, Affordable Health Care for All Americans

*Subtitle A – Provisions Relating to Title I*

***Section 10101 – Amendments to Subtitle A***

***Section 10103 – Amendments to Subtitle C***

**SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.**

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

[Showing changes made by Sec. 10101a -- Amendments to Subtitle A]

*(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 applicants, enrollees, and policyholders or certificate holders, 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.*

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*(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;*



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).*



**SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXISTING COVERAGE.**

[Showing changes made by Sec. 10103(d) – Amendments to Subtitle C and by the Health Care and Education Reconciliation Act of 2010 – Section 2301(a)]

*(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- Except as provided in paragraph (3), 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.*

*(3) APPLICATION OF CERTAIN PROVISIONS- The provisions of sections 2715 and 2718 of the Public Health Service Act (as added by subtitle A) shall*

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apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.'

(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).

(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.

(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) 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.

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**SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.**

[Showing changes made by Sec. 10104(b) – Amendments to Subtitle D]

[Note: Sec. 1302(b) is cross-referenced in Sec. 1001/Sec. 2715 of PHSA]

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

- (1) provides for the essential health benefits defined by the Secretary under subsection (b);*
- (2) limits cost-sharing for such coverage in accordance with subsection (c); and*
- (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).*

**(b) Essential Health Benefits-**

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

- (A) Ambulatory patient services.*
- (B) Emergency services.*
- (C) Hospitalization.*
- (D) Maternity and newborn care.*
- (E) Mental health and substance use disorder services, including behavioral health treatment.*
- (F) Prescription drugs.*
- (G) Rehabilitative and habilitative services and devices.*
- (H) Laboratory services.*
- (I) Preventive and wellness services and chronic disease management.*
- (J) Pediatric services, including oral and vision care.*

**(2) LIMITATION-**

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

*(B) CERTIFICATION- In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).*

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

*(4) REQUIRED ELEMENTS FOR CONSIDERATION- In defining the essential health benefits under paragraph (1), the Secretary shall--*

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

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

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

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

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

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

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

*(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and*

*(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--*

*(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;*

*(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;*

*(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;*

*(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and*

*(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).*

*(5) RULE OF CONSTRUCTION- Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.*

*(c) Requirements Relating to Cost-Sharing-*

*(1) ANNUAL LIMITATION ON COST-SHARING-*

*(A) 2014- The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.*

*(B) 2015 AND LATER- In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall--*

*(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and*

*(ii) in the case of other coverage, twice the amount in effect under clause (i).*

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

*(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS-*

*(A) IN GENERAL- In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed--*

*(i) \$2,000 in the case of a plan covering a single individual; and*

*(ii) \$4,000 in the case of any other plan.*

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

*(B) INDEXING OF LIMITS- In the case of any plan year beginning in a calendar year after 2014--*

*(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and*

*(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).*

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

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

*(D) COORDINATION WITH PREVENTIVE LIMITS- Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.*

*(3) COST-SHARING- In this title--*

*(A) IN GENERAL- The term 'cost-sharing' includes--*

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

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

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

*(d) Levels of Coverage-*

*(1) LEVELS OF COVERAGE DEFINED- The levels of coverage described in this subsection are as follows:*

*(A) BRONZE LEVEL- A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.*

*(B) SILVER LEVEL- A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.*

(C) *GOLD LEVEL*- A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) *PLATINUM LEVEL*- A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) *ACTUARIAL VALUE*-

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

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

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

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

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

(e) *Catastrophic Plan*-

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

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

(B) the plan provides--

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

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

(2) *INDIVIDUALS ELIGIBLE FOR ENROLLMENT*- An individual is described in this paragraph for any plan year if the individual--

(A) has not attained the age of 30 before the beginning of the plan year; or  
(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of--

- (i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or
- (ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) **RESTRICTION TO INDIVIDUAL MARKET-** If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

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

(g) **Payments to Federally-qualified Health Centers-** If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

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**SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.**

[Showing changes made by Sec. 10104(e), (f), (g) and (h) – Amendments to Subtitle D.]

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

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

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

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

(4) **RENEWABILITY OF GRANT-**

(A) **IN GENERAL-** Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant--

- (i) is making progress, as determined by the Secretary, toward--  
(I) establishing an Exchange; and

- (II) *implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and*
  - (ii) *is meeting such other benchmarks as the Secretary may establish.*

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

*(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES- The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.*

*(b) American Health Benefit Exchanges-*

*(1) IN GENERAL- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') for the State that--*

- (A) facilitates the purchase of qualified health plans;*
- (B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a 'SHOP Exchange') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and*
- (C) meets the requirements of subsection (d).*

*(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES- A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.*

*(c) Responsibilities of the Secretary-*

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

- (A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;*
- (B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;*
- (C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;*

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

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

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

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

***(G) utilize the standard format established for presenting health benefits plan options; and***

*(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.*

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

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

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

*(5) INTERNET PORTALS- The Secretary shall--*

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

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

**Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 [NOTE – THIS LIKELY SHOULD BE SECTION 2715] of the Public Health Service Act and to a copy of the plan's written policy.**

**(6) ENROLLMENT PERIODS-** *The Secretary shall require an Exchange to provide for--*

- (A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);*
- (B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;*
- (C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and*
- (D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).*

**(d) Requirements-**

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

**(2) OFFERING OF COVERAGE-**

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

**(B) LIMITATION-**

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

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

**(3) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS-**

**(A) IN GENERAL-** *Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision*

of law that may require benefits other than the essential health benefits specified under section 1302(b).

**(B) STATES MAY REQUIRE ADDITIONAL BENEFITS-**

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

*(ii) STATE MUST ASSUME COST- A State shall make payments--*

*(I) to an individual enrolled in a qualified health plan offered in such State; or*

*(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;*

*to defray the cost of any additional benefits described in clause (i). (4)*

**FUNCTIONS-** An Exchange shall, at a minimum--

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

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

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

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

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

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

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

*(H) subject to section 1411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section because--*

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

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

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

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

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

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

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

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

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

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

*(5) FUNDING LIMITATIONS-*

*(A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS- In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.*

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

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

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

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

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

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS- An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Certification-

(1) IN GENERAL- An Exchange may certify a health plan as a qualified health plan if--

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan--

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

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

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(3) TRANSPARENCY IN COVERAGE-

(A) IN GENERAL- The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

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(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

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- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.
- (ix) Other information as determined appropriate by the Secretary.

(B) USE OF PLAIN LANGUAGE- The information required to be submitted under subparagraph (A) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) COST SHARING TRANSPARENCY- The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) GROUP HEALTH PLANS- The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) Flexibility-

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES- An Exchange may operate in more than one State if--

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES- A State may establish one or more subsidiary Exchanges if--

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

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT-

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

(B) ELIGIBLE ENTITY- In this paragraph, the term 'eligible entity' means--

(i) a person--

(I) incorporated under, and subject to the laws of, 1 or more States;

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(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and  
(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) Rewarding Quality Through Market-Based Incentives-

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

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

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

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

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

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

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

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

(h) Quality Improvement-

(1) ENHANCING PATIENT SAFETY- Beginning on January 1, 2015, a qualified health plan may contract with--

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

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

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

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

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

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

(i) Navigators-

(1) IN GENERAL- An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) ELIGIBILITY-

(A) IN GENERAL- To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) TYPES- Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that--

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

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

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

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

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

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

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate

State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and  
(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) STANDARDS-

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

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

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

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

(j) Applicability of Mental Health Parity- Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

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

.....  
**SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**

[Note: Sec. 1501(b) / Sec. 5000A of IRC 1986 is cross-referenced in Sec. 1001 / Sec. 2715 PHSA.]

(b) In General- Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

CHAPTER 48--MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

Sec. 5000A. Requirement to maintain minimum essential coverage.

**SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**

\*\*\*\*\*

(f) Minimum Essential Coverage- For purposes of this section--

(1) IN GENERAL- The term 'minimum essential coverage' means any of the following:



*“(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.*  
*“(5) INSURANCE-RELATED TERMS- Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.*

.....  
**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.'*