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**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 3962
OFFERED BY MR. BOEHNER OF OHIO**

(Amendment to text of H.R. 3962)

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE; PURPOSE; TABLE OF CONTENTS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Common Sense Health Care Reform and Affordability
4 Act”.

5 (b) **PURPOSE.**—The purpose of this Act is to take
6 meaningful steps to lower health care costs and increase
7 access to health insurance coverage (especially for individ-
8 uals with preexisting conditions) without—

9 (1) raising taxes;

10 (2) *cutting Medicare benefits for seniors;*

11 (3) adding to the national deficit;

12 (4) intervening in the doctor-patient relation-
13 ship; or

14 (5) instituting a government takeover of health
15 care.

16 (c) **TABLE OF CONTENTS.**—The table of contents of
17 this Act is as follows:

Sec. 1. Short title; purpose; table of contents.

DIVISION A—MAKING HEALTH CARE COVERAGE AFFORDABLE
FOR EVERY AMERICAN

TITLE I—ENSURING COVERAGE FOR INDIVIDUALS WITH PRE-
EXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

Sec. 101. Establish universal access programs to improve high risk pools and
reinsurance markets.

Sec. 102. Elimination of certain requirements for guaranteed availability in in-
dividual market.

Sec. 103. No annual or lifetime spending caps.

Sec. 104. Preventing unjust cancellation of insurance coverage.

TITLE II—REDUCING HEALTH CARE PREMIUMS AND THE
NUMBER OF UNINSURED AMERICANS

Sec. 111. State innovation programs.

Sec. 112. Health plan finders.

Sec. 113. Administrative simplification.

DIVISION B—IMPROVING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL
BUSINESSES

Sec. 201. Rules governing association health plans.

Sec. 202. Clarification of treatment of single employer arrangements.

Sec. 203. Enforcement provisions relating to association health plans.

Sec. 204. Cooperation between Federal and State authorities.

Sec. 205. Effective date and transitional and other rules.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

Sec. 211. Extending coverage of dependents.

Sec. 212. Allowing auto-enrollment for employer sponsored coverage.

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO
BUY HEALTH CARE COVERAGE ACROSS STATE LINES

Sec. 221. Interstate purchasing of Health Insurance.

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

Sec. 231. Saver's credit for contributions to health savings accounts.

Sec. 232. HSA funds for premiums for high deductible health plans.

Sec. 233. Requiring greater coordination between HDHP administrators and
HSA account administrators so that enrollees can enroll in
both at the same time.

Sec. 234. Special rule for certain medical expenses incurred before establish-
ment of account.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

Sec. 301. Encouraging speedy resolution of claims.

Sec. 302. Compensating patient injury.

Sec. 303. Maximizing patient recovery.

Sec. 304. Additional health benefits.

- Sec. 305. Punitive damages.
- Sec. 306. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 307. Definitions.
- Sec. 308. Effect on other laws.
- Sec. 309. State flexibility and protection of states' rights.
- Sec. 310. Applicability; effective date.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

- Sec. 401. Rule of construction.
- Sec. 402. Repeal of Federal Coordinating Council for Comparative Effectiveness Research.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

- Sec. 501. Incentives for prevention and wellness programs.

DIVISION F—PROTECTING TAXPAYERS

- Sec. 601. Provide full funding to HHS OIG and ICFAC.
- Sec. 602. Prohibiting taxpayer funded abortions and conscience protections.
- Sec. 603. Improved enforcement of the Medicare and Medicaid secondary payer provisions.
- Sec. 604. Strengthen Medicare provider enrollment standards and safeguards.
- Sec. 605. Tracking banned providers across State lines.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

- Sec. 701. Licensure pathway for biosimilar biological products.
- Sec. 702. Fees relating to biosimilar biological products.
- Sec. 703. Amendments to certain patent provisions.

1 **DIVISION A—MAKING HEALTH**
2 **CARE COVERAGE AFFORD-**
3 **ABLE FOR EVERY AMERICAN**
4 **TITLE I—ENSURING COVERAGE**
5 **FOR INDIVIDUALS WITH PRE-**
6 **EXISTING CONDITIONS AND**
7 **MULTIPLE HEALTH CARE**
8 **NEEDS**

9 **SEC. 101. ESTABLISH UNIVERSAL ACCESS PROGRAMS TO**
10 **IMPROVE HIGH RISK POOLS AND REINSUR-**
11 **ANCE MARKETS.**

12 (a) STATE REQUIREMENT.—

13 (1) IN GENERAL.—Not later than January 1,
14 2010, each State shall—

15 (A) subject to paragraph (3), operate—

16 (i) a qualified State reinsurance pro-
17 gram described in subsection (b); or

18 (ii) qualifying State high risk pool de-
19 scribed in subsection (c)(1); and

20 (B) subject to paragraph (3), apply to the
21 operation of such a program from State funds
22 an amount equivalent to the portion of State
23 funds derived from State premium assessments
24 (as defined by the Secretary) that are not oth-
25 erwise used on State health care programs.

1 (2) RELATION TO CURRENT QUALIFIED HIGH
2 RISK POOL PROGRAM.—

3 (A) STATES NOT OPERATING A QUALIFIED
4 HIGH RISK POOL.—In the case of a State that
5 is not operating a current section 2745 quali-
6 fied high risk pool as of the date of the enact-
7 ment of this Act—

8 (i) the State may only meet the re-
9 quirement of paragraph (1) through the
10 operation of a qualified State reinsurance
11 program described in subsection (b); and

12 (ii) the State's operation of such a re-
13 insurance program shall be treated, for
14 purposes of section 2745 of the Public
15 Health Service Act, as the operation of a
16 qualified high risk pool described in such
17 section.

18 (B) STATE OPERATING A QUALIFIED HIGH
19 RISK POOL.—In the case of a State that is op-
20 erating a current section 2745 qualified high
21 risk pool as of the date of the enactment of this
22 Act—

23 (i) as of January 1, 2010, such a pool
24 shall not be treated as a qualified high risk
25 pool under section 2745 of the Public

1 Health Service Act unless the pool is a
2 qualifying State high risk pool described in
3 subsection (c)(1); and

4 (ii) the State may use premium as-
5 sessment funds described in paragraph
6 (1)(B) to transition from operation of such
7 a pool to operation of a qualified State re-
8 insurance program described in subsection
9 (b).

10 (3) APPLICATION OF FUNDS.—If the program
11 or pool operated under paragraph (1)(A) is in strong
12 fiscal health, as determined in accordance with
13 standards established by the National Association of
14 Insurance Commissioners and as approved by the
15 State Insurance Commissioner involved, the require-
16 ment of paragraph (1)(B) shall be deemed to be
17 met.

18 (b) QUALIFIED STATE REINSURANCE PROGRAM.—

19 (1) IN GENERAL.—For purposes of this section,
20 a “qualified State reinsurance program” means a
21 program operated by a State program that provides
22 reinsurance for health insurance coverage offered in
23 the small group market in accordance with the
24 model for such a program established (as of the date
25 of the enactment of this Act).

1 (2) FORM OF PROGRAM.—A qualified State re-
2 insurance program may provide reinsurance—

3 (A) on a prospective or retrospective basis;
4 and

5 (B) on a basis that protects health insur-
6 ance issuers against the annual aggregate
7 spending of their enrollees as well as purchase
8 protection against individual catastrophic costs.

9 (3) SATISFACTION OF HIPAA REQUIREMENT.—
10 A qualified State reinsurance program shall be
11 deemed, for purposes of section 2745 of the Public
12 Health Service Act, to be a qualified high-risk pool
13 under such section.

14 (c) QUALIFYING STATE HIGH RISK POOL.—

15 (1) IN GENERAL.—A qualifying State high risk
16 pool described in this subsection means a current
17 section 2745 qualified high risk pool that meets the
18 following requirements:

19 (A) The pool must provide at least two
20 coverage options, one of which must be a high
21 deductible health plan coupled with a health
22 savings account.

23 (B) The pool must be funded with a stable
24 funding source.

1 (C) The pool must eliminate any waiting
2 lists so that all eligible residents who are seek-
3 ing coverage through the pool should be allowed
4 to receive coverage through the pool.

5 (D) The pool must allow for coverage of
6 individuals who, but for the 24-month disability
7 waiting period under section 226(b) of the So-
8 cial Security Act, would be eligible for Medicare
9 during the period of such waiting period.

10 (E) The pool must limit the pool premiums
11 to no more than 150 percent of the average
12 premium for applicable standard risk rates in
13 that State.

14 (F) The pool must conduct education and
15 outreach initiatives so that residents and bro-
16 kers understand that the pool is available to eli-
17 gible residents.

18 (G) The pool must provide coverage for
19 preventive services and disease management for
20 chronic diseases.

21 (2) VERIFICATION OF CITIZENSHIP OR ALIEN
22 QUALIFICATION.—

23 (A) IN GENERAL.—Notwithstanding any
24 other provision of law, only citizens and nation-
25 als of the United States shall be eligible to par-

1 ticipate in a qualifying State high risk pool that
2 receives funds under section 2745 of the Public
3 Health Service Act or this section.

4 (B) CONDITION OF PARTICIPATION.—As a
5 condition of a State receiving such funds, the
6 Secretary shall require the State to certify, to
7 the satisfaction of the Secretary, that such
8 State requires all applicants for coverage in the
9 qualifying State high risk pool to provide satis-
10 factory documentation of citizenship or nation-
11 ality in a manner consistent with section
12 1903(x) of the Social Security Act.

13 (C) RECORDS.—The Secretary shall keep
14 sufficient records such that a determination of
15 citizenship or nationality only has to be made
16 once for any individual under this paragraph.

17 (3) RELATION TO SECTION 2745.—As of Janu-
18 ary 1, 2010, a pool shall not qualify as qualified
19 high risk pool under section 2745 of the Public
20 Health Service Act unless the pool is a qualifying
21 State high risk pool described in paragraph (1).

22 (d) WAIVERS.—In order to accommodate new and in-
23 novative programs, the Secretary may waive such require-
24 ments of this section for qualified State reinsurance pro-

1 grams and for qualifying State high risk pools as the Sec-
2 retary deems appropriate.

3 (e) FUNDING.—In addition to any other amounts ap-
4 propriated, there is appropriated to carry out section 2745
5 of the Public Health Service Act (including through a pro-
6 gram or pool described in subsection (a)(1))—

7 (1) \$15,000,000,000 for the period of fiscal
8 years 2010 through 2019; and

9 (2) an additional \$10,000,000,000 for the pe-
10 riod of fiscal years 2015 through 2019.

11 (f) DEFINITIONS.—In this section:

12 (1) HEALTH INSURANCE COVERAGE; HEALTH
13 INSURANCE ISSUER.—The terms “health insurance
14 coverage” and “health insurance issuer” have the
15 meanings given such terms in section 2791 of the
16 Public Health Service Act.

17 (2) CURRENT SECTION 2745 QUALIFIED HIGH
18 RISK POOL.—The term “current section 2745 quali-
19 fied high risk pool” has the meaning given the term
20 “qualified high risk pool” under section 2745(g) of
21 the Public Health Service Act as in effect as of the
22 date of the enactment of this Act.

23 (3) SECRETARY.—The term “Secretary” means
24 Secretary of Health and Human Services.

1 (4) STANDARD RISK RATE.—The term “stand-
2 ard risk rate” means a rate that—

3 (A) is determined under the State high
4 risk pool by considering the premium rates
5 charged by other health insurance issuers offer-
6 ing health insurance coverage to individuals in
7 the insurance market served;

8 (B) is established using reasonable actu-
9 arial techniques; and

10 (C) reflects anticipated claims experience
11 and expenses for the coverage involved.

12 (5) STATE.—The term “State” means any of
13 the 50 States or the District of Columbia.

14 **SEC. 102. ELIMINATION OF CERTAIN REQUIREMENTS FOR**
15 **GUARANTEED AVAILABILITY IN INDIVIDUAL**
16 **MARKET.**

17 (a) IN GENERAL.—Section 2741(b) of the Public
18 Health Service Act (42 U.S.C. 300gg–41(b)) is amend-
19 ed—

20 (1) in paragraph (1)—

21 (A) by striking “(1)(A)” and inserting
22 “(1)”; and

23 (B) by striking “and (B)” and all that fol-
24 lows up to the semicolon at the end;

1 (2) by adding “and” at the end of paragraph
2 (2);

3 (3) in paragraph (3)—

4 (A) by striking “(1)(A)” and inserting
5 “(1)”; and

6 (B) by striking the semicolon at the end
7 and inserting a period; and

8 (4) by striking paragraphs (4) and (5).

9 (b) EFFECTIVE DATE.—The amendments made by
10 subsection (a) shall take effect on the date of the enact-
11 ment of this Act.

12 **SEC. 103. NO ANNUAL OR LIFETIME SPENDING CAPS.**

13 Notwithstanding any other provision of law, a health
14 insurance issuer (including an entity licensed to sell insur-
15 ance with respect to a State or group health plan) may
16 not apply an annual or lifetime aggregate spending cap
17 on any health insurance coverage or plan offered by such
18 issuer.

19 **SEC. 104. PREVENTING UNJUST CANCELLATION OF INSUR-**
20 **ANCE COVERAGE.**

21 (a) CLARIFICATION REGARDING APPLICATION OF
22 GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH
23 INSURANCE COVERAGE.—Section 2742 of the Public
24 Health Service Act (42 U.S.C. 300gg-42) is amended—

1 (1) in its heading, by inserting “, **CONTINU-**
2 **ATION IN FORCE, INCLUDING PROHIBITION OF**
3 **RESCISSION,”** after “**GUARANTEED RENEW-**
4 **ABILITY”**;

5 (2) in subsection (a), by inserting “, including
6 without rescission,” after “continue in force”; and

7 (3) in subsection (b)(2), by inserting before the
8 period at the end the following: “, including inten-
9 tional concealment of material facts regarding a
10 health condition related to the condition for which
11 coverage is being claimed”.

12 (b) OPPORTUNITY FOR INDEPENDENT, EXTERNAL
13 THIRD PARTY REVIEW IN CERTAIN CASES.—Subpart 1
14 of part B of title XXVII of the Public Health Service Act
15 is amended by adding at the end the following new section:

16 **“SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL**
17 **THIRD PARTY REVIEW IN CERTAIN CASES.**

18 “(a) NOTICE AND REVIEW RIGHT.—If a health in-
19 surance issuer determines to nonrenew or not continue in
20 force, including rescind, health insurance coverage for an
21 individual in the individual market on the basis described
22 in section 2742(b)(2) before such nonrenewal, discontinu-
23 ation, or rescission, may take effect the issuer shall pro-
24 vide the individual with notice of such proposed non-
25 renewal, discontinuation, or rescission and an opportunity

1 for a review of such determination by an independent, ex-
2 ternal third party under procedures specified by the Sec-
3 retary.

4 “(b) INDEPENDENT DETERMINATION.—If the indi-
5 vidual requests such review by an independent, external
6 third party of a nonrenewal, discontinuation, or rescission
7 of health insurance coverage, the coverage shall remain in
8 effect until such third party determines that the coverage
9 may be nonrenewed, discontinued, or rescinded under sec-
10 tion 2742(b)(2).”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply after the date of the enactment
13 of this Act with respect to health insurance coverage
14 issued before, on, or after such date.

15 **TITLE II—REDUCING HEALTH**
16 **CARE PREMIUMS AND THE**
17 **NUMBER OF UNINSURED**
18 **AMERICANS**

19 **SEC. 111. STATE INNOVATION PROGRAMS.**

20 (a) PROGRAMS THAT REDUCE THE COST OF
21 HEALTH INSURANCE PREMIUMS.—

22 (1) PAYMENTS TO STATES.—

23 (A) FOR PREMIUM REDUCTIONS IN THE
24 SMALL GROUP MARKET.—If the Secretary de-
25 termines that a State has reduced the average

1 per capita premium for health insurance cov-
2 erage in the small group market in year 3, in
3 year 6, or year 9 (as defined in subsection (c))
4 below the premium baseline for such year (as
5 defined paragraph (2)), the Secretary shall pay
6 the State an amount equal to the product of—

7 (i) bonus premium percentage (as de-
8 fined in paragraph (3)) for the State, mar-
9 ket, and year; and

10 (ii) the maximum State premium pay-
11 ment amount (as defined in paragraph (4))
12 for the State, market, and year

13 (B) FOR PREMIUM REDUCTIONS IN THE
14 INDIVIDUAL MARKET.—If the Secretary deter-
15 mines that a State has reduced the average per
16 capita premium for health insurance coverage
17 in the individual market in year 3, in year 6,
18 or in year 9 below the premium baseline for
19 such year, the Secretary shall pay the State an
20 amount equal to the product of—

21 (i) bonus premium percentage for the
22 State, market, and year; and

23 (ii) the maximum State premium pay-
24 ment amount for the State, market, and
25 year.

1 (2) PREMIUM BASELINE.—For purposes of this
2 subsection, the term “premium baseline” means, for
3 a market in a State—

4 (A) for year 1, the average per capita pre-
5 miums for health insurance coverage in such
6 market in the State in such year; or

7 (B) for a subsequent year, the baseline for
8 the market in the State for the previous year
9 under this paragraph increased by a percentage
10 specified in accordance with a formula estab-
11 lished by the Secretary, in consultation with the
12 Congressional Budget Office and the Bureau of
13 the Census, that takes into account at least the
14 following:

15 (i) GROWTH FACTOR.—The inflation
16 in the costs of inputs to health care serv-
17 ices in the year.

18 (ii) HISTORIC PREMIUM GROWTH
19 RATES.—Historic growth rates, during the
20 10 years before year 1, of per capita pre-
21 miums for health insurance coverage.

22 (iii) DEMOGRAPHIC CONSIDER-
23 ATIONS.—Historic average changes in the
24 demographics of the population covered

1 that impact on the rate of growth of per
 2 capita health care costs.

3 (3) BONUS PREMIUM PERCENTAGE DEFINED.—

4 (A) IN GENERAL.—For purposes of this
 5 subsection, the term “bonus premium percent-
 6 age” means, for the small group market or indi-
 7 vidual market in a State for a year, such per-
 8 centage as determined in accordance with the
 9 following table based on the State’s premium
 10 performance level (as defined in subparagraph
 11 (B)) for such market and year:

The bonus premium percentage for a State is—	For year 3 if the premium performance level of the State is—	For year 6 if the premium performance level of the State is—	For year 9 if the premium performance level of the State is—
100 percent	at least 8.5%	at least 11%	at least 13.5%
50 percent	at least 6.38%, but less than 8.5%	at least 10.38%, but less than 11%	at least 12.88%, but less than 13.5%
25 percent	at least 4.25%, but less than 6.38%	at least 9.75%, but less than 10.38%	at least 12.25%, but less than 12.88%
0 percent	less than 4.25%	less than 9.75%	less than 12.25%

12 (B) PREMIUM PERFORMANCE LEVEL.—For
 13 purposes of this subsection, the term “premium
 14 performance level” means, for a State, market,
 15 and year, the percentage reduction in the aver-
 16 age per capita premiums for health insurance
 17 coverage for the State, market, and year, as

1 compared to the premium baseline for such
2 State, market, and year.

3 (4) MAXIMUM STATE PREMIUM PAYMENT
4 AMOUNT DEFINED.—For purposes of this sub-
5 section, the term “maximum State premium pay-
6 ment amount” means, for a State for the small
7 group market or the individual market for a year,
8 the product of—

9 (A) the proportion (as determined by the
10 Secretary), of the number of nonelderly individ-
11 uals lawfully residing in all the States who are
12 enrolled in health insurance coverage in the re-
13 spective market in the year, who are residents
14 of the State; and

15 (B) the amount available for obligation
16 from amounts appropriated under subsection
17 (d) for such market with respect to perform-
18 ance in such year.

19 (5) METHODOLOGY FOR CALCULATING AVER-
20 AGE PER CAPITA PREMIUMS.—

21 (A) ESTABLISHMENT.—The Secretary
22 shall establish, by rule and consistent with this
23 subsection, a methodology for computing the
24 average per capita premiums for health insur-
25 ance coverage for the small group market and

1 for the individual market in each State for each
2 year beginning with year 1.

3 (B) ADJUSTMENTS.—Under such method-
4 ology, the Secretary shall provide for the fol-
5 lowing adjustments (in a manner determined
6 appropriate by the Secretary):

7 (i) EXCLUSION OF ILLEGAL ALIENS.—
8 An adjustment so as not to take into ac-
9 count enrollees who are not lawfully
10 present in the United States and their pre-
11 mium costs.

12 (ii) TREATING STATE PREMIUM SUB-
13 SIDIES AS PREMIUM COSTS.—An adjust-
14 ment so as to increase per capita pre-
15 miums to remove the impact of premium
16 subsidies made directly by a State to re-
17 duce health insurance premiums.

18 (6) CONDITIONS OF PAYMENT.—As a condition
19 of receiving a payment under paragraph (1), a State
20 must agree to submit aggregate, non-individually
21 identifiable data to the Secretary, in a form and
22 manner specified by the Secretary, for use by the
23 Secretary to determine the State's premium baseline
24 and premium performance level for purposes of this
25 subsection.

1 (b) PROGRAMS THAT REDUCE THE NUMBER OF UN-
2 INSURED.—

3 (1) IN GENERAL.—If the Secretary determines
4 that a State has reduced the percentage of unin-
5 sured nonelderly residents in year 5, year 7, or year
6 9, below the uninsured baseline (as defined in para-
7 graph (2)) for the State for the year, the Secretary
8 shall pay the State an amount equal to the product
9 of—

10 (A) bonus uninsured percentage (as de-
11 fined in paragraph (3)) for the State and year;
12 and

13 (B) the maximum uninsured payment
14 amount (as defined in paragraph (4)) for the
15 State and year.

16 (2) UNINSURED BASELINE.—

17 (A) IN GENERAL.—For purposes of this
18 subsection, and subject to subparagraph (B),
19 the term “uninsured baseline” means, for a
20 State, the percentage of nonelderly residents in
21 the State who are uninsured in year 1.

22 (B) ADJUSTMENT.—The Secretary may, at
23 the written request of a State, adjust the unin-
24 sured baseline for States for a year to take into
25 account unanticipated and exceptional changes,

1 such as an unanticipated migration, of non-
 2 elderly individuals into, or out of, States in a
 3 manner that does not reflect substantially the
 4 proportion of uninsured nonelderly residents in
 5 the States involved in year 1. Any such adjust-
 6 ment shall only be done in a manner that does
 7 not result in the average of the uninsured base-
 8 lines for nonelderly residents for all States
 9 being changed.

10 (3) BONUS UNINSURED PERCENTAGE.—

11 (A) BONUS UNINSURED PERCENTAGE.—

12 For purposes of this subsection, the term
 13 “bonus uninsured percentage” means, for a
 14 State for a year, such percentage as determined
 15 in accordance with the following table, based on
 16 the uninsured performance level (as defined in
 17 subparagraph (B)) for such State and year:

The bonus un- insured per- centage for a State is—	For year 5 if the uninsured per- formance level of the State is—	For year 7 if the uninsured per- formance level of the State is—	For year 9 if the uninsured per- formance level of the State is—
100 percent	at least 10%	at least 15%	at least 20%
50 percent	at least 7.5% but less than 10%	at least 13.75% but less than 15%	at least 18.75% but less than 20%
25 percent	at least 5% but less than 7.5%	at least 12.5% but less than 13.75%	at least 17.5% but less than 18.75%
0 percent	less than 5%	less than 12.5%	less than 17.5%

1 (B) UNINSURED PERFORMANCE LEVEL.—

2 For purposes of this subsection, the term “un-
3 insured performance level” means, for a State
4 for a year, the reduction (expressed as a per-
5 centage) in the percentage of uninsured non-
6 elderly residents in such State in the year as
7 compared to the uninsured baseline for such
8 State for such year.

9 (4) MAXIMUM STATE UNINSURED PAYMENT
10 AMOUNT DEFINED.—For purposes of this sub-
11 section, the term “maximum State uninsured pay-
12 ment amount” means, for a State for a year, the
13 product of—

14 (A) the proportion (as determined by the
15 Secretary), of the number of uninsured non-
16 elderly individuals lawfully residing in all the
17 States in the year, who are residents of the
18 State; and

19 (B) the amount available for obligation
20 under this subsection from amounts appro-
21 priated under subsection (d) with respect to
22 performance in such year.

23 (5) METHODOLOGY FOR COMPUTING THE PER-
24 CENTAGE OF UNINSURED NONELDERLY RESIDENTS
25 IN A STATE.—

1 (A) ESTABLISHMENT.—The Secretary
2 shall establish, by rule and consistent with this
3 subsection, a methodology for computing the
4 percentage of nonelderly residents in a State
5 who are uninsured in each year beginning with
6 year 1.

7 (B) RULES.—

8 (i) TREATMENT OF UNINSURED.—
9 Such methodology shall treat as uninsured
10 those residents who do not have health in-
11 surance coverage or other creditable cov-
12 erage (as defined in section 9801(c)(1) of
13 the Internal Revenue Code of 1986), ex-
14 cept that such methodology shall rely upon
15 data on the nonelderly and uninsured pop-
16 ulations within each State in such year
17 provided through population surveys con-
18 ducted by federal agencies.

19 (ii) LIMITATION TO NONELDERLY.—
20 Such methodology shall exclude individuals
21 who are 65 years of age or older.

22 (iii) EXCLUSION OF ILLEGAL
23 ALIENS.—Such methodology shall exclude
24 individuals not lawfully present in the
25 United States.

1 (6) CONDITIONS OF PAYMENT.—As a condition
2 of receiving a payment under paragraph (1), a State
3 must agree to submit aggregate, non-individually
4 identifiable data to the Secretary, in a form and
5 manner specified by the Secretary, for use by the
6 Secretary in determining the State’s uninsured base-
7 line and uninsured performance level for purposes of
8 this subsection.

9 (c) DEFINITIONS.—For purposes of this section:

10 (1) GROUP HEALTH PLAN.—The term “group
11 health plan” has the meaning given such term in
12 section 9832(a) of the Internal Revenue Code of
13 1986.

14 (2) HEALTH INSURANCE COVERAGE.—The term
15 “health insurance coverage” has the meaning given
16 such term in section 9832(b)(1) of the Internal Rev-
17 enue Code of 1986.

18 (3) INDIVIDUAL MARKET.—Except as the Sec-
19 retary may otherwise provide in the case of group
20 health plans that have fewer than 2 participants as
21 current employees on the first day of a plan year,
22 the term “individual market” means the market for
23 health insurance coverage offered to individuals
24 other than in connection with a group health plan.

1 (4) SECRETARY.—The term “Secretary” means
2 the Secretary of Health and Human Services.

3 (5) SMALL GROUP MARKET.—The term “small
4 group market” means the market for health insur-
5 ance coverage under which individuals obtain health
6 insurance coverage (directly or through any arrange-
7 ment) on behalf of themselves (and their depend-
8 ents) through a group health plan maintained by an
9 employer who employed on average at least 2 but
10 not more than 50 employees on business days during
11 a calendar year.

12 (6) STATE.—The term “State” means any of
13 the 50 States and the District of Columbia.

14 (7) YEARS.—The terms “year 1”, “year 2”,
15 “year 3”, and similar subsequently numbered years
16 mean 2010, 2011, 2012, and subsequent sequen-
17 tially numbered years.

18 (d) APPROPRIATIONS; PAYMENTS.—

19 (1) PAYMENTS FOR REDUCTIONS IN COST OF
20 HEALTH INSURANCE COVERAGE.—

21 (A) SMALL GROUP MARKET.—

22 (i) IN GENERAL.—From any funds in
23 the Treasury not otherwise appropriated,
24 there is appropriated for payments under
25 subsection (a)(1)(A)—

1 (I) \$18,000,000,000 with respect
2 to performance in year 3;

3 (II) \$5,000,000,000 with respect
4 to performance in year 6; and

5 (III) \$2,000,000,000 with re-
6 spect to performance in year 9.

7 (ii) AVAILABILITY OF APPROPRIATED
8 FUNDS.—Funds appropriated under clause
9 (i) shall remain available until expended.

10 (B) INDIVIDUAL MARKET.—

11 (i) IN GENERAL.—Subject to clause
12 (ii), from any funds in the Treasury not
13 otherwise appropriated, there is appro-
14 priated for payments under subsection
15 (a)(1)(B)—

16 (I) \$7,000,000,000 with respect
17 to performance in year 3;

18 (II) \$2,000,000,000 with respect
19 to performance in year 6; and

20 (III) \$1,000,000,000 with re-
21 spect to performance in year 9.

22 (ii) AVAILABILITY OF APPROPRIATED
23 FUNDS.—Of the funds appropriated under
24 clause (i) that are not expended or obli-
25 gated by the end of the year following the

1 year for which the funds are appro-
2 priated—

3 (I) 75 percent shall remain avail-
4 able until expended for payments
5 under subsection (a)(1)(B); and

6 (II) 25 percent shall remain
7 available until expended for payments
8 under subsection (a)(1)(A).

9 (2) PAYMENTS FOR REDUCTIONS IN THE PER-
10 CENTAGE OF UNINSURED.—

11 (A) IN GENERAL.—From any funds in the
12 Treasury not otherwise appropriated, there is
13 appropriated for payments under subsection
14 (b)(1)—

15 (i) \$10,000,000,000 with respect to
16 performance in year 5;

17 (ii) \$3,000,000,000 with respect to
18 performance in year 7; and

19 (iii) \$2,000,000,000 with respect to
20 performance in year 9

21 (B) AVAILABILITY OF APPROPRIATED
22 FUNDS.—Funds appropriated under subpara-
23 graph (A) shall remain available until expended.

24 (3) PAYMENT TIMING.—Payments under this
25 section shall be made in a form and manner speci-

1 fied by the Secretary in the year after the perform-
2 ance year involved.

3 **SEC. 112. HEALTH PLAN FINDERS.**

4 (a) STATE PLAN FINDERS.—Not later than 12
5 months after the date of the enactment of this Act, each
6 State may contract with a private entity to develop and
7 operate a plan finder website (referred to in this section
8 as a “State plan finder”) which shall provide information
9 to individuals in such State on plans of health insurance
10 coverage that are available to individuals in such State (in
11 this section referred to as a “health insurance plan”) .
12 Such State may not operate a plan finder itself.

13 (b) MULTI-STATE PLAN FINDERS.—

14 (1) IN GENERAL.—A private entity may operate
15 a multi-State finder that operates under this section
16 in the States involved in the same manner as a State
17 plan finder would operate in a single State.

18 (2) SHARING OF INFORMATION.—States shall
19 regulate the manner in which data is shared between
20 plan finders to ensure consistency and accuracy in
21 the information about health insurance plans con-
22 tained in such finders.

23 (c) REQUIREMENTS FOR PLAN FINDERS.—Each plan
24 finder shall meet the following requirements:

1 (1) The plan finder shall ensure that each
2 health insurance plan in the plan finder meets the
3 requirements for such plans under subsection (d).

4 (2) The plan finder shall present complete in-
5 formation on the costs and benefits of health insur-
6 ance plans (including information on monthly pre-
7 mium, copayments, and deductibles) in a uniform
8 manner that—

9 (A) uses the standard definitions developed
10 under paragraph (3); and

11 (B) is designed to allow consumers to eas-
12 ily compare such plans.

13 (3) The plan finder shall be available on the
14 internet and accessible to all individuals in the State
15 or, in the case of a multi-State plan finder, in all
16 States covered by the multi-State plan finder.

17 (4) The plan finder shall allow consumers to
18 search and sort data on the health insurance plans
19 in the plan finder on criteria such as coverage of
20 specific benefits (such as coverage of disease man-
21 agement services or pediatric care services), as well
22 as data available on quality.

23 (5) The plan finder shall meet all relevant State
24 laws and regulations, including laws and regulations
25 related to the marketing of insurance products. In

1 the case of a multi-State plan finder, the finder shall
2 meet such laws and regulations for all of the States
3 involved.

4 (6) The plan finder shall meet solvency, finan-
5 cial, and privacy requirements established by the
6 State or States in which the plan finder operates or
7 the Secretary for multi-State finders.

8 (7) The plan finder and the employees of the
9 plan finder shall be appropriately licensed in the
10 State or States in which the plan finder operates, if
11 such licensure is required by such State or States.

12 (8) Notwithstanding subsection (f)(1), the plan
13 finder shall assist individuals who are eligible for the
14 Medicaid program under title XIX of the Social Se-
15 curity Act or State Children's Health Insurance Pro-
16 gram under title XXI of such Act by including infor-
17 mation on Medicaid options, eligibility, and how to
18 enroll.

19 (d) REQUIREMENTS FOR PLANS PARTICIPATING IN
20 A PLAN FINDER.—

21 (1) IN GENERAL.—Each State shall ensure that
22 health insurance plans participating in the State
23 plan finder or in a multi-State plan finder meet the
24 requirements of paragraph (2) (relating to adequacy

1 of insurance coverage, consumer protection, and fi-
2 nancial strength).

3 (2) SPECIFIC REQUIREMENTS.—In order to
4 participate in a plan finder, a health insurance plan
5 must meet all of the following requirements, as de-
6 termined by each State in which such plan operates:

7 (A) The health insurance plan shall be ac-
8 tuarially sound.

9 (B) The health insurance plan may not
10 have a history of abusive policy rescissions.

11 (C) The health insurance plan shall meet
12 financial and solvency requirements.

13 (D) The health insurance plan shall dis-
14 close—

15 (i) all financial arrangements involv-
16 ing the sale and purchase of health insur-
17 ance, such as the payment of fees and
18 commissions; and

19 (ii) such arrangements may not be
20 abusive.

21 (E) The health insurance plan shall main-
22 tain electronic health records that comply with
23 the requirements of the American Recovery and
24 Reinvestment Act of 2009 (Public Law 111–5)
25 related to electronic health records.

1 (F) The health insurance plan shall make
2 available to plan enrollees via the finder, wheth-
3 er by information provided to the finder or by
4 a website link directing the enrollee from the
5 finder to the health insurance plan website,
6 data that includes the price and cost to the in-
7 dividual of services offered by a provider ac-
8 cording to the terms and conditions of the
9 health plan. Data described in this paragraph is
10 not made public by the finder, only made avail-
11 able to the individual once enrolled in the
12 health plan.

13 (e) PROHIBITIONS.—

14 (1) DIRECT ENROLLMENT.—The State plan
15 finder may not directly enroll individuals in health
16 insurance plans.

17 (2) CONFLICTS OF INTEREST.—

18 (A) COMPANIES.—A health insurance
19 issuer offering a health insurance plan through
20 a plan finder may not—

21 (i) be the private entity developing
22 and maintaining a plan finder under sub-
23 sections (a) and (b); or

24 (ii) have an ownership interest in such
25 private entity or in the plan finder.

1 (B) INDIVIDUALS.—An individual em-
2 ployed by a health insurance issuer offering a
3 health insurance plan through a plan finder
4 may not serve as a director or officer for—

5 (i) the private entity developing and
6 maintaining a plan finder under sub-
7 sections (a) and (b); or

8 (ii) the plan finder.

9 (f) CONSTRUCTION.—Nothing in this section shall be
10 construed to allow the Secretary authority to regulate ben-
11 efit packages or to prohibit health insurance brokers and
12 agents from—

13 (1) utilizing the plan finder for any purpose; or

14 (2) marketing or offering health insurance
15 products.

16 (g) PLAN FINDER DEFINED.—For purposes of this
17 section, the term “plan finder” means a State plan finder
18 under subsection (a) or a multi-State plan finder under
19 subsection (b).

20 (h) STATE DEFINED.—In this section, the term
21 “State” has the meaning given such term for purposes of
22 title XIX of the Social Security Act.

23 **SEC. 113. ADMINISTRATIVE SIMPLIFICATION.**

24 (a) OPERATING RULES FOR HEALTH INFORMATION
25 TRANSACTIONS.—

1 (1) DEFINITION OF OPERATING RULES.—Sec-
2 tion 1171 of the Social Security Act (42 U.S.C.
3 1320d) is amended by adding at the end the fol-
4 lowing:

5 “(9) OPERATING RULES.—The term ‘operating
6 rules’ means the necessary business rules and guide-
7 lines for the electronic exchange of information that
8 are not defined by a standard or its implementation
9 specifications as adopted for purposes of this part.”.

10 (2) OPERATING RULES AND COMPLIANCE.—
11 Section 1173 of the Social Security Act (42 U.S.C.
12 1320d–2) is amended—

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

15 “(J) Electronic funds transfers.”; and

16 (B) by adding at the end the following new
17 subsections:

18 “(g) OPERATING RULES.—

19 “(1) IN GENERAL.—The Secretary shall adopt
20 a single set of operating rules for each transaction
21 described in subsection (a)(2) with the goal of cre-
22 ating as much uniformity in the implementation of
23 the electronic standards as possible. Such operating
24 rules shall be consensus-based and reflect the nec-
25 essary business rules affecting health plans and

1 health care providers and the manner in which they
2 operate pursuant to standards issued under Health
3 Insurance Portability and Accountability Act of
4 1996.

5 “(2) OPERATING RULES DEVELOPMENT.—In
6 adopting operating rules under this subsection, the
7 Secretary shall rely on recommendations for oper-
8 ating rules developed by a qualified nonprofit entity,
9 as selected by the Secretary, that meets the fol-
10 lowing requirements:

11 “(A) The entity focuses its mission on ad-
12 ministrative simplification.

13 “(B) The entity demonstrates an estab-
14 lished multi-stakeholder and consensus-based
15 process for development of operating rules, in-
16 cluding representation by or participation from
17 health plans, health care providers, vendors, rel-
18 evant Federal agencies, and other standard de-
19 velopment organizations.

20 “(C) The entity has established a public
21 set of guiding principles that ensure the oper-
22 ating rules and process are open and trans-
23 parent.

24 “(D) The entity coordinates its activities
25 with the HIT Policy Committee and the HIT

1 Standards Committee (as established under
2 title XXX of the Public Health Service Act)
3 and complements the efforts of the Office of the
4 National Healthcare Coordinator and its related
5 health information exchange goals.

6 “(E) The entity incorporates national
7 standards, including the transaction standards
8 issued under Health Insurance Portability and
9 Accountability Act of 1996.

10 “(F) The entity supports nondiscrimina-
11 tion and conflict of interest policies that dem-
12 onstrate a commitment to open, fair, and non-
13 discriminatory practices.

14 “(G) The entity allows for public review
15 and updates of the operating rules.

16 “(3) REVIEW AND RECOMMENDATIONS.—The
17 National Committee on Vital and Health Statistics
18 shall—

19 “(A) review the operating rules developed
20 by a nonprofit entity described under paragraph
21 (2);

22 “(B) determine whether such rules rep-
23 resent a consensus view of the health care in-
24 dustry and are consistent with and do not alter
25 current standards;

1 “(C) evaluate whether such rules are con-
2 sistent with electronic standards adopted for
3 health information technology; and

4 “(D) submit to the Secretary a rec-
5 ommendation as to whether the Secretary
6 should adopt such rules.

7 “(4) IMPLEMENTATION.—

8 “(A) IN GENERAL.—The Secretary shall
9 adopt operating rules under this subsection, by
10 regulation in accordance with subparagraph
11 (C), following consideration of the rules devel-
12 oped by the non-profit entity described in para-
13 graph (2) and the recommendation submitted
14 by the National Committee on Vital and Health
15 Statistics under paragraph (3)(D) and having
16 ensured consultation with providers.

17 “(B) ADOPTION REQUIREMENTS; EFFEC-
18 TIVE DATES.—

19 “(i) ELIGIBILITY FOR A HEALTH
20 PLAN AND HEALTH CLAIM STATUS.—The
21 set of operating rules for transactions for
22 eligibility for a health plan and health
23 claim status shall be adopted not later
24 than July 1, 2011, in a manner ensuring
25 that such rules are effective not later than

1 January 1, 2013, and may allow for the
2 use of a machine readable identification
3 card.

4 “(ii) ELECTRONIC FUNDS TRANSFERS
5 AND HEALTH CARE PAYMENT AND REMIT-
6 TANCE ADVICE.—The set of operating
7 rules for electronic funds transfers and
8 health care payment and remittance advice
9 shall be adopted not later than July 1,
10 2012, in a manner ensuring that such
11 rules are effective not later than January
12 1, 2014.

13 “(iii) OTHER COMPLETED TRANS-
14 ACTIONS.—The set of operating rules for
15 the remainder of the completed trans-
16 actions described in subsection (a)(2), in-
17 cluding health claims or equivalent encoun-
18 ter information, enrollment and
19 disenrollment in a health plan, health plan
20 premium payments, and referral certifi-
21 cation and authorization, shall be adopted
22 not later than July 1, 2014, in a manner
23 ensuring that such rules are effective not
24 later than January 1, 2016.

1 “(C) EXPEDITED RULEMAKING.—The Sec-
2 retary shall promulgate an interim final rule
3 applying any standard or operating rule rec-
4 ommended by the National Committee on Vital
5 and Health Statistics pursuant to paragraph
6 (3). The Secretary shall accept public comments
7 on any interim final rule published under this
8 subparagraph for 60 days after the date of such
9 publication.

10 “(h) COMPLIANCE.—

11 “(1) HEALTH PLAN CERTIFICATION.—

12 “(A) ELIGIBILITY FOR A HEALTH PLAN,
13 HEALTH CLAIM STATUS, ELECTRONIC FUNDS
14 TRANSFERS, HEALTH CARE PAYMENT AND RE-
15 MITTANCE ADVICE.—Not later than December
16 31, 2013, a health plan shall file a statement
17 with the Secretary, in such form as the Sec-
18 retary may require, certifying that the data and
19 information systems for such plan are in com-
20 pliance with any applicable standards (as de-
21 scribed under paragraph (7) of section 1171)
22 and operating rules (as described under para-
23 graph (9) of such section) for electronic funds
24 transfers, eligibility for a health plan, health

1 claim status, and health care payment and re-
2 mittance advice, respectively.

3 “(B) OTHER COMPLETED TRANS-
4 ACTIONS.—Not later than December 31, 2015,
5 a health plan shall file a statement with the
6 Secretary, in such form as the Secretary may
7 require, certifying that the data and informa-
8 tion systems for such plan are in compliance
9 with any applicable standards and operating
10 rules for the remainder of the completed trans-
11 actions described in subsection (a)(2), including
12 health claims or equivalent encounter informa-
13 tion, enrollment and disenrollment in a health
14 plan, health plan premium payments, and refer-
15 ral certification and authorization, respectively.
16 A health plan shall provide the same level of
17 documentation to certify compliance with such
18 transactions as is required to certify compliance
19 with the transactions specified in subparagraph
20 (A).

21 “(2) DOCUMENTATION OF COMPLIANCE.—A
22 health plan shall provide the Secretary, in such form
23 as the Secretary may require, with adequate docu-
24 mentation of compliance with the standards and op-
25 erating rules described under paragraph (1). A

1 health plan shall not be considered to have provided
2 adequate documentation and shall not be certified as
3 being in compliance with such standards, unless the
4 health plan—

5 “(A) demonstrates to the Secretary that
6 the plan conducts the electronic transactions
7 specified in paragraph (1) in a manner that
8 fully complies with the regulations of the Sec-
9 retary; and

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

14 “(3) SERVICE CONTRACTS.—A health plan shall
15 be required to comply with any applicable certifi-
16 cation and compliance requirements (and provide the
17 Secretary with adequate documentation of such com-
18 pliance) under this subsection for any entities that
19 provide services pursuant to a contract with such
20 health plan.

21 “(4) CERTIFICATION BY OUTSIDE ENTITY.—
22 The Secretary may contract with an independent,
23 outside entity to certify that a health plan has com-
24 plied with the requirements under this subsection,
25 provided that the certification standards employed

1 by such entities are in accordance with any stand-
2 ards or rules issued by the Secretary.

3 “(5) COMPLIANCE WITH REVISED STANDARDS
4 AND RULES.—A health plan (including entities de-
5 scribed under paragraph (3)) shall comply with the
6 certification and documentation requirements under
7 this subsection for any interim final rule promul-
8 gated by the Secretary under subsection (i) that
9 amends any standard or operating rule described
10 under paragraph (1) of this subsection. A health
11 plan shall comply with such requirements not later
12 than the effective date of the applicable interim final
13 rule.

14 “(6) AUDITS OF HEALTH PLANS.—The Sec-
15 retary shall conduct periodic audits to ensure that
16 health plans (including entities described under
17 paragraph (3)) are in compliance with any standards
18 and operating rules that are described under para-
19 graph (1).

20 “(i) REVIEW AND AMENDMENT OF STANDARDS AND
21 RULES.—

22 “(1) ESTABLISHMENT.—Not later than Janu-
23 ary 1, 2014, the Secretary shall establish a review
24 committee (as described under paragraph (4)).

25 “(2) EVALUATIONS AND REPORTS.—

1 “(A) HEARINGS.—Not later than April 1,
2 2014, and not less than biennially thereafter,
3 the Secretary, acting through the review com-
4 mittee, shall conduct hearings to evaluate and
5 review the existing standards and operating
6 rules established under this section.

7 “(B) REPORT.—Not later than July 1,
8 2014, and not less than biennially thereafter,
9 the review committee shall provide rec-
10 ommendations for updating and improving such
11 standards and rules. The review committee
12 shall recommend a single set of operating rules
13 per transaction standard and maintain the goal
14 of creating as much uniformity as possible in
15 the implementation of the electronic standards.

16 “(3) INTERIM FINAL RULEMAKING.—

17 “(A) IN GENERAL.—Any recommendations
18 to amend existing standards and operating
19 rules that have been approved by the review
20 committee and reported to the Secretary under
21 paragraph (2)(B) shall be adopted by the Sec-
22 retary through promulgation of an interim final
23 rule not later than 90 days after receipt of the
24 committee’s report.

25 “(B) PUBLIC COMMENT.—

1 “(i) PUBLIC COMMENT PERIOD.—The
2 Secretary shall accept public comments on
3 any interim final rule published under this
4 paragraph for 60 days after the date of
5 such publication.

6 “(ii) EFFECTIVE DATE.—The effective
7 date of any amendment to existing stand-
8 ards or operating rules that is adopted
9 through an interim final rule published
10 under this paragraph shall be 25 months
11 following the close of such public comment
12 period.

13 “(4) REVIEW COMMITTEE.—

14 “(A) DEFINITION.—For the purposes of
15 this subsection, the term ‘review committee’
16 means a committee within the Department of
17 Health and Human services that has been des-
18 ignated by the Secretary to carry out this sub-
19 section, including—

20 “(i) the National Committee on Vital
21 and Health Statistics; or

22 “(ii) any appropriate committee as de-
23 termined by the Secretary.

24 “(B) COORDINATION OF HIT STAND-
25 ARDS.—In developing recommendations under

1 this subsection, the review committee shall con-
2 sider the standards approved by the Office of
3 the National Coordinator for Health Informa-
4 tion Technology.

5 “(j) PENALTIES.—

6 “(1) PENALTY FEE.—

7 “(A) IN GENERAL.—Not later than April
8 1, 2014, and annually thereafter, the Secretary
9 shall assess a penalty fee (as determined under
10 subparagraph (B)) against a health plan that
11 has failed to meet the requirements under sub-
12 section (h) with respect to certification and doc-
13 umentation of compliance with the standards
14 (and their operating rules) as described under
15 paragraph (1) of such subsection.

16 “(B) FEE AMOUNT.—Subject to subpara-
17 graphs (C), (D), and (E), the Secretary shall
18 assess a penalty fee against a health plan in the
19 amount of \$1 per covered life until certification
20 is complete. The penalty shall be assessed per
21 person covered by the plan for which its data
22 systems for major medical policies are not in
23 compliance and shall be imposed against the
24 health plan for each day that the plan is not in

1 compliance with the requirements under sub-
2 section (h).

3 “(C) ADDITIONAL PENALTY FOR MIS-
4 REPRESENTATION.—A health plan that know-
5 ingly provides inaccurate or incomplete informa-
6 tion in a statement of certification or docu-
7 mentation of compliance under subsection (h)
8 shall be subject to a penalty fee that is double
9 the amount that would otherwise be imposed
10 under this subsection.

11 “(D) ANNUAL FEE INCREASE.—The
12 amount of the penalty fee imposed under this
13 subsection shall be increased on an annual basis
14 by the annual percentage increase in total na-
15 tional health care expenditures, as determined
16 by the Secretary.

17 “(E) PENALTY LIMIT.—A penalty fee as-
18 sessed against a health plan under this sub-
19 section shall not exceed, on an annual basis—

20 “(i) an amount equal to \$20 per cov-
21 ered life under such plan; or

22 “(ii) an amount equal to \$40 per cov-
23 ered life under the plan if such plan has
24 knowingly provided inaccurate or incom-

1 plete information (as described under sub-
2 paragraph (C)).

3 “(F) DETERMINATION OF COVERED INDI-
4 VIDUALS.—The Secretary shall determine the
5 number of covered lives under a health plan
6 based upon the most recent statements and fil-
7 ings that have been submitted by such plan to
8 the Securities and Exchange Commission.

9 “(2) NOTICE AND DISPUTE PROCEDURE.—The
10 Secretary shall establish a procedure for assessment
11 of penalty fees under this subsection that provides a
12 health plan with reasonable notice and a dispute res-
13 olution procedure prior to provision of a notice of as-
14 sessment by the Secretary of the Treasury (as de-
15 scribed under paragraph (4)(B)).

16 “(3) PENALTY FEE REPORT.—Not later than
17 May 1, 2014, and annually thereafter, the Secretary
18 shall provide the Secretary of the Treasury with a
19 report identifying those health plans that have been
20 assessed a penalty fee under this subsection.

21 “(4) COLLECTION OF PENALTY FEE.—

22 “(A) IN GENERAL.—The Secretary of the
23 Treasury, acting through the Financial Man-
24 agement Service, shall administer the collection
25 of penalty fees from health plans that have been

1 identified by the Secretary in the penalty fee re-
2 port provided under paragraph (3).

3 “(B) NOTICE.—Not later than August 1,
4 2014, and annually thereafter, the Secretary of
5 the Treasury shall provide notice to each health
6 plan that has been assessed a penalty fee by the
7 Secretary under this subsection. Such notice
8 shall include the amount of the penalty fee as-
9 sessed by the Secretary and the due date for
10 payment of such fee to the Secretary of the
11 Treasury (as described in subparagraph (C)).

12 “(C) PAYMENT DUE DATE.—Payment by a
13 health plan for a penalty fee assessed under
14 this subsection shall be made to the Secretary
15 of the Treasury not later than November 1,
16 2014, and annually thereafter.

17 “(D) UNPAID PENALTY FEES.—Any
18 amount of a penalty fee assessed against a
19 health plan under this subsection for which pay-
20 ment has not been made by the due date pro-
21 vided under subparagraph (C) shall be—

22 “(i) increased by the interest accrued
23 on such amount, as determined pursuant
24 to the underpayment rate established

1 under section 6601 of the Internal Rev-
2 enue Code of 1986; and

3 “(ii) treated as a past-due, legally en-
4 forceable debt owed to a Federal agency
5 for purposes of section 6402(d) of the In-
6 ternal Revenue Code of 1986.

7 “(E) ADMINISTRATIVE FEES.—Any fee
8 charged or allocated for collection activities con-
9 ducted by the Financial Management Service
10 will be passed on to a health plan on a pro-rata
11 basis and added to any penalty fee collected
12 from the plan.”.

13 (b) PROMULGATION OF RULES.—

14 (1) UNIQUE HEALTH PLAN IDENTIFIER.—The
15 Secretary shall promulgate a final rule to establish
16 a unique health plan identifier (as described in sec-
17 tion 1173(b) of the Social Security Act (42 U.S.C.
18 1320d-2(b))) based on the input of the National
19 Committee of Vital and Health Statistics. The Sec-
20 retary may do so on an interim final basis and such
21 rule shall be effective not later than October 1,
22 2012.

23 (2) ELECTRONIC FUNDS TRANSFER.—The Sec-
24 retary shall promulgate a final rule to establish a
25 standard for electronic funds transfers (as described

