Public Law 111–148
111th Congress

An Act

Entitled The Patient Protection and Affordable Care Act.

Mar. 23, 2010
[H.R. 3590]

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

Patient Protection and Affordable Care Act.
42 USC 18001 note.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

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

"(1) the extent to which self-insured group health plans can offer less costly coverage and, if so, whether lower costs are due to more efficient plan administration and lower overhead or to the denial of claims and the offering very limited benefit packages;

"(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns), and the impact of the limited recourse options on consumers; and

"(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer's financial contribution or profit margin, and the impact of such conflict on administration of the health plan.

"(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).".

SEC. 10104. AMENDMENTS TO SUBTITLE D.

42 USC 18021.

(a) Section 1301(a) of this Act is amended by striking paragraph (2) and inserting the following:

"(2) INCLUSION OF CO–OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO–OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

Criteria.

"(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

"(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).".

42 USC 18022.

(b) Section 1302 of this Act is amended—

(1) in subsection (d)(2)(B), by striking "may issue" and inserting "shall issue"; and

(2) by adding at the end the following:

"(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.".

(c) Section 1303 of this Act is amended to read as follows:

42 USC 18023.

"SEC. 1303. SPECIAL RULES.

"(a) STATE OPT-OUT OF ABORTION COVERAGE.—

"(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

"(2) TERMINATION OF OPT OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

"(b) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

"(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

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

"(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

"(B) ABORTION SERVICES.—

"(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

"(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

"(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

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

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

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

"(B) ESTABLISHMENT OF ALLOCATION ACCOUNTS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

"(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

"(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

"(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

"(ii) shall deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

"(C) SEGREGATION OF FUNDS.—

"(i) IN GENERAL.—The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(ii) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall deposit—

"(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

"(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

"(D) ACTUARIAL VALUE.—

"(i) IN GENERAL.—The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

"(ii) CONSIDERATIONS.—In making such estimate, the issuer—

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

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

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

"(E) ENSURING COMPLIANCE WITH SEGREGATION REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

"(ii) CLARIFICATION.—Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

"(3) RULES RELATING TO NOTICE.—

"(A) NOTICE.—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

"(B) RULES RELATING TO PAYMENTS.—The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

"(4) NO DISCRIMINATION ON BASIS OF PROVISION OF ABORTION.—No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions

"(c) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

"(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

"(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

"(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

"(i) conscience protection;

"(ii) willingness or refusal to provide abortion; and

"(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

"(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

"(d) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as 'EMTALA').".

42 USC 18024.

(d) Section 1304 of this Act is amended by adding at the end the following:

Definition.

"(e) EDUCATED HEALTH CARE CONSUMERS.—The term 'educated health care consumer' means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.".

42 USC 18031.

(e) Section 1311(d) of this Act is amended—

(1) in paragraph (3)(B), by striking clause (ii) and inserting the following:

"(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)."; and

(2) in paragraph (6)(A), by inserting "educated" before "health care".

(f) Section 1311(e) of this Act is amended—

(1) in paragraph (2), by striking "may" in the second sentence and inserting "shall"; and

(2) by adding at the end the following:

"(3) TRANSPARENCY IN COVERAGE.—

Public information.

"(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:

"(i) Claims payment policies and practices.

"(ii) Periodic financial disclosures.

"(iii) Data on enrollment.

"(iv) Data on disenrollment.

"(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.

Definition.

Guidance.

"(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. Web posting.

"(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).".

(g) Section 1311(g)(1) of this Act is amended— 42 USC 18031.

(1) in subparagraph (C), by striking "; and" and inserting a semicolon;

(2) in subparagraph (D), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(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.".

(h) Section 1311(i)(2)((B) of this Act is amended by striking "small business development centers" and inserting "resource partners of the Small Business Administration".

(i) Section 1312 of this Act is amended— 42 USC 18032.

(1) in subsection (a)(1), by inserting "and for which such individual is eligible" before the period;

(2) in subsection (e)—

(A) in paragraph (1), by inserting "and employers" after "enroll individuals"; and

(B) by striking the flush sentence at the end; and

(3) in subsection (f)(1)(A)(ii), by striking the parenthetical.

(j)(1) Subparagraph (B) of section 1313(a)(6) of this Act is hereby deemed null, void, and of no effect. 42 USC 18033 note.

(2) Section 3730(e) of title 31, United States Code, is amended by striking paragraph (4) and inserting the following:

"(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed— Courts.

"(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

"(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

"(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

"(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Definition.

Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.".

42 USC 18033. (k) Section 1313(b) of this Act is amended—

(1) in paragraph (3), by striking "and" at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

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

"(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and".

42 USC 18042. (l) Section 1322(b) of this Act is amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2), the following:

Deadlines. Regulations. "(3) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO–OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.".

42 USC 18043. (m) Part III of subtitle D of title I of this Act is amended by striking section 1323.

42 USC 18044. (n) Section 1324(a) of this Act is amended by striking ", a community health" and all that follows through "1333(b)" and inserting ", or a multi-State qualified health plan under section 1334".

42 USC 18051. (o) Section 1331 of this Act is amended—

(1) in subsection (d)(3)(A)(i), by striking "85" and inserting "95"; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: ", or, in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status".

42 USC 18053. (p) Section 1333 of this Act is amended by striking subsection (b).

(q) Part IV of subtitle D of title I of this Act is amended by adding at the end the following:

Contracts. 42 USC 18054.

"SEC. 1334. MULTI-STATE PLANS.

"(a) OVERSIGHT BY THE OFFICE OF PERSONNEL MANAGEMENT.—

"(1) IN GENERAL.—The Director of the Office of Personnel Management (referred to in this section as the 'Director') shall enter into contracts with health insurance issuers (which may

include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark), without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding, to offer at least 2 multi-State qualified health plans through each Exchange in each State. Such plans shall provide individual, or in the case of small employers, group coverage.

"(2) TERMS.—Each contract entered into under paragraph (1) shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. In entering into such contracts, the Director shall ensure that health benefits coverage is provided in accordance with the types of coverage provided for under section 2701(a)(1)(A)(i) of the Public Health Service Act.

"(3) NON-PROFIT ENTITIES.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

"(4) ADMINISTRATION.—The Director shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program under chapter 89 of title 5, United States Code, including (through negotiating with each multi-state plan)—

"(A) a medical loss ratio;

"(B) a profit margin;

"(C) the premiums to be charged; and

"(D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.

"(5) AUTHORITY TO PROTECT CONSUMERS.—The Director may prohibit the offering of any multi-State health plan that does not meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

"(6) ASSURED AVAILABILITY OF VARIED COVERAGE.—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1303(b)(1)(B)(i).

"(7) WITHDRAWAL.—Approval of a contract under this subsection may be withdrawn by the Director only after notice and opportunity for hearing to the issuer concerned without regard to subchapter II of chapter 5 and chapter 7 of title 5, United States Code.

"(b) ELIGIBILITY.—A health insurance issuer shall be eligible to enter into a contract under subsection (a)(1) if such issuer—

"(1) agrees to offer a multi-State qualified health plan that meets the requirements of subsection (c) in each Exchange in each State;

"(2) is licensed in each State and is subject to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act or a requirement of this title;

"(3) otherwise complies with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

"(4) meets such other requirements as determined appropriate by the Director, in consultation with the Secretary.

"(c) REQUIREMENTS FOR MULTI-STATE QUALIFIED HEALTH PLAN.—

"(1) IN GENERAL.—A multi-State qualified health plan meets the requirements of this subsection if, in the determination of the Director—

"(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1302;

"(B) the plan meets all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange;

"(C) except as provided in paragraph (5), the issuer provides for determinations of premiums for coverage under the plan on the basis of the rating requirements of part A of title XXVII of the Public Health Service Act; and

"(D) the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating before the date of enactment of this Act.

"(2) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in paragraph (1)(A) shall preclude a State from requiring that benefits in addition to the essential health benefits required under such paragraph be provided to enrollees of a multi-State qualified health plan offered in such State.

"(3) CREDITS.—

"(A) IN GENERAL.—An individual enrolled in a multi-State qualified health plan under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 and cost sharing assistance under section 1402 in the same manner as an individual who is enrolled in a qualified health plan.

"(B) NO ADDITIONAL FEDERAL COST.—A requirement by a State under paragraph (2) that benefits in addition to the essential health benefits required under paragraph (1)(A) be provided to enrollees of a multi-State qualified health plan shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

"(4) STATE MUST ASSUME COST.—A State shall make payments—

"(A) to an individual enrolled in a multi-State qualified health plan offered in such State; or

"(B) on behalf of an individual described in subparagraph (A) directly to the multi-State qualified health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in paragraph (2).

"(5) APPLICATION OF CERTAIN STATE RATING REQUIREMENTS.—With respect to a multi-State qualified health plan that is offered in a State with age rating requirements that

are lower than 3:1, the State may require that Exchanges operating in such State only permit the offering of such multi-State qualified health plans if such plans comply with the State's more protective age rating requirements.

"(d) PLANS DEEMED TO BE CERTIFIED.—A multi-State qualified health plan that is offered under a contract under subsection (a) shall be deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A).

"(e) PHASE-IN.—Notwithstanding paragraphs (1) and (2) of subsection (b), the Director shall enter into a contract with a health insurance issuer for the offering of a multi-State qualified health plan under subsection (a) if— Contracts.

"(1) with respect to the first year for which the issuer offers such plan, such issuer offers the plan in at least 60 percent of the States;

"(2) with respect to the second such year, such issuer offers the plan in at least 70 percent of the States;

"(3) with respect to the third such year, such issuer offers the plan in at least 85 percent of the States; and

"(4) with respect to each subsequent year, such issuer offers the plan in all States.

"(f) APPLICABILITY.—The requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section to the extent that such requirements do not conflict with a provision of this title.

"(g) CONTINUED SUPPORT FOR FEHBP.—

"(1) MAINTENANCE OF EFFORT.—Nothing in this section shall be construed to permit the Director to allocate fewer financial or personnel resources to the functions of the Office of Personnel Management related to the administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(2) SEPARATE RISK POOL.—Enrollees in multi-State qualified health plans under this section shall be treated as a separate risk pool apart from enrollees in the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(3) AUTHORITY TO ESTABLISH SEPARATE ENTITIES.—The Director may establish such separate units or offices within the Office of Personnel Management as the Director determines to be appropriate to ensure that the administration of multi-State qualified health plans under this section does not interfere with the effective administration of the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(4) EFFECTIVE OVERSIGHT.—The Director may appoint such additional personnel as may be necessary to enable the Director to carry out activities under this section.

"(5) ASSURANCE OF SEPARATE PROGRAM.—In carrying out this section, the Director shall ensure that the program under this section is separate from the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code. Premiums paid for coverage under a multi-State qualified health plan under this section shall not be considered to be Federal funds for any purposes.

"(6) FEHBP PLANS NOT REQUIRED TO PARTICIPATE.—Nothing in this section shall require that a carrier offering coverage under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, also offer a multi-State qualified health plan under this section.

Establishment.

"(h) ADVISORY BOARD.—The Director shall establish an advisory board to provide recommendations on the activities described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

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

42 USC 18061.

(r) Section 1341 of this Act is amended—

(1) in the section heading, by striking "**AND SMALL GROUP MARKETS**" and inserting "**MARKET**";

(2) in subsection (b)(2)(B), by striking "paragraph (1)(A)" and inserting "paragraph (1)(B)"; and

(3) in subsection (c)(1)(A), by striking "and small group markets" and inserting "market".

SEC. 10105. AMENDMENTS TO SUBTITLE E.

26 USC 36B.

(a) Section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking "is in excess of" and inserting "equals or exceeds".

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting "equals or" before "exceeds".

(c) Section 36B(c)(2)(C)(iv) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by striking "subsection (b)(3)(A)(ii)" and inserting "subsection (b)(3)(A)(iii)".

26 USC 6211.

(d) Section 1401(d) of this Act is amended by adding at the end the following:

"(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting '36B,' after '36A,'.".

26 USC 45R.

(e)(1) Subparagraph (B) of section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended to read as follows:

"(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B) and subsection (c)(2)—

"(i) 2010, 2011, 2012, AND 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2010, 2011, 2012, or 2013 is $25,000.

"(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.".

(2) Subsection (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by striking "2011" both places it appears and inserting "2010, 2011".

26 USC 280C.

(3) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1) of this Act, is amended by striking "2011" and inserting "2010, 2011".