

111TH CONGRESS  
1ST SESSION

# S. 1099

To provide comprehensive solutions for the health care system of the United States, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MAY 20, 2009

Mr. COBURN (for himself, Mr. BURR, Mr. BUNNING, Mr. CHAMBLISS, Mr. ALEXANDER, and Mr. INHOFE) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide comprehensive solutions for the health care system of the United States, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

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

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Patients’ Choice Act”.

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

Sec. 1. Short title; table of contents.

### TITLE I—INVESTING IN PREVENTION

Sec. 101. Strategic approach to outcome-based prevention.

Sec. 102. State grants for outcome-based prevention effort.

- Sec. 103. Focusing the food stamp program on nutrition.  
 Sec. 104. Immunizations.

#### TITLE II—STATE-BASED HEALTH CARE EXCHANGES

- Sec. 201. State-based health care exchanges.  
 Sec. 202. Requirements.  
 Sec. 203. State Exchange incentives.

#### TITLE III—FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE

- Sec. 300. Reference.

##### Subtitle A—Refundable and Advanceable Credit for Certain Health Insurance Coverage

- Sec. 301. Refundable and advanceable credit for certain health insurance coverage.  
 Sec. 302. Requiring employer transparency about employee benefits.  
 Sec. 303. Changes to existing tax preferences for medical coverage, etc., for individuals eligible for qualified health insurance credit.

##### Subtitle B—Health Savings Accounts

- Sec. 311. Improvements to health savings accounts.  
 Sec. 312. Exception to requirement for employers to make comparable health savings account contributions.

#### TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

##### Subtitle A—Medicaid Modernization

- Sec. 401. Medicaid modernization.  
 Sec. 402. Outreach.  
 Sec. 403. Transition rules; miscellaneous provisions.

##### Subtitle B—Supplemental Health Care Assistance for Low-Income Families

- Sec. 411. Supplemental Health Care Assistance for Low-Income Families.

#### TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

##### Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

- Sec. 501. Eliminating inefficiencies and increasing choice in Medicare Advantage.  
 Sec. 502. Medicare Accountable Care Organization demonstration program.  
 Sec. 503. Reducing government handouts to wealthier seniors.  
 Sec. 504. Rewarding prevention.  
 Sec. 505. Promoting healthcare provider transparency.  
 Sec. 506. Availability of Medicare and Medicaid claims and patient encounter data.

##### Subtitle B—Reducing Fraud and Abuse

- Sec. 511. Requiring the Secretary of Health and Human Services to change the Medicare beneficiary identifier used to identify Medicare beneficiaries under the Medicare program.

- Sec. 512. Use of technology for real-time data review.
- Sec. 513. Detection of medicare fraud and abuse.
- Sec. 514. Edits on 855S Medicare enrollment application and exemption of pharmacists from surety bond requirement.
- Sec. 515. GAO study and report on effectiveness of surety bond requirements for suppliers of durable medical equipment in combating fraud.

#### TITLE VI—ENDING LAWSUIT ABUSE

- Sec. 601. State grants to create health court solutions.

#### TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

##### Subtitle A—Assisting the Development of Health Information Technology

- Sec. 701. Purpose.
- Sec. 702. Health record banking.
- Sec. 703. Application of Federal and State security and confidentiality standards.

##### Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

- Sec. 711. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.
- Sec. 712. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
- Sec. 713. Rules of construction regarding use of consortia.

#### TITLE VIII—HEALTH CARE SERVICES COMMISSION

##### Subtitle A—Establishment and General Duties

- Sec. 801. Establishment.
- Sec. 802. General authorities and duties.
- Sec. 803. Dissemination.

##### Subtitle B—Forum for Quality and Effectiveness in Health Care

- Sec. 811. Establishment of office.
- Sec. 812. Membership.
- Sec. 813. Duties.
- Sec. 814. Adoption and enforcement of guidelines and standards.
- Sec. 815. Additional requirements.

##### Subtitle C—General Provisions

- Sec. 821. Certain administrative authorities.
- Sec. 822. Funding.
- Sec. 823. Definitions.

##### Subtitle D—Terminations and Transition

- Sec. 831. Termination of Agency for Healthcare Research and Quality.
- Sec. 832. Transition.

##### Subtitle E—Independent Health Record Trust

- Sec. 841. Short title.  
 Sec. 842. Purpose.  
 Sec. 843. Definitions.  
 Sec. 844. Establishment, certification, and membership of Independent Health Record Trusts.  
 Sec. 845. Duties of IHRT to IHRT participants.  
 Sec. 846. Availability and use of information from records in IHRT consistent with privacy protections and agreements.  
 Sec. 847. Voluntary nature of trust participation and information sharing.  
 Sec. 848. Financing of activities.  
 Sec. 849. Regulatory oversight.

#### TITLE IX—MISCELLANEOUS

- Sec. 901. Health care choice for veterans.  
 Sec. 902. Health care choice for Indians.  
 Sec. 903. Termination of Federal Coordinating Council for Comparative Effectiveness Research.  
 Sec. 904. HHS and GAO joint study and report on costs of the 5 medical conditions that have the greatest impact.

## 1                   **TITLE I—INVESTING IN** 2                   **PREVENTION**

### 3   **SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PRE-** 4                   **VENTION.**

5                   (a) INTERAGENCY COORDINATING COMMITTEE.—

6                   (1) IN GENERAL.—The Secretary of Health and  
 7                   Human Services (referred to in this title as the  
 8                   “Secretary”) shall convene an interagency coordi-  
 9                   nating committee to develop a national strategic  
 10                  plan for prevention. The Secretary shall serve as the  
 11                  chairperson of the committee.

12                  (2) COMPOSITION.—In carrying out paragraph  
 13                  (1), the Secretary shall include the participation  
 14                  of—

15                         (A) the Director of the National Institutes  
 16                         of Health;

1 (B) the Director of the Centers for Disease  
2 Control and Prevention;

3 (C) the Administrator of the Agency for  
4 Healthcare Research and Quality;

5 (D) the Administrator of the Substance  
6 Abuse and Mental Health Services Administra-  
7 tion;

8 (E) the Administrator of the Health Re-  
9 sources and Services Administration;

10 (F) the Secretary of Agriculture;

11 (G) the Director of the Centers for Medi-  
12 care & Medicaid Services;

13 (H) the Administrator of the Environ-  
14 mental Protection Agency;

15 (I) the Director of the Indian Health Serv-  
16 ice;

17 (J) the Administrator of the Administra-  
18 tion on Aging;

19 (K) the Secretary of Veterans Affairs;

20 (L) the Secretary of Defense;

21 (M) the Secretary of Education; and

22 (N) the Secretary of Labor.

23 (3) REPORT AND PLAN.—Not later than 1 year  
24 after the date of enactment of this Act, the Sec-  
25 retary, acting through the coordinating committee

1 convened under paragraph (1), shall submit to Con-  
2 gress a report concerning the recommendation of the  
3 committee for health promotion and disease preven-  
4 tion activities. Such report shall include a specific  
5 strategic plan that shall include—

6 (A) a list of national priorities on health  
7 promotion and disease prevention to address  
8 lifestyle behavior modification (smoking ces-  
9 sation, proper nutrition, and appropriate exer-  
10 cise) and the prevention measures for the 5  
11 leading disease killers in the United States;

12 (B) specific science-based initiatives to  
13 achieve the measurable goals of Healthy People  
14 2010 regarding nutrition, exercise, and smoking  
15 cessation, and targeting the 5 leading disease  
16 killers in the United States;

17 (C) specific plans for consolidating Federal  
18 health programs and Centers that exist to pro-  
19 mote healthy behavior and reduce disease risk  
20 (including eliminating programs and offices de-  
21 termined to be ineffective in meeting the pri-  
22 ority goals of Healthy People 2010), that in-  
23 clude transferring the nutrition guideline devel-  
24 opment responsibility from the Secretary of Ag-

1           riculture to the Director of the Centers for Dis-  
2           ease Control and Prevention;

3           (D) specific plans to ensure that all Fed-  
4           eral health care programs are fully coordinated  
5           with science-based prevention recommendations  
6           promulgated by the Director of the Centers for  
7           Disease Control and Prevention;

8           (E) specific plans to ensure that all non-  
9           Department of Health and Human Services  
10          prevention programs are based on the science-  
11          based guidelines developed by the Centers for  
12          Disease Control and Prevention under subpara-  
13          graph (D); and

14          (F) a list of new non-Federal and non-gov-  
15          ernment partners identified by the committee to  
16          build Federal capacity in health promotion and  
17          disease prevention efforts.

18          (4) ANNUAL REQUEST TO GIVE TESTIMONY.—

19          The Secretary shall annually request an opportunity  
20          to testify before Congress concerning the progress  
21          made by the United States in meeting the outcome-  
22          based standards of Healthy People 2010 with re-  
23          spect to disease prevention and measurable outcomes  
24          and effectiveness of Federal programs related to this  
25          goal.

1           (5) PERIODIC REVIEWS.—The Secretary shall  
2           conduct periodic reviews, not less than every 5 years,  
3           and grading of every Federal disease prevention and  
4           health promotion initiatives, programs, and agencies.  
5           Such reviews shall be evaluated based on effective-  
6           ness in meeting metrics-based goals with an analysis  
7           posted on such agencies' public Internet websites.

8           (b) FEDERAL MESSAGING ON HEALTH PROMOTION  
9           AND DISEASE PREVENTION.—

10           (1) MEDIA CAMPAIGNS.—

11           (A) IN GENERAL.—Not later than 1 year  
12           after the date of enactment of this Act, the Sec-  
13           retary, acting through the Director of the Cen-  
14           ters for Disease Control and Prevention, shall  
15           establish and implement a national science-  
16           based media campaign on health promotion and  
17           disease prevention.

18           (B) REQUIREMENTS OF CAMPAIGN.—The  
19           campaign implemented under subparagraph  
20           (A)—

21           (i) shall be designed to address proper  
22           nutrition, regular exercise, smoking ces-  
23           sation, obesity reduction, the 5 leading dis-  
24           ease killers in the United States, and sec-



1           ondary prevention through disease screen-  
2           ing promotion;

3           (ii) shall be carried out through com-  
4           petitively bid contracts awarded to entities  
5           providing for the professional production  
6           and design of such campaign;

7           (iii) may include the use of television,  
8           radio, Internet, and other commercial mar-  
9           keting venues and may be targeted to spe-  
10          cific age groups based on peer-reviewed so-  
11          cial research;

12          (iv) shall not be duplicative of any  
13          other Federal efforts relating to health  
14          promotion and disease prevention; and

15          (v) may include the use of humor and  
16          nationally recognized positive role models.

17          (C) EVALUATION.—The Secretary shall en-  
18          sure that the campaign implemented under sub-  
19          paragraph (A) is subject to an independent  
20          evaluation every 2 years and shall report every  
21          2 years to Congress on the effectiveness of such  
22          campaigns towards meeting science-based  
23          metrics.

24          (2) WEBSITE.—The Secretary, in consultation  
25          with private-sector experts, shall maintain or enter

1 into a contract to maintain an Internet website to  
2 provide science-based information on guidelines for  
3 nutrition, regular exercise, obesity reduction, smok-  
4 ing cessation, and specific chronic disease preven-  
5 tion. Such website shall be designed to provide infor-  
6 mation to health care providers and consumers.

7 (3) DISSEMINATION OF INFORMATION  
8 THROUGH PROVIDERS.—The Secretary, acting  
9 through the Centers for Disease Control and Preven-  
10 tion, shall develop and implement a plan for the dis-  
11 semination of health promotion and disease preven-  
12 tion information consistent with national priorities  
13 described in the strategic and implementing plan  
14 under subsection (a)(3)(A), to health care providers  
15 who participate in Federal programs, including pro-  
16 grams administered by the Indian Health Service,  
17 the Department of Veterans Affairs, the Department  
18 of Defense, and the Health Resources and Services  
19 Administration, and the Medicare and Medicaid Pro-  
20 grams.

21 (4) PERSONALIZED PREVENTION PLANS.—

22 (A) CONTRACT.—The Secretary, acting  
23 through the Director of the Centers for Disease  
24 Control and Prevention, shall enter into a con-  
25 tract with a qualified entity for the development

1 and operation of a Federal Internet website  
2 personalized prevention plan tool.

3 (B) USE.—The website developed under  
4 subparagraph (A) shall be designed to be used  
5 as a source of the most up-to-date scientific evi-  
6 dence relating to disease prevention for use by  
7 individuals. Such website shall contain a compo-  
8 nent that enables an individual to determine  
9 their disease risk (based on personal health and  
10 family history, BMI, and other relevant infor-  
11 mation) relating to the 5 leading diseases in the  
12 United States, and obtain personalized sugges-  
13 tions for preventing such diseases.

14 (5) INTERNET PORTAL.—The Secretary shall  
15 establish an Internet portal for accessing risk-assess-  
16 ment tools developed and maintained by private and  
17 academic entities.

18 (6) PRIORITY FUNDING.—Funding for the ac-  
19 tivities authorized under this section shall take pri-  
20 ority over funding from the Centers for Disease Con-  
21 trol and Prevention provided for grants to States  
22 and other entities for similar purposes and goals as  
23 provided for in this section. Not to exceed  
24 \$500,000,000 shall be expended on the campaigns  
25 and activities required under this Act.

1 **SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVEN-**  
2 **TION EFFORT.**

3 (a) IN GENERAL.—If the Secretary determines that  
4 it is essential to meeting the national priorities described  
5 in the plan required under section 101(a)(3)(A), the Sec-  
6 retary may award grants to States for the conduct of spe-  
7 cific health promotion and disease prevention activities.

8 (b) ELIGIBILITY.—To be eligible to receive a grant  
9 under subsection (a), a State shall submit to the Secretary  
10 an application at such time, in such manner, and con-  
11 taining such information as the Secretary may require, in-  
12 cluding a strategic plan that shall—

13 (1) describe the specific health promotion and  
14 disease prevention activities to be carried out under  
15 this grant;

16 (2) include a list of the barriers that exist with-  
17 in the State to meeting specific goals of Healthy  
18 People 2010;

19 (3) include targeted demographic indicators and  
20 measurable objectives with respect to health pro-  
21 motion and disease prevention;

22 (4) contain a set of process outcomes and mile-  
23 stones, based on the process outcomes and mile-  
24 stones developed by the Secretary, for measuring the  
25 effectiveness of activities carried out under the grant  
26 in the State; and

1           (5) outline the manner in which interventions to  
2           be carried out under this grant will reduce morbidity  
3           and mortality within the State over a 5-year period  
4           (or over a 10-year period, if the Secretary deter-  
5           mines such period appropriate for adequately meas-  
6           uring progress).

7           (c) PROCESS OUTCOMES AND MILESTONES.—

8           (1) IN GENERAL.—The Secretary shall develop  
9           process outcomes and milestones to be used to meas-  
10          ure the effectiveness of activities carried out under  
11          a grant under this section by a State.

12          (2) DETERMINATIONS.—If, beginning 2 years  
13          after the date on which a grant is awarded to a  
14          State under this section, the Secretary determines  
15          that the State is failing to make adequate progress  
16          in meeting the outcomes and milestones contained in  
17          the State plan under subsection (b)(4), the Secretary  
18          shall provide the State with technical assistance on  
19          how to make such progress. Such technical assist-  
20          ance shall continue for a period of 2 years.

21          (3) CONTINUED FAILURE TO MEET OBJEC-  
22          TIVES.—If after the expiration of the 2-year period  
23          described in paragraph (2), the Secretary determines  
24          that the State is failing to make adequate progress  
25          in meeting the outcomes and milestones contained in

1 the State plan under subsection (b)(4) over a 5-year  
2 period, the Secretary shall terminate all funding to  
3 the State under a grant under this section.

4 (d) REGIONAL ACTIVITIES.—A State may use an  
5 amount, not to exceed 15 percent of the total grant  
6 amount to such State, to carry out regional activities in  
7 conjunction with other States.

8 (e) TARGETED ACTIVITIES.—A State may use grant  
9 funds to target specific populations within the State to  
10 achieve specific outcomes described in Healthy People  
11 2010.

12 (f) INNOVATIVE INCENTIVE STRUCTURES.—The Sec-  
13 retary may award grants to States for the purposes of de-  
14 veloping innovative incentive structures to encourage indi-  
15 viduals to adopt specific prevention behaviors such as re-  
16 ducing their body mass index or for smoking cessation.

17 (g) WELLNESS BONUSES.—

18 (1) IN GENERAL.—The Secretary shall award  
19 wellness bonus payments to at least 5, but not more  
20 than 10, States that demonstrate the greatest  
21 progress in reducing disease rates and risk factors  
22 and increasing healthy behaviors.

23 (2) REQUIREMENT.—To be eligible to receive a  
24 bonus payment under paragraph (1), a State shall  
25 demonstrate—

1 (A) the progress described in paragraph  
2 (1); and

3 (B) that the State has met a specific floor  
4 for progress outlined in the science-based  
5 metrics of Healthy People 2010.

6 (3) USE OF PAYMENTS.—Bonus payments  
7 under this subsection may only be used by a State  
8 for the purposes of health promotion and disease  
9 prevention.

10 (4) FUNDING.—Out of funds appropriated to  
11 the Director of the Centers for Disease Control and  
12 Prevention for each fiscal year beginning with fiscal  
13 year 2010, the Director shall give priority to using  
14 \$50,000,000 of such funds to make bonus payments  
15 under this subsection.

16 (h) ADMINISTRATIVE EXPENSES.—A State may use  
17 not more than 5 percent of the amount of a grant under  
18 this section to carry out administrative activities.

19 (i) STATE.—In this section, the term “State” means  
20 the 50 States, the District of Columbia, the Common-  
21 wealth of Puerto Rico, Guam, Samoa, the United States  
22 Virgin Islands, and the Commonwealth of the Northern  
23 Mariana Islands.

24 (j) AUTHORIZATION OF APPROPRIATIONS.—Funding  
25 for the activities authorized under this section shall take

1 priority over funding from the Centers for Disease Control  
2 and Prevention provided for grants to States and other  
3 entities for similar purposes and goals as provided for in  
4 this section, not to exceed \$300,000,000 for each fiscal  
5 year.

6 **SEC. 103. FOCUSING THE FOOD STAMP PROGRAM ON NU-**  
7 **TRITION.**

8 (a) COUNSELING BROCHURE.—The Director of the  
9 Centers for Disease Control and Prevention shall develop,  
10 and the Secretary of Agriculture shall distribute to each  
11 individual and family enrolled in the Food Stamp Program  
12 under the Food Stamp Act of 1977 (7 U.S.C. 2011 et  
13 seq.), a science-based nutrition counseling brochure.

14 (b) LIMITATIONS ON FOOD STAMP PURCHASES.—

15 (1) IN GENERAL.—Not later than 6 months  
16 after the date of enactment of this Act, the Sec-  
17 retary of Agriculture shall, based on scientific, peer-  
18 reviewed recommendations provided by a Commis-  
19 sion that includes public health, medical, and nutri-  
20 tion experts and the Director of the Centers for Dis-  
21 ease Control and Prevention, develop lists of foods  
22 that do not meet science-based standards for proper  
23 nutrition and that may not be purchased under the  
24 food stamp program. Such list shall be updated on  
25 an annual basis to ensure the most current science-



1 based recommendations are applied to the food  
2 stamp program.

3 (2) AUTOMATED ENFORCEMENT.—The Sec-  
4 retary of Agriculture shall, through regulations, en-  
5 sure that the limitations on food purchases under  
6 paragraph (1) is enforced through the food stamp  
7 program’s automated system.

8 (3) IMPLEMENTATION.—The Secretary of Agri-  
9 culture shall promulgate the regulations described in  
10 paragraph (2) by the date that is not later than 1  
11 year after the date of enactment of this section.

12 **SEC. 104. IMMUNIZATIONS.**

13 (a) PURCHASE OF VACCINES.—Notwithstanding any  
14 other provision of law, a State may use amounts provided  
15 under section 317 of the Public Health Service Act (42  
16 U.S.C. 247b) for immunization programs to purchase vac-  
17 cines for use in health care provider offices and schools.

18 (b) TECHNICAL ASSISTANCE AND REDUCTION IN  
19 FUNDING.—If a State does not achieve a benchmark of  
20 80 percent coverage within the State for Centers for Dis-  
21 ease Control and Prevention-recommended vaccines, the  
22 Director of the Centers shall provide technical assistance  
23 to the State for a period of 2 years. If after the expiration  
24 of such 2-year period the State continues to fail to achieve  
25 such benchmark, the Secretary shall reduce funding pro-

1 vided under section 317 of the Public Health Service Act  
2 to such State by 5 percent.

3 (c) BONUS GRANT.—A State achieving a benchmark  
4 of 90 percent or greater coverage within the State for Cen-  
5 ters for Disease Control and Prevention-recommended  
6 vaccines shall be eligible for a bonus grant from amounts  
7 appropriated under subsection (d).

8 (d) AUTHORIZATION OF APPROPRIATIONS.—Out of  
9 funds appropriated to the Director of the Centers for Dis-  
10 ease Control and Prevention for each fiscal year beginning  
11 with fiscal year 2010, there shall be made available to  
12 carry out this section, \$50,000,000 for each fiscal year.

13 (e) FUNDING FOR SECTION 317.—Section 317(j)(1)  
14 of the Public Health Service Act (42 U.S.C. 247b(j)(1))  
15 is amended by striking “2005” and inserting “2012”.

## 16 **TITLE II—STATE-BASED HEALTH** 17 **CARE EXCHANGES**

### 18 **SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.**

19 (a) IN GENERAL.—The Secretary of Health and  
20 Human Services (referred to in this title as the “Sec-  
21 retary”) shall establish a process for the review of applica-  
22 tions submitted by States for the establishment and imple-  
23 mentation of State-based health care Exchanges (referred  
24 to in this title as a “State Exchange”) and for the certifi-  
25 cation of such Exchanges. The Secretary shall certify a

1 State Exchange if the Secretary determines that such Ex-  
2 change meets the requirements of this title.

3 (b) CONTINUED CERTIFICATION.—The certification  
4 of a State Exchange under subsection (a) shall remain in  
5 effect until the Secretary determines that the Exchange  
6 has failed to meet any of the requirements under this title.

7 **SEC. 202. REQUIREMENTS.**

8 (a) GENERAL REQUIREMENTS FOR CERTIFI-  
9 CATION.—An application for certification under section  
10 201(a) shall demonstrate compliance with the following:

11 (1) PURPOSE.—The primary purpose of a State  
12 Exchange shall be the facilitation of the individual  
13 purchase of innovative private health insurance and  
14 the creation of a market where private health plans  
15 compete for enrollees based on price and quality.

16 (2) ADMINISTRATION.—A State shall ensure  
17 the operation of the State Exchange through direct  
18 contracts with the health insurance plans that are  
19 participating in the State Exchange or through a  
20 contract with a third party administrator for the op-  
21 eration of the Exchange.

22 (3) PLAN PARTICIPATION.—A State shall not  
23 restrict or otherwise limit the ability of a health in-  
24 surance plan to participate in, and offer health in-  
25 surance coverage through, the State Exchange, so

1 long as the health insurance issuers involved are  
2 duly licensed under State insurance laws applicable  
3 to all health insurance issuers in the State and oth-  
4 erwise comply with the requirements of this title.

5 (4) PREMIUMS.—

6 (A) AMOUNT.—A State shall not determine  
7 premium or cost sharing amounts for health in-  
8 surance coverage offered through the State Ex-  
9 change.

10 (B) COLLECTION METHOD.—A State shall  
11 ensure the existence of an effective and efficient  
12 method for the collection of premiums for  
13 health insurance coverage offered through the  
14 State Exchange.

15 (b) BENEFIT PARITY WITH MEMBERS OF CON-  
16 GRESS.—With respect to health insurance issuers offering  
17 health insurance coverage through the State Exchange,  
18 the State shall not impose any requirement that such  
19 issuers provide coverage that includes benefits different  
20 than requirements on plans offered to Members of Con-  
21 gress under chapter 89 of title 5, United States Code.

22 (c) FACILITATING UNIVERSAL COVERAGE FOR  
23 AMERICANS.—

24 (1) AUTOMATIC ENROLLMENT.—The State Ex-  
25 change shall ensure that health insurance coverage

1 offered through the Exchange provides for the appli-  
2 cation of uniform mechanisms that are designed to  
3 encourage and facilitate the enrollment of all eligible  
4 individuals in Exchange-based health insurance cov-  
5 erage. Such mechanisms shall include automatic en-  
6 rollment through various venues, which may include  
7 emergency rooms, the submission of State tax forms,  
8 places of employment in the State, and State depart-  
9 ments of motor vehicles.

10 (2) OTHER ENROLLMENT OPPORTUNITIES.—

11 (A) IN GENERAL.—The State Exchange  
12 shall ensure that health insurance coverage of-  
13 fered through the Exchange permits enrollment,  
14 and changes in enrollment, of individuals at the  
15 time such individuals become eligible individuals  
16 in the State.

17 (B) ANNUAL OPEN ENROLLMENT PERI-  
18 ODS.—The State Exchange shall ensure that  
19 health insurance coverage offered through the  
20 Exchange permits eligible individuals to annu-  
21 ally change enrollment among the coverage of-  
22 fered through the Exchange, subject to sub-  
23 paragraph (A).

24 (C) INCENTIVES FOR CONTINUOUS AN-  
25 NUAL COVERAGE.—The State Exchange shall

1 include an incentive for eligible individuals to  
2 remain insured from plan year to plan year,  
3 and may include incentives such as State tax  
4 incentives or premium-based incentives.

5 (3) GUARANTEED ACCESS FOR INDIVIDUALS.—

6 The State Exchange shall ensure that, with respect  
7 to health insurance coverage offered through the Ex-  
8 change, all eligible individuals are able to enroll in  
9 the coverage of their choice provided that such indi-  
10 viduals agree to make applicable premium and cost  
11 sharing payments.

12 (4) LIMITATION ON PRE-EXISTING CONDITION

13 EXCLUSIONS.—The State Exchange shall ensure  
14 that health insurance coverage offered through the  
15 Exchange meets the requirements of section 9801 of  
16 the Internal Revenue Code of 1986 in the same  
17 manner as if such coverage was a group health plan.

18 (5) OPT-OUT.—Nothing in this title shall be

19 construed to require that an individual be enrolled in  
20 health insurance coverage.

21 (d) LIMITATION ON EXORBITANT PREMIUMS.—

22 (1) ESTABLISHMENT OF MECHANISM.—With

23 respect to health insurance coverage offered through  
24 the State Exchange, the Exchange shall establish a  
25 mechanisms to protect enrollees from the imposition

1 of excessive premiums, to reduce adverse selection,  
2 and to share risk.

3 (2) MECHANISM OPTIONS.—The mechanisms  
4 referred to in paragraph (1) may include the fol-  
5 lowing:

6 (A) INDEPENDENT RISK ADJUSTMENT.—  
7 The implementation of risk-adjustment among  
8 health insurance coverage offered through the  
9 State Exchange through a contract entered into  
10 with a private, independent board. Such board  
11 shall include representation of health insurance  
12 issuers and State officials but shall be inde-  
13 pendently controlled. The State Exchange shall  
14 ensure that risk-adjustment implemented under  
15 this subparagraph shall be based on a blend of  
16 patient diagnoses and estimated costs.

17 (B) HEALTH SECURITY POOLS.—The es-  
18 tablishment (or continued operation under sec-  
19 tion 2745 of the Public Health Service Act) of  
20 a health security pool to guarantee high-risk in-  
21 dividuals access to affordable, quality health  
22 care.

23 (C) REINSURANCE.—The implementation  
24 of a successful reinsurance mechanisms to guar-

1           antee high-risk individuals access to affordable,  
2           quality health care.

3           (e) MEDICAID AND SCHIP BENEFICIARIES.—The  
4 State Exchange shall include procedures to permit eligible  
5 individuals who are receiving (or who are eligible to re-  
6 ceive) health care under title XIX or XXI of the Social  
7 Security Act to enroll in health insurance coverage offered  
8 through the Exchange.

9           (f) DISSEMINATION OF COVERAGE INFORMATION.—  
10 The State Exchange shall ensure that each health insur-  
11 ance issuer that provides health insurance coverage  
12 through the Exchange disseminate to eligible individuals  
13 and employers within the State information concerning  
14 health insurance coverage options, including the plans of-  
15 fered and premiums and benefits for such plans.

16           (g) REGIONAL OPTIONS.—

17           (1) INTERSTATE COMPACTS.—Two or more  
18 States that establish a State Exchange may enter  
19 into interstate compacts providing for the regula-  
20 tions of health insurance coverage offered within  
21 such States.

22           (2) MODEL LEGISLATION.—States adopting  
23 model legislation as developed by the National Asso-  
24 ciation of Insurance Commissioners shall be eligible



1 to enter into an interstate compact as provided for  
2 in this section.

3 (3) MULTI-STATE POOLING ARRANGEMENTS.—

4 State Exchanges may implement a multi-state health  
5 care coverage pooling arrangement under this title.

6 (h) ELIGIBLE INDIVIDUAL.—In this title, the term  
7 “eligible individual” means an individual who is—

8 (1) a citizen or national of the United States or  
9 an alien lawfully admitted to the United States for  
10 permanent residence or otherwise residing in the  
11 United States under color of law;

12 (2) a resident of the State involved;

13 (3) not incarcerated; and

14 (4) not eligible for coverage under parts A and  
15 B (or C) of the Medicare program under title XVIII  
16 of the Social Security Act.

17 **SEC. 203. STATE EXCHANGE INCENTIVES.**

18 (a) GRANTS.—The Secretary may award grants, pur-  
19 suant to subsection (b), to States for the development, im-  
20 plementation, and evaluation of certified State Exchanges  
21 and to provide more options and choice for individuals  
22 purchasing health insurance coverage.

23 (b) ONE-TIME INCREASE IN MEDICAID PAYMENT.—

24 In the case of a State awarded a grant to carry out this  
25 section, the total amount of the Federal payment deter-

1 mined for the State under section 1913 of the Social Secu-  
2 rity Act (as amended by section 401) for fiscal year 2011  
3 shall be increased by an amount equal to 1 percent of the  
4 total amount of payments made to the State for fiscal year  
5 2010 under section 1903(a) of the Social Security Act (42  
6 U.S.C. 1396b(a)) for purposes of carrying out a grant  
7 awarded under this section. Amounts paid to a State pur-  
8 suant to this subsection shall remain available until ex-  
9 pended.

10 **TITLE III—FAIR TAX TREAT-**  
11 **MENT FOR ALL AMERICANS**  
12 **TO AFFORD HEALTH CARE**

13 **SEC. 300. REFERENCE.**

14 Except as otherwise expressly provided, whenever in  
15 this title an amendment or repeal is expressed in terms  
16 of an amendment to, or repeal of, a section or other provi-  
17 sion, the reference shall be considered to be made to a  
18 section or other provision of the Internal Revenue Code  
19 of 1986.

1 **Subtitle A—Refundable and**  
2 **Advanceable Credit for Certain**  
3 **Health Insurance Coverage**

4 **SEC. 301. REFUNDABLE AND ADVANCEABLE CREDIT FOR**  
5 **CERTAIN HEALTH INSURANCE COVERAGE.**

6 (a) **ADVANCEABLE CREDIT.**—Subpart A of part IV  
7 of subchapter A of chapter 1 (relating to nonrefundable  
8 personal credits) is amended by adding at the end the fol-  
9 lowing new section:

10 **“SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.**

11 “(a) **ALLOWANCE OF CREDIT.**—In the case of an in-  
12 dividual, there shall be allowed as a credit against the tax  
13 imposed by this chapter for the taxable year the sum of  
14 the monthly limitations determined under subsection (b)  
15 for the taxpayer and the taxpayer’s spouse and depend-  
16 ents.

17 “(b) **MONTHLY LIMITATION.**—

18 “(1) **IN GENERAL.**—The monthly limitation for  
19 each month during the taxable year for an eligible  
20 individual is  $\frac{1}{12}$ th of—

21 “(A) the applicable adult amount, in the  
22 case that the eligible individual is the taxpayer  
23 or the taxpayer’s spouse,

1           “(B) the applicable adult amount, in the  
2 case that the eligible individual is an adult de-  
3 pendent, and

4           “(C) the applicable child amount, in the  
5 case that the eligible individual is a child de-  
6 pendent.

7           “(2) LIMITATION ON AGGREGATE AMOUNT.—  
8 Notwithstanding paragraph (1), the aggregate  
9 monthly limitations for the taxpayer and the tax-  
10 payer’s spouse and dependents for any month shall  
11 not exceed  $\frac{1}{12}$ th of the applicable aggregate amount.

12           “(3) NO CREDIT FOR INELIGIBLE MONTHS.—  
13 With respect to any individual, the monthly limita-  
14 tion shall be zero for any month for which such indi-  
15 vidual is not an eligible individual.

16           “(4) APPLICABLE AMOUNT.—

17           “(A) IN GENERAL.—For purposes of this  
18 section—

19           “(i) APPLICABLE ADULT AMOUNT.—  
20 The applicable adult amount is \$2,290.

21           “(ii) APPLICABLE CHILD AMOUNT.—  
22 The applicable child amount is \$1,710.

23           “(iii) APPLICABLE AGGREGATE  
24 AMOUNT.—The applicable aggregate  
25 amount is \$5,710.

1 “(B) COST-OF-LIVING ADJUSTMENTS.—

2 “(i) IN GENERAL.—In the case of any  
3 taxable year beginning in a calendar year  
4 after 2011, each dollar amount contained  
5 in subparagraph (A) shall be increased by  
6 an amount equal to such dollar amount  
7 multiplied by the blended cost-of-living ad-  
8 justment.

9 “(ii) BLENDED COST-OF-LIVING AD-  
10 JUSTMENT.—For purposes of clause (i),  
11 the blended cost-of-living adjustment  
12 means one-half of the sum of—

13 “(I) the cost-of-living adjustment  
14 determined under section 1(f)(3) for  
15 the calendar year in which the taxable  
16 year begins by substituting ‘calendar  
17 year 2010’ for ‘calendar year 1992’ in  
18 subparagraph (B) thereof, plus

19 “(II) the cost-of-living adjust-  
20 ment determined under section  
21 213(d)(10)(B)(ii) for the calendar  
22 year in which the taxable year begins  
23 by substituting ‘2010’ for ‘1996’ in  
24 subclause (II) thereof.

1           “(iii) ROUNDING.—Any increase de-  
2           termined under clause (i) shall be rounded  
3           to the nearest multiple of \$10.

4           “(C) REVENUE NEUTRALITY ADJUST-  
5           MENTS.—

6           “(i) IN GENERAL.—In the case of any  
7           taxable year beginning in a calendar year  
8           after 2011, each dollar amount contained  
9           in subparagraph (A), as adjusted under  
10          subparagraph (B), shall be further ad-  
11          justed (if necessary) such that the aggre-  
12          gate of such dollar amounts allowed as  
13          credits under this section for such taxable  
14          year equals but does not exceed the total  
15          increase in revenues in the Treasury re-  
16          sulting from the amendments made by sec-  
17          tions 303 and 401 of the Patients’ Choice  
18          Act for such taxable year as estimated by  
19          the Secretary.

20          “(ii) DATE OF ADJUSTMENT.—The  
21          Secretary shall announce the adjustments  
22          for any taxable year under this subpara-  
23          graph not later than the preceding October  
24          1.

1       “(c) LIMITATION BASED ON AMOUNT OF TAX.—In  
2 the case of a taxable year to which section 26(a)(2) does  
3 not apply, the credit allowed under subsection (a) for the  
4 taxable year shall not exceed the excess of—

5           “(1) the sum of the regular tax liability (as de-  
6 fined in section 26(b)) plus the tax imposed by sec-  
7 tion 55, over

8           “(2) the sum of the credits allowable under this  
9 subpart (other than this section) and section 27 for  
10 the taxable year.

11       “(d) EXCESS CREDIT REFUNDABLE TO CERTAIN  
12 TAX-FAVORED ACCOUNTS.—If—

13           “(1) the credit which would be allowable under  
14 subsection (a) if only qualified refund eligible health  
15 insurance were taken into account under this sec-  
16 tion, exceeds

17           “(2) the limitation imposed by section 26 or  
18 subsection (c) for the taxable year,

19 such excess shall be paid by the Secretary into the des-  
20 ignated account of the taxpayer.

21       “(e) ELIGIBLE INDIVIDUAL.—For purposes of this  
22 section—

23           “(1) IN GENERAL.—The term ‘eligible indi-  
24 vidual’ means, with respect to any month, an indi-  
25 vidual who—

1           “(A) is the taxpayer, the taxpayer’s  
2 spouse, or the taxpayer’s dependent, and

3           “(B) is covered under qualified health in-  
4 surance as of the 1st day of such month.

5           “(2) MEDICARE COVERAGE, MEDICAID DIS-  
6 ABILITY COVERAGE, AND MILITARY COVERAGE.—  
7 The term ‘eligible individual’ shall not include any  
8 individual who for any month is—

9           “(A) entitled to benefits under part A of  
10 title XVIII of the Social Security Act or en-  
11 rolled under part B of such title, and the indi-  
12 vidual is not a participant or beneficiary in a  
13 group health plan or large group health plan  
14 that is a primary plan (as defined in section  
15 1862(b)(2)(A) of such Act),

16           “(B) enrolled by reason of disability in the  
17 program under title XIX of such Act, or

18           “(C) entitled to benefits under chapter 55  
19 of title 10, United States Code, including under  
20 the TRICARE program (as defined in section  
21 1072(7) of such title).

22           “(3) IDENTIFICATION REQUIREMENTS.—The  
23 term ‘eligible individual’ shall not include any indi-  
24 vidual for any month unless the policy number asso-  
25 ciated with the qualified health insurance and the



1 TIN of each eligible individual covered under such  
2 health insurance for such month are included on the  
3 return of tax for the taxable year in which such  
4 month occurs.

5 “(4) PRISONERS.—The term ‘eligible individual’  
6 shall not include any individual for a month if, as  
7 of the first day of such month, such individual is im-  
8 prisoned under Federal, State, or local authority.

9 “(5) ALIENS.—The term ‘eligible individual’  
10 shall not include any alien individual who is not a  
11 lawful permanent resident of the United States.

12 “(f) HEALTH INSURANCE.—For purposes of this sec-  
13 tion—

14 “(1) QUALIFIED HEALTH INSURANCE.—The  
15 term ‘qualified health insurance’ means any insur-  
16 ance constituting medical care which (as determined  
17 under regulations prescribed by the Secretary)—

18 “(A) has a reasonable annual and lifetime  
19 benefit maximum, and

20 “(B) provides coverage for inpatient and  
21 outpatient care, emergency benefits, and physi-  
22 cian care.

23 Such term does not include any insurance substan-  
24 tially all of the coverage of which is coverage de-  
25 scribed in section 223(c)(1)(B).

1           “(2) QUALIFIED REFUND ELIGIBLE HEALTH  
2 INSURANCE.—The term ‘qualified refund eligible  
3 health insurance’ means any qualified health insur-  
4 ance which is coverage under a group health plan  
5 (as defined in section 5000(b)(1)).

6           “(g) DESIGNATED ACCOUNTS.—

7           “(1) DESIGNATED ACCOUNT.—For purposes of  
8 this section, the term ‘designated account’ means  
9 any specified account established and maintained by  
10 the provider of the taxpayer’s qualified refund eligi-  
11 ble health insurance—

12                   “(A) which is designated by the taxpayer  
13 (in such form and manner as the Secretary may  
14 provide) on the return of tax for the taxable  
15 year,

16                   “(B) which, under the terms of the ac-  
17 count, accepts the payment described in sub-  
18 section (d) on behalf of the taxpayer, and

19                   “(C) which, under such terms, provides for  
20 the payment of expenses by the taxpayer or on  
21 behalf of such taxpayer by the trustee or custo-  
22 dian of such account, including payment to  
23 such provider.

24           “(2) SPECIFIED ACCOUNT.—For purposes of  
25 this paragraph, the term ‘specified account’ means—

1           “(A) any health savings account under sec-  
2           tion 223 or Archer MSA under section 220, or

3           “(B) any health insurance reserve account.

4           “(3) HEALTH INSURANCE RESERVE AC-  
5           COUNT.—For purposes of this subsection, the term  
6           ‘health insurance reserve account’ means a trust cre-  
7           ated or organized in the United States as a health  
8           insurance reserve account exclusively for the purpose  
9           of paying the qualified medical expenses (within the  
10          meaning of section 223(d)(2)) of the account bene-  
11          ficiary (as defined in section 223(d)(3)), but only if  
12          the written governing instrument creating the trust  
13          meets the requirements described in subparagraphs  
14          (B), (C), (D), and (E) of section 223(d)(1). Rules  
15          similar to the rules under subsections (g) and (h) of  
16          section 408 shall apply for purposes of this subpara-  
17          graph.

18          “(4) TREATMENT OF PAYMENT.—Any payment  
19          under subsection (d) to a designated account shall  
20          not be taken into account with respect to any dollar  
21          limitation which applies with respect to contributions  
22          to such account (or to tax benefits with respect to  
23          such contributions).

24          “(h) OTHER DEFINITIONS.—For purposes of this  
25          section—

1           “(1) DEPENDENT.—The term ‘dependent’ has  
2 the meaning given such term by section 152 (deter-  
3 mined without regard to subsections (b)(1), (b)(2),  
4 and (d)(1)(B) thereof). An individual who is a child  
5 to whom section 152(e) applies shall be treated as  
6 a dependent of the custodial parent for a coverage  
7 month unless the custodial and noncustodial parent  
8 provide otherwise.

9           “(2) ADULT.—The term ‘adult’ means an indi-  
10 vidual who is not a child.

11           “(3) CHILD.—The term ‘child’ means a quali-  
12 fying child (as defined in section 152(c)).

13           “(i) SPECIAL RULES.—

14           “(1) COORDINATION WITH MEDICAL DEDUC-  
15 TION.—Any amount paid by a taxpayer for insur-  
16 ance which is taken into account for purposes of de-  
17 termining the credit allowable to the taxpayer under  
18 subsection (a) shall not be taken into account in  
19 computing the amount allowable to the taxpayer as  
20 a deduction under section 213(a) or 162(l).

21           “(2) COORDINATION WITH HEALTH CARE TAX  
22 CREDIT.—No credit shall be allowed under sub-  
23 section (a) for any taxable year to any taxpayer and  
24 qualifying family members with respect to whom a

1 credit under section 35 is allowed for such taxable  
2 year.

3 “(3) DENIAL OF CREDIT TO DEPENDENTS.—No  
4 credit shall be allowed under this section to any indi-  
5 vidual with respect to whom a deduction under sec-  
6 tion 151 is allowable to another taxpayer for a tax-  
7 able year beginning in the calendar year in which  
8 such individual’s taxable year begins.

9 “(4) MARRIED COUPLES MUST FILE JOINT RE-  
10 TURN.—

11 “(A) IN GENERAL.—If the taxpayer is  
12 married at the close of the taxable year, the  
13 credit shall be allowed under subsection (a) only  
14 if the taxpayer and his spouse file a joint return  
15 for the taxable year.

16 “(B) MARITAL STATUS; CERTAIN MARRIED  
17 INDIVIDUALS LIVING APART.—Rules similar to  
18 the rules of paragraphs (3) and (4) of section  
19 21(e) shall apply for purposes of this para-  
20 graph.

21 “(5) VERIFICATION OF COVERAGE, ETC.—No  
22 credit shall be allowed under this section with re-  
23 spect to any individual unless such individual’s cov-  
24 erage (and such related information as the Secretary

1 may require) is verified in such manner as the Sec-  
2 retary may prescribe.

3 “(6) INSURANCE WHICH COVERS OTHER INDI-  
4 VIDUALS; TREATMENT OF PAYMENTS.—Rules similar  
5 to the rules of paragraphs (7) and (8) of section  
6 35(g) shall apply for purposes of this section.

7 “(j) COORDINATION WITH ADVANCE PAYMENTS.—

8 “(1) REDUCTION IN CREDIT FOR ADVANCE PAY-  
9 MENTS.—With respect to any taxable year, the  
10 amount which would (but for this subsection) be al-  
11 lowed as a credit to the taxpayer under subsection  
12 (a) shall be reduced (but not below zero) by the ag-  
13 gregate amount paid on behalf of such taxpayer  
14 under section 7527A for months beginning in such  
15 taxable year.

16 “(2) RECAPTURE OF EXCESS ADVANCE PAY-  
17 MENTS.—If the aggregate amount paid on behalf of  
18 the taxpayer under section 7527A for months begin-  
19 ning in the taxable year exceeds the sum of the  
20 monthly limitations determined under subsection (b)  
21 for the taxpayer and the taxpayer’s spouse and de-  
22 pendents for such months, then the tax imposed by  
23 this chapter for such taxable year shall be increased  
24 by the sum of—

25 “(A) such excess, plus

1 “(B) interest on such excess determined at  
2 the underpayment rate established under sec-  
3 tion 6621 for the period from the date of the  
4 payment under section 7527A to the date such  
5 excess is paid.

6 For purposes of subparagraph (B), an equal part of  
7 the aggregate amount of the excess shall be deemed  
8 to be attributable to payments made under section  
9 7527A on the first day of each month beginning in  
10 such taxable year, unless the taxpayer establishes  
11 the date on which each such payment giving rise to  
12 such excess occurred, in which case subparagraph  
13 (B) shall be applied with respect to each date so es-  
14 tablished. The Secretary may rescind or waive all or  
15 any portion of any amount imposed by reason of  
16 subparagraph (B) if such excess was not the result  
17 of the actions of the taxpayer.”

18 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 77  
19 (relating to miscellaneous provisions) is amended by in-  
20 serting after section 7527 the following new section:

21 **“SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALI-**  
22 **FIED REFUND ELIGIBLE HEALTH INSUR-**  
23 **ANCE.**

24 “(a) IN GENERAL.—The Secretary shall establish a  
25 program for making payments on behalf of individuals to

1 providers of qualified refund eligible health insurance (as  
2 defined in section 25E(f)(2)) for such individuals.

3 “(b) LIMITATION.—The Secretary may make pay-  
4 ments under subsection (a) only to the extent that the Sec-  
5 retary determines that the amount of such payments made  
6 on behalf of any taxpayer for any month does not exceed  
7 the sum of the monthly limitations determined under sec-  
8 tion 25E(b) for the taxpayer and taxpayer’s spouse and  
9 dependents for such month.”.

10 (c) INFORMATION REPORTING.—

11 (1) IN GENERAL.—Subpart B of part III of  
12 subchapter A of chapter 61 (relating to information  
13 concerning transactions with other persons) is  
14 amended by inserting after section 6050W the fol-  
15 lowing new section:

16 **“SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALI-**  
17 **FIED REFUND ELIGIBLE HEALTH INSUR-**  
18 **ANCE.**

19 “(a) REQUIREMENT OF REPORTING.—Every person  
20 who is entitled to receive payments for any month of any  
21 calendar year under section 7527A (relating to advance  
22 payment of credit for qualified refund eligible health insur-  
23 ance) with respect to any individual shall, at such time  
24 as the Secretary may prescribe, make the return described  
25 in subsection (b) with respect to each such individual.



1       “(b) FORM AND MANNER OF RETURNS.—A return  
2 is described in this subsection if such return—

3           “(1) is in such form as the Secretary may pre-  
4 scribe, and

5           “(2) contains, with respect to each individual  
6 referred to in subsection (a)—

7           “(A) the name, address, and TIN of each  
8 such individual,

9           “(B) the months for which amounts pay-  
10 ments under section 7527A were received,

11           “(C) the amount of each such payment,

12           “(D) the type of insurance coverage pro-  
13 vided by such person with respect to such indi-  
14 vidual and the policy number associated with  
15 such coverage,

16           “(E) the name, address, and TIN of the  
17 spouse and each dependent covered under such  
18 coverage, and

19           “(F) such other information as the Sec-  
20 retary may prescribe.

21       “(c) STATEMENTS TO BE FURNISHED TO INDIVID-  
22 UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
23 QUIRED.—Every person required to make a return under  
24 subsection (a) shall furnish to each individual whose name

1 is required to be set forth in such return a written state-  
2 ment showing—

3 “(1) the contact information of the person re-  
4 quired to make such return, and

5 “(2) the information required to be shown on  
6 the return with respect to such individual.

7 The written statement required under the preceding sen-  
8 tence shall be furnished on or before January 31 of the  
9 year following the calendar year for which the return  
10 under subsection (a) is required to be made.

11 “(d) RETURNS WHICH WOULD BE REQUIRED TO BE  
12 MADE BY 2 OR MORE PERSONS.—Except to the extent  
13 provided in regulations prescribed by the Secretary, in the  
14 case of any amount received by any person on behalf of  
15 another person, only the person first receiving such  
16 amount shall be required to make the return under sub-  
17 section (a).”.

18 (2) ASSESSABLE PENALTIES.—

19 (A) Subparagraph (B) of section  
20 6724(d)(1) (relating to definitions) is amended  
21 by striking “or” at the end of clause (xxii), by  
22 striking “and” at the end of clause (xxiii) and  
23 inserting “or”, and by inserting after clause  
24 (xxiii) the following new clause:

1           “(xxiv) section 6050X (relating to re-  
2           turns relating to credit for qualified refund  
3           eligible health insurance), and”.

4           (B) Paragraph (2) of section 6724(d) is  
5           amended by striking “or” at the end of sub-  
6           paragraph (EE), by striking the period at the  
7           end of subparagraph (FF) and inserting “, or”  
8           and by inserting after subparagraph (FF) the  
9           following new subparagraph:

10           “(GG) section 6050X (relating to returns  
11           relating to credit for qualified refund eligible  
12           health insurance).”.

13           (d) CONFORMING AMENDMENTS.—

14           (1) Paragraph (2) of section 1324(b) of title  
15           31, United States Code, is amended by inserting  
16           “25E,” before “35,”.

17           (2)(A) Section 24(b)(3)(B) is amended by in-  
18           serting “, 25E,” after “25D”.

19           (B) Section 25(e)(1)(C)(ii) is amended by in-  
20           serting “25E,” after “25D,”.

21           (C) Section 25B(g)(2) is amended by inserting  
22           “25E,” after “25D,”.

23           (D) Section 26(a)(1) is amended by inserting  
24           “25E,” after “25D,”.

1 (E) Section 30(c)(2)(B)(ii) is amended by in-  
2 sserting “25E,” after “25D,”.

3 (F) Section 30D(c)(2)(B)(ii) is amended by  
4 striking “and 25D” and inserting “, 25D, and  
5 25E”.

6 (G) Section 904(i) is amended by inserting  
7 “25E,” after “25B,”.

8 (H) Section 1400C(d)(2) is amended by insert-  
9 ing “25E,” after “25D,”.

10 (3) The table of sections for subpart A of part  
11 IV of subchapter A of chapter 1 is amended by in-  
12 sserting after the item relating to section 25D the  
13 following new item:

“Sec. 25E. Qualified health insurance credit.”.

14 (4) The table of sections for chapter 77 is  
15 amended by inserting after the item relating to sec-  
16 tion 7527 the following new item:

“Sec. 7527A. Advance payment of credit for qualified refund eligible health in-  
surance.”.

17 (5) The table of sections for subpart B of part  
18 III of subchapter A of chapter 61 is amended by  
19 adding at the end the following new item:

“Sec. 6050X. Returns relating to credit for qualified refund eligible health in-  
surance.”.

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

1 **SEC. 302. REQUIRING EMPLOYER TRANSPARENCY ABOUT**  
2 **EMPLOYEE BENEFITS.**

3 (a) IN GENERAL.—Section 6051(a) (relating to W–  
4 2 requirement) is amended by striking “and” at the end  
5 of paragraph (12), by striking the period at the end of  
6 paragraph (13) and inserting “, and” and by inserting  
7 after paragraph (13) the following new paragraph:

8 “(14) the aggregate cost (within the meaning of  
9 section 4980B(f)(4)) for coverage of the employee  
10 under an accident or health plan which is excludable  
11 from the gross income of the employee under section  
12 106(a) (other than coverage under a health flexible  
13 spending arrangement).”.

14 (b) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to statements for calendar years  
16 beginning after 2009.

17 **SEC. 303. CHANGES TO EXISTING TAX PREFERENCES FOR**  
18 **MEDICAL COVERAGE, ETC., FOR INDIVIDUALS**  
19 **ELIGIBLE FOR QUALIFIED HEALTH INSUR-**  
20 **ANCE CREDIT.**

21 (a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER  
22 TO ACCIDENT AND HEALTH PLANS.—

23 (1) IN GENERAL.—Section 106 (relating to con-  
24 tributions by employer to accident and health plans)  
25 is amended by adding at the end the following new  
26 subsection:

1       “(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE  
2 FOR QUALIFIED HEALTH INSURANCE CREDIT.—Sub-  
3 section (a) shall not apply with respect to any employer-  
4 provided coverage under an accident or health plan for any  
5 individual for any month unless such individual is de-  
6 scribed in paragraph (2) or (5) of section 25E(e) for such  
7 month. The amount includible in gross income by reason  
8 of this subsection shall be determined under rules similar  
9 to the rules of section 4980B(f)(4).”.

10           (2) CONFORMING AMENDMENTS.—

11           (A) Section 106(b)(1) is amended—

12               (i) by inserting “gross income does  
13 not include” before “amounts contrib-  
14 uted”, and

15               (ii) by striking “shall be treated as  
16 employer-provided coverage for medical ex-  
17 penses under an accident or health plan”.

18           (B) Section 106(d)(1) is amended—

19               (i) by inserting “gross income does  
20 not include” before “amounts contrib-  
21 uted”, and

22               (ii) by striking “shall be treated as  
23 employer-provided coverage for medical ex-  
24 penses under an accident or health plan”.

1 (b) AMOUNTS RECEIVED UNDER ACCIDENT AND  
2 HEALTH PLANS.—Section 105 (relating to amounts re-  
3 ceived under accident and health plans) is amended by  
4 adding at the end the following new subsection:

5 “(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE  
6 FOR QUALIFIED HEALTH INSURANCE CREDIT.—Sub-  
7 section (b) shall not apply with respect to any employer-  
8 provided coverage under an accident or health plan for any  
9 individual for any month unless such individual is de-  
10 scribed in paragraph (2) or (5) of section 25E(e) for such  
11 month.”.

12 (c) SPECIAL RULES FOR HEALTH INSURANCE COSTS  
13 OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of  
14 section 162 (relating to special rules for health insurance  
15 costs of self-employed individuals) is amended by adding  
16 at the end the following new paragraph:

17 “(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE  
18 FOR QUALIFIED HEALTH INSURANCE.—Paragraph  
19 (1) shall not apply for any individual for any month  
20 unless such individual is described in paragraph (2)  
21 or (5) of section 25E(e) for such month.”.

22 (d) EARNED INCOME CREDIT UNAFFECTED BY RE-  
23 PEATED EXCLUSIONS.—Subparagraph (B) of section  
24 32(c)(2) is amended by redesignating clauses (v) and (vi)

1 as clauses (vi) and (vii), respectively, and by inserting  
 2 after clause (iv) the following new clause:

3 “(v) the earned income of an indi-  
 4 vidual shall be computed without regard to  
 5 sections 105(f) and 106(f).”.

6 (e) MODIFICATION OF DEDUCTION FOR MEDICAL  
 7 EXPENSES.—Subsection (d) of section 213 is amended by  
 8 adding at the end the following new paragraph:

9 “(12) PREMIUMS FOR QUALIFIED HEALTH IN-  
 10 SURANCE.—The term ‘medical care’ does not include  
 11 any amount paid as a premium for coverage of an  
 12 eligible individual (as defined in section 25E(e))  
 13 under qualified health insurance (as defined in sec-  
 14 tion 25E(f)) for any month.”.

15 (f) REPORTING REQUIREMENT.—Subsection (a) of  
 16 section 6051 is amended by striking “and” at the end of  
 17 paragraph (12), by striking the period at the end of para-  
 18 graph (13) and inserting “and”, and by inserting after  
 19 paragraph (13) the following new paragraph:

20 “(14) the total amount of employer-provided  
 21 coverage under an accident or health plan which is  
 22 includible in gross income by reason of sections  
 23 105(f) and 106(f).”.

24 (g) RETIRED PUBLIC SAFETY OFFICERS.—Section  
 25 402(l)(4)(D) is amended by adding at the end the fol-



1 lowing: “Such term shall not include any premium for cov-  
 2 erage by an accident or health insurance plan for any  
 3 month unless such individual is described in paragraph (2)  
 4 or (5) of section 25E(e) for such month.”.

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

8 (i) NO INTENT TO ENCOURAGE STATE TAXATION OF  
 9 HEALTH BENEFITS.—No intent to encourage any State  
 10 to treat health benefits as taxable income for the purpose  
 11 of increasing State income taxes may be inferred from the  
 12 provisions of, and amendments made by, this section.

## 13 **Subtitle B—Health Savings** 14 **Accounts**

### 15 **SEC. 311. IMPROVEMENTS TO HEALTH SAVINGS ACCOUNTS.**

16 (a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

17 (1) IN GENERAL.—Paragraph (2) of section  
 18 223(b) (relating to limitations) is amended to read  
 19 as follows:

20 “(2) MONTHLY LIMITATION.—

21 “(A) IN GENERAL.—In the case of an eligi-  
 22 ble individual who has coverage under a high  
 23 deductible health plan, the monthly limitation  
 24 for any month of such coverage is  $\frac{1}{12}$  of the  
 25 sum of—

1 “(i) the greater of—

2 “(I) the sum of the annual de-  
3 ductible and the other annual out-of-  
4 pocket expenses (other than for pre-  
5 miums) required to be paid under the  
6 plan by the eligible individual for cov-  
7 ered benefits, or

8 “(II) in the case of an eligible in-  
9 dividual who has—

10 “(aa) self-only coverage  
11 under a high deductible health  
12 plan as of the first day of such  
13 month, \$3,000, or

14 “(bb) family coverage under  
15 a high deductible health plan as  
16 of the first day of such month,  
17 \$5,950, and

18 “(ii) in the case of an eligible indi-  
19 vidual who has coverage under a qualified  
20 long-term care insurance contract (as de-  
21 fined in section 7702B(b)), the lesser of—

22 “(I) the annual premium for  
23 such coverage, or

24 “(II) \$1,000.

1           “(B) SPECIAL RULES RELATING TO OUT-  
2 OF-POCKET EXPENSES.—

3           “(i) REDUCTION FOR SEPARATE  
4 PLAN.—The annual out-of-pocket expenses  
5 taken into account under subparagraph  
6 (A)(i)(I) with respect to any eligible indi-  
7 vidual shall be reduced by any out-of-pock-  
8 et expense payable under a separate plan  
9 covering the individual.

10           “(ii) SECRETARIAL AUTHORITY.—The  
11 Secretary may by regulations provide that  
12 annual out-of-pocket expenses will not be  
13 taken into account under subparagraph  
14 (A)(i)(I) to the extent that there is only a  
15 remote likelihood that such amounts will  
16 be required to be paid.”.

17           (2) APPLICATION OF SPECIAL RULES FOR MAR-  
18 RIED INDIVIDUALS.—Paragraph (5) of section  
19 223(b) (relating to limitations) is amended to read  
20 as follows:

21           “(5) SPECIAL RULES FOR MARRIED INDIVID-  
22 UALS.—

23           “(A) IN GENERAL.—In the case of individ-  
24 uals who are married to each other and who are  
25 both eligible individuals, the limitation under

1 paragraph (1) for each spouse shall be equal to  
2 the spouse's applicable share of the combined  
3 marital limit.

4 “(B) COMBINED MARITAL LIMIT.—For  
5 purposes of subparagraph (A), the combined  
6 marital limit is the excess (if any) of—

7 “(i) the lesser of—

8 “(I) subject to subparagraph (C),  
9 the sum of the limitations computed  
10 separately under paragraph (1) for  
11 each spouse (including any additional  
12 contribution amount under paragraph  
13 (3)), or

14 “(II) the dollar amount in effect  
15 under subsection (c)(2)(A)(ii)(II),  
16 over

17 “(ii) the aggregate amount paid to  
18 Archer MSAs of such spouses for the tax-  
19 able year.

20 “(C) SPECIAL RULE WHERE BOTH  
21 SPOUSES HAVE FAMILY COVERAGE.—For pur-  
22 poses of subparagraph (B)(i)(I), if either spouse  
23 has family coverage which covers both spouses,  
24 both spouses shall be treated as having only  
25 such coverage (and if both spouses each have

1 such coverage under different plans, shall be  
2 treated as having only family coverage with the  
3 plan with respect to which the lowest amount is  
4 determined under paragraph (2)(A)(i)(I).

5 “(D) APPLICABLE SHARE.—For purposes  
6 of subparagraph (A), a spouse’s applicable  
7 share is  $\frac{1}{2}$  of the combined marital limit unless  
8 both spouses agree on a different division.

9 “(E) COUPLES NOT MARRIED ENTIRE  
10 YEAR.—The Secretary shall prescribe rules for  
11 the application of this paragraph in the case of  
12 any taxable year for which the individuals were  
13 not married to each other during all months in-  
14 cluded in the taxable year, including rules  
15 which allow individuals in appropriate cases to  
16 take into account coverage prior to marriage in  
17 computing the combined marital limit for pur-  
18 poses of this paragraph.”.

19 (3) SELF-ONLY COVERAGE.—Paragraph (4) of  
20 section 223(c) (relating to definitions and special  
21 rules) is amended to read as follows:

22 “(4) COVERAGE.—

23 “(A) FAMILY COVERAGE.—The term ‘fam-  
24 ily coverage’ means any coverage other than  
25 self-only coverage.

1           “(B) SELF-ONLY COVERAGE.—If more  
2 than 1 individual is covered by a high deduct-  
3 ible health plan but only 1 of the individuals is  
4 an eligible individual, the coverage shall be  
5 treated as self-only coverage.”.

6 (4) CONFORMING AMENDMENTS.—

7           (A) Section 223(b)(3)(A) is amended by  
8 striking “subparagraphs (A) and (B) of”.

9           (B) Section 223(c)(2)(A) is amended—

10           (i) by striking “\$1,000” in clause

11           (i)(I) and inserting “\$1,150”, and

12           (ii) by striking “\$5,000” in clause

13           (ii)(I) and inserting “\$5,800”.

14           (C) Section 223(d)(1)(A)(ii)(I) is amended  
15 by striking “subsection (b)(2)(B)(ii)” and in-  
16 serting “subsection (c)(2)(A)(ii)(II)”.

17           (D) Clause (ii) of section 223(c)(2)(D) is  
18 amended to read as follows:

19           “(ii) CERTAIN ITEMS DISREGARDED  
20 IN COMPUTING MONTHLY LIMITATION.—

21 Such plan’s annual deductible, and such  
22 plan’s annual out-of-pocket limitation, for  
23 services provided outside of such network  
24 shall not be taken into account for pur-  
25 poses of subsection (b)(2).”

1           (E) Subsection (g) of section 223 is  
2           amended to read as follows:

3           “(g) COST-OF-LIVING ADJUSTMENTS.—

4           “(1) IN GENERAL.—In the case of any taxable  
5           year beginning in a calendar year after 2009, each  
6           dollar amount contained in subsections (b)(2)(A)  
7           and (c)(2)(A) shall be increased by an amount equal  
8           to such dollar amount multiplied by the blended  
9           cost-of-living adjustment.

10           “(2) BLENDED COST-OF-LIVING ADJUST-  
11           MENT.—For purposes of paragraph (1), the blended  
12           cost-of-living adjustment means one-half of the sum  
13           of—

14           “(A) the cost-of-living adjustment deter-  
15           mined under section 1(f)(3) for the calendar  
16           year in which the taxable year begins by sub-  
17           stituting ‘calendar year 2008’ for ‘calendar year  
18           1992’ in subparagraph (B) thereof, plus

19           “(B) the cost-of-living adjustment deter-  
20           mined under section 213(d)(10)(B)(ii) for the  
21           calendar year in which the taxable year begins  
22           by substituting ‘2008’ for ‘1996’ in subclause  
23           (II) thereof.

1           “(3) ROUNDING.—Any increase determined  
2           under paragraph (2) shall be rounded to the nearest  
3           multiple of \$50.”.

4           (b) USE OF ACCOUNT FOR INDIVIDUAL HIGH DE-  
5 DUCTIBLE HEALTH PLAN PREMIUMS.—Section  
6 223(d)(2)(C) (relating to exceptions) is amended by strik-  
7 ing “or” at the end of clause (iii), by striking the period  
8 at the end of clause (iv) and inserting “, or”, and by add-  
9 ing at the end the following new clause:

10                           “(v) a high deductible health plan, but  
11                           only if—

12   “(I) the plan is not a group  
13   health plan (as defined in section  
14   5000(b)(1) without regard to section  
15   5000(d)), and

16   “(II) the expenses are for cov-  
17   erage for a month with respect to  
18   which the account beneficiary is an el-  
19   igible individual by reason of the cov-  
20   erage under the plan.

21           For purposes of clause (v), an arrangement  
22           which constitutes individual health insurance  
23           shall not be treated as a group health plan, not-  
24           withstanding that an employer or employee or-



1           ganization negotiates the cost of benefits of  
2           such arrangement.”.

3           (c) SAFE HARBOR FOR ABSENCE OF MAINTENANCE  
4 OF CHRONIC DISEASE.—Section 223(c)(2)(C) (safe har-  
5 bor for absence of preventive care deductible) is amend-  
6 ed—

7           (1) by inserting “or maintenance of chronic dis-  
8 ease, or both” after “the Secretary”, and

9           (2) by inserting “OR MAINTENANCE OF CHRON-  
10 IC DISEASE” in the heading after “PREVENTIVE  
11 CARE”.

12          (d) CLARIFICATION OF TREATMENT OF CAPITATED  
13 PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MED-  
14 ICAL CARE.—Section 213(d) (relating to definitions) is  
15 amended by adding at the end the following new para-  
16 graph:

17           “(12) TREATMENT OF CAPITATED PRIMARY  
18 CARE PAYMENTS.—Capitated primary care payments  
19 shall be treated as amounts paid for medical care.”.

20          (e) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR  
21 VETERANS OR INDIAN HEALTH BENEFITS.—Section  
22 223(c)(1) (defining eligible individual) is amended by add-  
23 ing at the end the following new subparagraph:

24           “(C) SPECIAL RULE FOR INDIVIDUALS ELI-  
25 GIBLE FOR VETERANS OR INDIAN HEALTH BEN-

1 EFITS.—For purposes of subparagraph (A)(ii),  
 2 an individual shall not be treated as covered  
 3 under a health plan described in such subpara-  
 4 graph merely because the individual receives  
 5 periodic hospital care or medical services under  
 6 any law administered by the Secretary of Vet-  
 7 erans Affairs or the Bureau of Indian Affairs.”.

8 (f) CERTAIN PHYSICIAN FEES TO BE TREATED AS  
 9 MEDICAL CARE.—

10 (1) IN GENERAL.—Section 213(d), is amended  
 11 by adding at the end the following new paragraph:

12 “(12) PRE-PAID PHYSICIAN FEES.—The term  
 13 ‘medical care’ shall include amounts paid by patients  
 14 to their primary physician in advance for the right  
 15 to receive medical services on an as-needed basis.”.

16 (2) EFFECTIVE DATE.—The amendment made  
 17 by this section shall apply to taxable years beginning  
 18 after the date of the enactment of this Act.

19 (g) EFFECTIVE DATES.—

20 (1) IN GENERAL.—Except as provided in para-  
 21 graph (2), the amendments made by this section  
 22 shall apply to taxable years beginning after Decem-  
 23 ber 31, 2009.

24 (2) CAPITATED PRIMARY CARE PAYMENTS.—  
 25 The amendment made by subsection (d) shall apply

1 to amounts paid before, on, or after the date of the  
2 enactment of this Act.

3 **SEC. 312. EXCEPTION TO REQUIREMENT FOR EMPLOYERS**  
4 **TO MAKE COMPARABLE HEALTH SAVINGS AC-**  
5 **COUNT CONTRIBUTIONS.**

6 (a) GREATER EMPLOYER-PROVIDED CONTRIBU-  
7 TIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES  
8 TREATED AS MEETING COMPARABILITY REQUIRE-  
9 MENTS.—Subsection (b) of section 4980G (relating to fail-  
10 ure of employer to make comparable health savings ac-  
11 count contributions) is amended to read as follows:

12 “(b) RULES AND REQUIREMENTS.—

13 “(1) IN GENERAL.—Except as provided in para-  
14 graph (2), rules and requirements similar to the  
15 rules and requirements of section 4980E shall apply  
16 for purposes of this section.

17 “(2) TREATMENT OF EMPLOYER-PROVIDED  
18 CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL  
19 EMPLOYEES.—For purposes of this section—

20 “(A) IN GENERAL.—Any contribution by  
21 an employer to a health savings account of an  
22 employee who is (or the spouse or any depend-  
23 ent of the employee who is) a chronically ill in-  
24 dividual in an amount which is greater than a  
25 contribution to a health savings account of a

1 comparable participating employee who is not a  
2 chronically ill individual shall not fail to be con-  
3 sidered a comparable contribution.

4 “(B) NONDISCRIMINATION REQUIRE-  
5 MENT.—Subparagraph (A) shall not apply un-  
6 less the excess employer contributions described  
7 in subparagraph (A) are the same for all chron-  
8 ically ill individuals who are similarly situated.

9 “(C) CHRONICALLY ILL INDIVIDUAL.—For  
10 purposes of this paragraph, the term ‘chron-  
11 ically ill individual’ means any individual whose  
12 qualified medical expenses for any taxable year  
13 are more than 50 percent greater than the av-  
14 erage qualified medical expenses of all employ-  
15 ees of the employer for such year.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 this section shall apply to taxable years beginning after  
18 December 31, 2009.

1 **TITLE IV—FAIRNESS FOR EVERY**  
 2 **AMERICAN PATIENT**  
 3 **Subtitle A—Medicaid**  
 4 **Modernization**

5 **SEC. 401. MEDICAID MODERNIZATION.**

6 (a) IN GENERAL.—Effective January 1, 2011, title  
 7 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)  
 8 is amended to read as follows:

9 **“TITLE XIX—GRANTS TO STATES**  
 10 **FOR MEDICAL ASSISTANCE**  
 11 **PROGRAMS**

“TABLE OF CONTENTS OF TITLE

“Sec. 1900. References to pre-modernized Medicaid provisions; continuity for commonwealths and territories.

“PART A—GRANTS TO STATES FOR ACUTE CARE FOR INDIVIDUALS WITH DISABILITIES AND CERTAIN LOW-INCOME INDIVIDUALS

“Sec. 1901. Purpose; Appropriation.

“Sec. 1902. Payments to States for acute care medical assistance.

“Sec. 1903. Definitions of eligible individuals and acute care medical assistance.

“Sec. 1904. State plan requirements for acute care medical assistance.

“Sec. 1905. Definitions.

“Sec. 1906. Enrollment of individuals under group health plans and other arrangements.

“Sec. 1907. Drug rebates.

“Sec. 1908. Managed care.

“Sec. 1909. Annual reports.

“PART B—GRANTS TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS

“Sec. 1911. Purpose.

“Sec. 1912. State plan.

“Sec. 1913. State allotments.

“Sec. 1914. Use of grants.

“Sec. 1915. Administrative provisions.

“Sec. 1916. Definition of long-term care services and supports.

“Sec. 1917. Provision requirements for long-term care services and supports, including option for self-directed services and supports.

“Sec. 1918. Treatment of income and resources for certain institutionalized spouses.

“Sec. 1919. Annual reports.

“PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF  
MEDICAL FACILITIES AND OTHER REQUIREMENTS

“Sec. 1931. Authorization of appropriations.

“Sec. 1932. Application of certain requirements under pre-modernized Medicaid.

“PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

“Sec. 1941. Authorization of appropriations.

“Sec. 1942. Application of certain requirements under pre-modernized Medicaid.

“PART E—GRANTS TO STATES FOR ADMINISTRATION

“Sec. 1951. Authorization of appropriations; payments to states.

“Sec. 1952. Cost-sharing protections.

“Sec. 1953. Application of certain requirements under pre-modernized Medicaid.

“PART F—OTHER PROVISIONS

“Sec. 1961. Application of certain requirements under pre-modernized Medicaid.

1 **“SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID**  
2 **PROVISIONS; CONTINUITY FOR COMMON-**  
3 **WEALTHS AND TERRITORIES.**

4 “(a) IN GENERAL.—In this title, if a reference to this  
5 title or to a provision of this title is prefaced by the term  
6 ‘old’, such reference is to this title or a provision of this  
7 title as in effect on December 31, 2010.

8 “(b) REGULATIONS.—The Secretary shall promul-  
9 gate regulations to bring requirements imposed under an  
10 old provision of this title that applies under this title after  
11 December 31, 2010, into conformity with the policies em-  
12 bodied in this title as in effect on and after January 1,  
13 2011.

1       “(c) CONTINUITY FOR COMMONWEALTHS AND TER-  
2 RITORIES.—In the case of Puerto Rico, the United States  
3 Virgin Islands, Guam, the Northern Mariana Islands, and  
4 American Samoa, this title as in effect on and after Janu-  
5 ary 1, 2011, shall not apply to such commonwealths and  
6 territories, and old title XIX shall apply to a Medicaid pro-  
7 gram operated by such commonwealths or territories on  
8 and after that date.

9       **“PART A—GRANTS TO STATES FOR ACUTE CARE**  
10           **FOR INDIVIDUALS WITH DISABILITIES AND**  
11           **CERTAIN LOW-INCOME INDIVIDUALS**

12       **“SEC. 1901. PURPOSE; APPROPRIATION.**

13       “(a) PURPOSE.—It is the purpose of this part to en-  
14 able each State, as far as practicable under the conditions  
15 in the State, to provide acute care medical assistance to  
16 eligible individuals described in section 1903 whose income  
17 and resources are insufficient to meet the costs of nec-  
18 essary medical services, and (2) rehabilitation and other  
19 services to help such individuals attain or retain capability  
20 for independence or self-care.

21       “(b) APPROPRIATION.—For the purpose of making  
22 payments to States under this part, there is appropriated  
23 out of any money in the Treasury not otherwise appro-  
24 priated, such sums as are necessary for fiscal year 2011  
25 and each fiscal year thereafter.

1 **“SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MED-**  
2 **ICAL ASSISTANCE.**

3 “(a) IN GENERAL.—From the amounts appropriated  
4 under section 1901 for a fiscal year, the Secretary shall  
5 pay to each State which has a plan approved under this  
6 part, for each quarter, beginning with the quarter com-  
7 mencing January 1, 2011, an amount equal to the Federal  
8 medical assistance percentage (as defined in section  
9 1905(b)) of the total amount expended during such quar-  
10 ter as acute care medical assistance under the State plan  
11 under this part.

12 “(b) ADMINISTRATIVE EXPENSES.—Each State with  
13 a plan approved under this part shall receive a payment  
14 determined in accordance with part E for administrative  
15 expenses incurred in carrying out the plan under this part  
16 and part B (if the State has a plan approved under that  
17 part).

18 **“SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND**  
19 **ACUTE CARE MEDICAL ASSISTANCE.**

20 “(a) ELIGIBLE INDIVIDUALS.—

21 “(1) IN GENERAL.—In this part, the term ‘eli-  
22 gible individual’ means an individual—

23 “(A) who is—

24 “(i) a blind or disabled individual; or

25 “(ii) an individual described in para-  
26 graph (2); and



1 “(B) who the State determines satisfies—

2 “(i) the income and resources eligi-  
3 bility requirements established by the State  
4 under the State plan under this part; and

5 “(ii) such other requirements for as-  
6 sistance as are imposed under this title, in-  
7 cluding documentation of citizenship or  
8 status as a qualified alien under title IV of  
9 the Personal Responsibility and Work Op-  
10 portunity Reconciliation Act of 1996.

11 “(2) INDIVIDUALS DESCRIBED.—For purposes  
12 of paragraph (1)(A)(ii), the following individuals are  
13 described in this paragraph:

14 “(A) A child in foster care under the re-  
15 sponsibility of the State.

16 “(B) A low-income woman with breast or  
17 cervical cancer described in old section  
18 1902(aa).

19 “(C) Certain TB-infected individuals de-  
20 scribed in old section 1902(z)(1).

21 “(3) GRANDFATHERED INDIVIDUALS.—An indi-  
22 vidual shall be an eligible individual under the State  
23 plan under this part if—

24 “(A) the individual is described in para-  
25 graph (1)(A);

1           “(B) the individual satisfies the docu-  
2           mentation requirements referred to in para-  
3           graph (1)(B)(ii); and

4           “(C) the State would have provided med-  
5           ical assistance under the State plan under old  
6           title XIX to the individual, but only so long as  
7           the individual continues to satisfy such old eligi-  
8           bility requirements.

9           “(4) CONCURRENT ELIGIBILITY FOR PART B.—  
10          An eligible individual under this part may be eligible  
11          under part B, but only if the individual satisfies the  
12          eligibility requirements of part B in addition to sat-  
13          isfying the requirements for eligibility under this  
14          part.

15          “(5) PRESUMPTIVE ELIGIBILITY FOR CERTAIN  
16          BREAST OR CERVICAL CANCER PATIENTS.—Old sec-  
17          tion 1920B (relating to presumptive eligibility for  
18          certain breast or cervical cancer patients) shall apply  
19          under this part.

20          “(b) BENEFITS.—Subject to paragraph (3), in this  
21          part, the term ‘acute care medical assistance’ means the  
22          following:

23                 “(1) MANDATORY BENEFITS.—The care and  
24                 services listed in paragraphs (1) through (5), (17),  
25                 and (21) of old section 1905(a) (but, in the case of

1 paragraph (4)(A) of such section, without regard to  
2 any limitation based on age or services in an institu-  
3 tion for mental diseases).

4 “(2) OPTIONAL BENEFITS.—Any care or serv-  
5 ices listed in a paragraph of old section 1905(a)  
6 (other than paragraph (16)).

7 “(3) EXCEPTIONS.—

8 “(A) CERTAIN SERVICES LIMITED TO PART  
9 B.—Services described in paragraphs (15),  
10 (22), (23), (24), and (26) of old section  
11 1905(a) shall only be provided under the State  
12 plan under part B.

13 “(B) LIMIT ON PROVISION OF LONG-TERM  
14 CARE SERVICES AND SUPPORTS.—A care or  
15 service that the Secretary determines is a long-  
16 term care service and support (including nurs-  
17 ing facility services described in old section  
18 1905(a)(4)(A)) shall not be provided to an indi-  
19 vidual under the State plan under this part for  
20 more than 30 days within any 12-month period.

21 “(C) EXCLUSIONS.—Such term shall not  
22 include any payments with respect to care or  
23 services for any individual who is an inmate of  
24 a public institution or a patient in an institu-  
25 tion for mental diseases (regardless of age).

1 **“SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE**  
2 **MEDICAL ASSISTANCE.**

3 “(a) IN GENERAL.—In order to receive payments  
4 under this part, a State shall have an approved State plan  
5 for acute care medical assistance. For purposes of this  
6 part, such assistance includes payments for preventive  
7 care, primary care, diagnosis and treatment of acute and  
8 chronic health conditions, emergency care, diagnosis and  
9 treatment of mental illnesses and related conditions, and  
10 rehabilitation and other services to help eligible individuals  
11 attain or retain capability for independence or self-care.

12 A State medical assistance plan shall include a descrip-  
13 tion, consistent with the requirements of this part of—

14 “(1) eligibility standards, including income and  
15 asset standards;

16 “(2) benefits, including the amount, duration,  
17 and scope of covered items and services;

18 “(3) strategies for improving access and quality  
19 of care; and

20 “(4) methods of service delivery.

21 “(b) PUBLIC AVAILABILITY OF STATE PLAN.—The  
22 State shall make available to the public the State plan  
23 under this part and any amendments submitted by the  
24 State to the plan.

25 “(c) AMOUNT, DURATION, AND SCOPE.—The State  
26 plan shall provide that the acute care medical assistance

1 made available to any eligible individual shall not be less  
2 in amount, duration, or scope than the acute care medical  
3 assistance made available to any other eligible individual.

4 “(d) APPLICATION OF CERTAIN PRE-MODERNIZED  
5 MEDICAID REQUIREMENTS.—

6 “(1) OLD STATE PLAN REQUIREMENTS.—The  
7 following provisions of old section 1902 shall apply  
8 to the State plans under this part:

9 “(A) Old section 1902(a)(10)(C) (relating  
10 to certain eligibility and other requirements).

11 “(B) Old section 1902(a)(10)(D) (relating  
12 to home health services).

13 “(C) Old section 1902(a)(10)(G) (relating  
14 to nonapplication of certain supplemental secu-  
15 rity income eligibility criteria).

16 “(D) The subclauses in the flush matter  
17 following old section 1902(a)(10)(G) (relating  
18 to the provision of certain services) other than  
19 subclauses (V), (VII), (VIII), and (IX).

20 “(E) Old section 1902(a)(17) (relating to  
21 reasonable standards for determining eligi-  
22 bility).

23 “(F) Old section 1902(a)(19) (relating to  
24 eligibility safeguards).

1           “(G) Old section 1902(a)(34) (relating to  
2           eligibility beginning with the third month prior  
3           to the month of application).

4           “(H) Subparagraphs (A), (B), and (C) of  
5           old section 1902(a)(43) (relating to early and  
6           periodic screening, diagnostic, and treatment  
7           services).

8           “(I) Old section 1902(a)(46)(A) (relating  
9           to compliance with section 1137 requirements).

10          “(J) The fourth and sixth sentences of old  
11          section 1902(a) (relating to eligibility for cer-  
12          tain individuals).

13          “(2) OTHER OLD TITLE XIX REQUIREMENTS.—

14               “(A) Old section 1902(e)(3) (relating to  
15               optional eligibility for certain disabled individ-  
16               uals).

17               “(B) Old section 1902(e)(9) (relating to  
18               optional respiratory care services).

19               “(C) Old section 1902(f) (relating to eligi-  
20               bility of certain aged, blind, or disabled individ-  
21               uals).

22               “(D) Old section 1902(m) (relating to eli-  
23               gibility of certain aged or disabled individuals),  
24               other than paragraph (4).

1           “(E) Old section 1902(o) (relating to dis-  
2           regard of certain supplemental security income  
3           benefits).

4           “(F) Old section 1902(v) (relating to eligi-  
5           bility determinations of blind or disabled indi-  
6           viduals).

7           “(e) OTHER REQUIREMENTS.—The State plan under  
8 this part shall—

9           “(1) comply with the requirements of the other  
10 parts of this title; and

11           “(2) provide that the State will make the con-  
12 tributions specified under section 340A–1(e) of the  
13 Public Health Service Act .

14 **“SEC. 1905. DEFINITIONS.**

15           “(a) IN GENERAL.—The definitions specified in this  
16 section shall apply for purposes of this part and, to the  
17 extent applicable and consistent with the policy embodied  
18 in such part, parts B, C, D, E, and F.

19           “(b) FEDERAL MEDICAL ASSISTANCE PERCENT-  
20 AGE.—The term ‘Federal medical assistance percentage’  
21 for any State shall be 100 percent less the State percent-  
22 age; and the State percentage shall be that percentage  
23 which bears the same ratio to 45 percent as the square  
24 of the per capita income of such State bears to the square  
25 of the per capita income of the continental United States

1 (including Alaska) and Hawaii, except that the Federal  
2 medical assistance percentage shall in no case be less than  
3 50 percent or more than 83 percent. The Federal medical  
4 assistance percentage for any State shall be determined  
5 and promulgated in accordance with the provisions of sec-  
6 tion 1101(a)(8)(B).

7 “(c) APPLICATION OF CERTAIN PRE-MODERNIZED  
8 MEDICAID PROVISIONS.—The following old provisions  
9 shall apply under this part:

10 “(1) OLD SECTION 1905 PROVISIONS.—The fol-  
11 lowing provisions of old section 1905:

12 “(A) Old section 1905(d) (relating to the  
13 definition of an intermediate care facility for  
14 the mentally retarded).

15 “(B) Old section 1905(e) (relating to the  
16 definition of physicians services).

17 “(C) Old section 1905(f) (relating to the  
18 definition of nursing facility services).

19 “(D) Old section 1905(g) (relating to the  
20 provision of chiropractors’ services).

21 “(E) Old section 1905(j) (relating to State  
22 supplementary payments).

23 “(F) Old section 1905(k) (relating to sup-  
24 plemental security income benefits payable pur-  
25 suant to section 211 of Public Law 93–66).



1           “(G) Old section 1905(l)(1) (relating to  
2 rural health clinic services).

3           “(H) Old section 1905(o) (relating to hos-  
4 pice care).

5           “(I) Old section 1905(q) (relating to the  
6 definition of a qualified severely impaired indi-  
7 vidual).

8           “(J) Old section 1905(r) (relating to the  
9 definition of early and periodic screening, diag-  
10 nostic, and treatment services).

11          “(K) Old section 1905(s) (relating to the  
12 definition of a qualified disabled and working  
13 individual).

14          “(L) Old section 1905(t) (relating to the  
15 definition of primary care case management  
16 services).

17          “(M) Old section 1905(v) (relating to the  
18 definition of an employed individual with a  
19 medically improved disability).

20          “(N) Paragraphs (1) and (3) of old section  
21 1905(w) (relating to the definition of an inde-  
22 pendent foster care adolescent).

23          “(O) Old section 1905(x) (relating to  
24 strategies, treatment, and services for individ-  
25 uals with Sickle Cell Disease).

1           “(2) OTHER OLD PROVISIONS.—

2                   “(A) Old section 1903(m) (relating to the  
3           definition of a medicaid managed care organiza-  
4           tion).

5   **“SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP**  
6                   **HEALTH PLANS AND OTHER ARRANGEMENTS.**

7           “The following old provisions shall apply under this  
8   part:

9                   “(1) Old section 1906 (relating to enrollment of  
10           individuals under group health plans).

11                   “(2) Old section 1902(a)(70) (relating to State  
12           option to establish a non-emergency medical trans-  
13           portation brokerage program).

14                   “(3) Paragraphs (2) and (11) of old section  
15           1902(e) (relating to eligibility for individuals en-  
16           rolled with a group health plan or under a managed  
17           care arrangement during a minimum enrollment pe-  
18           riod).

19   **“SEC. 1907. DRUG REBATES.**

20           “Old sections 1902(a)(54) and 1927 (relating to pay-  
21           ment for covered outpatient drugs and rebates) shall apply  
22           under this part.

23   **“SEC. 1908. MANAGED CARE.**

24           “The following old provisions shall apply under this  
25           part:

1           “(1) Old section 1932 (relating to managed  
2           care), other than subsection (a)(2) of such section.

3           “(2) Old section 1903(k) (relating to technical  
4           and actuarial assistance for States).

5   **“SEC. 1909. ANNUAL REPORTS.**

6           “(a) IN GENERAL.—Each State that receives pay-  
7           ments under this part shall submit an annual report to  
8           the Secretary, in such form and manner as the Secretary  
9           shall specify.

10          “(b) APPLICATION OF OLD EPSDT REPORTING RE-  
11          QUIREMENTS.—Each annual report shall include the in-  
12          formation required to be reported under old section  
13          1902(a)(43)(D)(iv).

14   **“PART B—GRANTS TO STATES FOR LONG-TERM**  
15               **CARE SERVICES AND SUPPORTS**

16   **“SEC. 1911. PURPOSE.**

17          “(a) IN GENERAL.—The purpose of this part is to  
18          increase the flexibility of States in operating a system of  
19          long-term care services and supports designed to—

20               “(1) provide assistance to needy families so that  
21               individuals with disabilities and low-income senior  
22               citizens may be served and supported in their own  
23               homes and communities;

24               “(2) emphasize the independence and dignity of  
25               the person served by public programs;

1           “(3) end the institutional bias that existed  
2           under the Medicaid program prior to January 1,  
3           2011;

4           “(4) provide stable and predictable funding for  
5           States as they rebalance their long-term care sys-  
6           tems from institutions to communities;

7           “(5) provide flexibility to States to adopt new  
8           and innovative service delivery methods; and

9           “(6) promote independence and support activi-  
10          ties that will enable individuals to return or main-  
11          tain ties to the community, including through em-  
12          ployment.

13          “(b) **NO INDIVIDUAL ENTITLEMENT.**—No individual  
14          determined eligible for long-term care services and sup-  
15          ports under this part shall be entitled to a specific service  
16          or type of delivery of service.

17          **“SEC. 1912. STATE PLAN.**

18          “(a) **IN GENERAL.**—In order to receive payments  
19          under this part, a State must have an approved State plan  
20          for long-term care services and supports. A State long  
21          term care services and supports plan shall include a de-  
22          scription, consistent with the requirements of this part,  
23          of—

1           “(1) income and assets eligibility standards and  
2           spousal impoverishment protections consistent with  
3           subsection (b);

4           “(2) the standardized assessments tools used to  
5           determine eligibility for specific long-term care serv-  
6           ices and supports;

7           “(3) the person-centered plans used to provide  
8           such services and supports;

9           “(4) the proposed uses of funding, if applicable,  
10          to provide targeted methods to meet individual level  
11          of support needs including tiering (preventive, emer-  
12          gency, low, medium, high); and

13          “(5) the long-term care services and supports to  
14          be available under the plan based on individual as-  
15          sessment of need in accordance with sections 1916  
16          and 1917.

17          “(b) MINIMUM ELIGIBILITY STANDARDS.—

18                 “(1) POPULATIONS COVERED.—The State plan  
19                 shall specify the disabled and elderly populations  
20                 who are eligible for long-term care services and sup-  
21                 ports.

22                 “(2) NEEDS-BASED CRITERIA.—The plan shall  
23                 include a description of the needs-based criteria the  
24                 State will use to assess an individual’s need for spe-

1 cific services and supports available under the State  
2 plan.

3 “(3) OTHER ELIGIBILITY REQUIREMENTS.—

4 “(A) INCOME AND ASSETS.—A State may  
5 use different income and asset standards and  
6 methodologies for determining eligibility than  
7 those used for determining eligibility for acute  
8 care medical assistance under part A. A State  
9 may not make eligibility standards related to  
10 income, asset, and spousal impoverishment pro-  
11 tection more restrictive than the Federal min-  
12 imum requirements of December 31, 2008.

13 “(B) APPLICATION OF SPOUSAL IMPOVER-  
14 ISHMENT PROTECTIONS.—The State plan shall  
15 provide that the State shall comply with the re-  
16 quirements of section 1918 (relating to spousal  
17 impoverishment protections).

18 “(C) STATEWIDENESS.—The State plan  
19 shall provide that, except with respect to meth-  
20 ods used for determining homestead exemp-  
21 tions, the income and asset standards and  
22 methodologies shall be in effect in all political  
23 subdivisions of the State.

24 “(4) TRANSITION ASSISTANCE.—The State plan  
25 shall specify how the State will provide transition as-

1 assistance for individuals who, on December 31, 2010,  
2 are enrolled under the State plan under old title  
3 XIX (or under a waiver of that plan) and receiving  
4 long-term care services or supports on that date.  
5 The State shall provide such assistance to individ-  
6 uals who are and are not likely to be determined eli-  
7 gible for long-term care services and supports under  
8 the State plan under this part, as in effect on Janu-  
9 ary 1, 2011 (or the first day on which the State plan  
10 is in effect under this part).

11 “(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

12 “(1) IN GENERAL.—The State plan shall de-  
13 scribe the methodologies used to determine payments  
14 to providers. Such methodologies—

15 “(A) may be varied to assist in  
16 transitioning from facilities-based to commu-  
17 nity-based care; and

18 “(B) shall not be subject to Secretarial ap-  
19 proval.

20 “(2) TRANSPARENCY.—The State plan shall  
21 provide that the State shall make publicly avail-  
22 able—

23 “(A) the payment methodologies applicable  
24 under the plan; and

1           “(B) the name of any provider that re-  
2           ceives \$1,000,000 or more in any 12-month pe-  
3           riod and the actual amount paid to the provider  
4           during that period.

5           “(d) COORDINATION OF EFFORT WITH OTHER RE-  
6           LATED PUBLIC AND PRIVATE PROGRAMS.—The plan shall  
7           include a description of the State’s efforts to coordinate  
8           the delivery of services and supports under the plan with  
9           other related public and private programs that serve indi-  
10          viduals with disabilities or aged populations that need or  
11          may be at risk of needing long term care.

12          “(e) PUBLIC AVAILABILITY OF STATE PLAN.—The  
13          State shall make available to the public the State plan  
14          under this part and any amendments submitted by the  
15          State to the plan.

16          “(f) APPLICATION OF OLD TITLE XIX REQUIRE-  
17          MENTS.—The following old title XIX provisions shall  
18          apply to a State plan under this part:

19                 “(1) Subsections (a)(50) and (q) of old section  
20                 1902 (relating to a monthly personal needs allow-  
21                 ance for certain institutionalized individuals and  
22                 couples).

23                 “(2) Old section 1902(a)(67) (relating to pay-  
24                 ment for certain services furnished to a PACE pro-  
25                 gram eligible individual).



1           “(3) Paragraph (1) of old section 1902(r) (re-  
 2 relating to the post-eligibility treatment of income for  
 3 certain individuals) and paragraph (2) of such sec-  
 4 tion (relating to methodologies for determining in-  
 5 come and resource eligibility for individuals, but only  
 6 with respect to individuals who are eligible under  
 7 this part on or after January 1, 2011).

8           “(4) Old section 1905(i) (relating to the defini-  
 9 tion of an institution for mental diseases).

10          “(g) OTHER REQUIREMENTS OF OTHER PARTS.—  
 11 The State plan under this part shall—

12           “(1) comply with the requirements of the other  
 13 parts of this title; and

14           “(2) provide that the State will make the con-  
 15 tributions specified under section 340A–1(e) of the  
 16 Public Health Service Act.

17 **“SEC. 1913. STATE ALLOTMENTS.**

18          “(a) APPROPRIATION.—For the purpose of providing  
 19 allotments to States under this section, there is appro-  
 20 priated out of any money in the Treasury not otherwise  
 21 appropriated—

22           “(1) for fiscal year 2011, \$65,274,560,000;

23           “(2) for fiscal year 2012, \$67,885,540,000;

24           “(3) for fiscal year 2013, \$70,600,964,100;

25           “(4) for fiscal year 2014, \$73,425,000,000;

1 “(5) for fiscal year 2015, \$76,362,000,000;

2 “(6) for fiscal year 2016, \$79,416,480,000;

3 “(7) for fiscal year 2017, \$82,593,140,000;

4 “(8) for fiscal year 2018, \$85,896,870,000; and

5 “(9) for fiscal year 2019, \$89,332,743,000.

6 “(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT  
7 OF COLUMBIA.—

8 “(1) FISCAL YEAR 2011 ALLOTMENTS.—Subject  
9 to subsection (e), the Secretary shall allot to each  
10 State with a long term care plan approved under  
11 this title an amount in fiscal year 2011 equal to the  
12 Federal expenditures made by the State for long-  
13 term care as defined in section 1916 in fiscal year  
14 2008, increased by 8 percent.

15 “(2) SUBSEQUENT FISCAL YEAR ALLOT-  
16 MENTS.—For fiscal year 2012 and each subsequent  
17 fiscal year through fiscal year 2019, the allotment  
18 for a State under this section is equal to the allot-  
19 ment for the State determined for the preceding fis-  
20 cal year, increased by 4 percent.

21 “(c) LIMITATION.—

22 “(1) IN GENERAL.—Except as provided in para-  
23 graph (2), no other Federal funds are available  
24 under this title for expenditures incurred for long-  
25 term care services and supports after December 31,

1       2010, except as provided under a State plan ap-  
2       proved under this part.

3           “(2) EXCEPTION.—

4               “(A) IN GENERAL.—If a State does not  
5       have an approved State plan by October 1,  
6       2010, the Secretary may make payments equal  
7       to 85 percent of the State’s estimated quarterly  
8       allotment until June 30, 2011.

9               “(B) FULL FUNDING.—A State shall re-  
10      ceive 100 percent of its allotment for fiscal year  
11      2011 if the State has a plan approved under  
12      this part by June 30, 2011.

13           “(d) MAINTENANCE OF EFFORT.—In order to qualify  
14      for the grant payable under this section, the State must  
15      demonstrate in each fiscal year that it made long-term  
16      care service and supports expenditures (including funding  
17      from local government sources) equal to the amount of  
18      not less than 95 percent of the nonfederal share amount  
19      spent in fiscal year 2009 under the State plan under old  
20      title XIX on long term care services and supports (as de-  
21      fined in section 1916). Expenditures not made under this  
22      part shall not be recognized by the Secretary for purposes  
23      of this requirement.

24           “(e) GRANTS REDUCED IF INSUFFICIENT APPRO-  
25      PRIATIONS.—

1           “(1) IN GENERAL.—If the amount appropriated  
 2           for fiscal year 2011 under subsection (a)(1) is less  
 3           than the amount necessary to fund each State’s al-  
 4           lotment for that fiscal year, the Secretary shall re-  
 5           duce the allotment for each State for that fiscal year  
 6           based on the applicable percentage determined for  
 7           the State under paragraph (2).

8           “(2) APPLICABLE PERCENTAGE.—For purposes  
 9           of paragraph (1), the applicable percentage deter-  
 10          mined with respect to a State is as follows:

<b>“If the ratio of the State’s non-institutional            spending to total long-term care spending            for fiscal year 2009 is:</b>	<b>The applicable            percentage is:</b>
50 percent or greater .....	100
at least 46, but less than 50 percent .....	99
at least 40, but less than 46 percent .....	98
at least 36, but less than 40 .....	97
at least 30, but less than 36 .....	96
less than 30 percent .....	95.

11          “(f) ADMINISTRATIVE EXPENSES.—

12           “(1) IN GENERAL.—Each State with a plan ap-  
 13           proved under this part shall receive a payment deter-  
 14           mined in accordance with amounts appropriated for  
 15           part E for administrative expenses incurred in car-  
 16           rying out the plan under this part and part A.

17           “(2) ASSESSMENT-RELATED COSTS.—Costs at-  
 18           tributable to providing an individualized needs-based  
 19           assessment for purposes of identifying the long-term  
 20           care services and supports to be provided under the  
 21           State plan to an individual shall be considered a

1 long-term care service and support and shall not be  
2 treated as an administrative expense.

3 **“SEC. 1914. USE OF GRANTS.**

4 “(a) IN GENERAL.—A State shall use funds for long-  
5 term care services and supports as defined in section  
6 1916.

7 “(b) SELF-DIRECTION.—A State shall offer individ-  
8 uals the opportunity to self-direct their long-term care  
9 services and supports.

10 **“SEC. 1915. ADMINISTRATIVE PROVISIONS.**

11 “(a) FUNDING ON A QUARTERLY BASIS.—The Sec-  
12 retary shall make payments to States in equal amounts  
13 of a State’s annual allotment on a quarterly basis. Each  
14 quarterly payment shall remain available for use by the  
15 State for twelve succeeding fiscal year quarters.

16 “(b) PUBLICATION.—The Secretary shall publish  
17 each State’s allotment—

18 “(1) for fiscal year 2011 not later than Decem-  
19 ber 15, 2009; and

20 “(2) for each subsequent fiscal year, not later  
21 than December 15 of the calendar year preceding  
22 the calendar year in which the fiscal year begins.

23 **“SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES  
24 AND SUPPORTS.**

25 “(a) DEFINITION.—

1           “(1) IN GENERAL.—Subject to subsection (e),  
2           in this part, the term ‘long-term care services and  
3           supports’ means any of the services or supports  
4           specified in paragraphs (2) or (3) that may be pro-  
5           vided in a nursing facility, an institution, a home, or  
6           other setting.

7           “(2) SERVICES AND SUPPORTS DESCRIBED.—  
8           For purposes of paragraph (1), the services and sup-  
9           ports described in this paragraph include assistive  
10          technology, adaptive equipment, remote monitoring  
11          equipment, case management for the aged, case  
12          management for individuals with disabilities, nursing  
13          home services, long-term rehabilitative services nec-  
14          essary to restore functional abilities, services pro-  
15          vided in intermediate care facilities for people with  
16          disabilities, habilitation services (including adult day  
17          care programs), community treatment teams for in-  
18          dividuals with mental illness, home health services,  
19          services provided in an institution for mental dis-  
20          ease, a Program of All-Inclusive Care for the Elderly  
21          (PACE), personal care (including personal assist-  
22          ance services), recovery support including peer coun-  
23          seling, supportive employment, training skills nec-  
24          essary to assist the individual in achieving or main-  
25          taining independence, training of family members in-

1 including foster parents in supportive and behavioral  
2 modification skills, ongoing and periodic training to  
3 maintain life skills, transitional care including room  
4 and board not to exceed 60 days within a 12-month  
5 period.

6 “(3) INCLUSION OF CERTAIN BENEFITS UNDER  
7 OLD TITLE XIX.—Such services and supports may  
8 include any of the following services:

9 “(A) Old section 1905(a)(15) (relating to  
10 services in an intermediate care facility for the  
11 mentally retarded).

12 “(B) Services described in subsections  
13 (a)(16) and (h) of old section 1905, but without  
14 regard to any restriction on such services on  
15 the basis of age (relating to inpatient psy-  
16 chiatric hospital services).

17 “(C) Old section 1905(a)(22) (relating to  
18 home and community care (to the extent al-  
19 lowed and as defined in old section 1929) for  
20 functionally disabled elderly individuals).

21 “(D) Old section 1905(a)(23) (relating to  
22 community supported living arrangements serv-  
23 ices (to the extent allowed and as defined in old  
24 section 1930)).

1           “(E) Subject to subsection (e), old section  
2           1905(a)(24) but without regard to any restric-  
3           tion on furnishing services to patients or resi-  
4           dents of facilities or institutions (relating to  
5           personal care services).

6           “(F) Old sections 1905(a)(26) and 1934  
7           (relating to services furnished under a PACE  
8           program under old section 1934 to PACE pro-  
9           gram eligible individuals enrolled under the pro-  
10          gram under such old section).

11          “(G) Old section 1915(c)(5) (relating to  
12          the definition of habilitation services).

13          “(4) LIMITATION.—Long-term care services  
14          and supports cannot be used for services and admin-  
15          istrative costs provided through the foster care (with  
16          the exception of training of foster care parents),  
17          child welfare, adult protective services, juvenile jus-  
18          tice, public guardianship, or correctional systems.

19          “(b) REHABILITATIVE CARE.—For purposes of reha-  
20          bilitation due to acute care medical needs, a State may  
21          claim rehabilitative services provided in an institutional  
22          setting, nursing home, or as part of home health expendi-  
23          tures as acute care benefits under the State plan under  
24          part A rather than under the State plan under this part  
25          for a cumulative period of 30 days within a 12-month pe-



1 riod if such care is directly related to the onset of an acute  
2 care need. A State shall demonstrate the services were  
3 provided as a direct result of an acute care need.

4 “(c) MANAGED CARE.—If a State provides long-term  
5 care services and supports through managed care, the  
6 State shall submit a methodology for determining the level  
7 of expenditures attributed to long term care for approval  
8 by the Secretary.

9 “(d) APPLICATION OF PART A DEFINITIONS.—A def-  
10 inition specified in section 1905 shall apply to the same  
11 term used in this part, unless the Secretary determines  
12 that the application of such definition would be incon-  
13 sistent with the purpose of this part.

14 “(e) EXCLUSION.—No payments shall be made under  
15 the State plan under this part with respect to long-term  
16 care supports and services provided for any individual who  
17 is an inmate of a public institution. Nothing in the pre-  
18 ceding sentence shall be construed as precluding the provi-  
19 sion of long-term care services and supports under the  
20 State plan under this part to an individual who is a pa-  
21 tient in an institution for mental diseases.

1 **“SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM**  
2 **CARE SERVICES AND SUPPORT, INCLUDING**  
3 **OPTION FOR SELF-DIRECTED SERVICES AND**  
4 **SUPPORTS.**

5 “(a) REQUIREMENTS FOR THE PROVISION OF LONG-  
6 TERM CARE SERVICES AND SUPPORTS.—

7 “(1) IN GENERAL.—Subject to the succeeding  
8 provisions of this subsection, a State may provide  
9 through a State plan amendment for the provision  
10 of long-term care services and supports for individ-  
11 uals eligible under the State plan under this part,  
12 subject to the following requirements:

13 “(A) NEEDS-BASED CRITERIA FOR ELIGI-  
14 BILITY FOR, AND RECEIPT OF, LONG-TERM  
15 CARE SERVICES AND SUPPORTS.—The State es-  
16 tablishes needs-based criteria for determining  
17 an individual’s eligibility under the State plan  
18 for medical assistance for such long-term care  
19 services and supports, and if the individual is  
20 eligible for such services and supports, the spe-  
21 cific services and supports that will be available  
22 under the State plan to the individual.

23 “(B) CRITERIA FOR INSTITUTIONALIZED  
24 VERSUS NON-INSTITUTIONALIZED SERVICES.—  
25 In establishing needs-based criteria, the State  
26 may establish criteria for determining eligibility

1 for, and receipt of, services and supports pro-  
2 vided in a facility or institution that are more  
3 stringent that the criteria established for eligi-  
4 bility and receipt of services and supports in a  
5 non-facility or non-institutionalized setting.

6 “(C) AUTHORITY TO LIMIT NUMBER OF  
7 ELIGIBLE INDIVIDUALS.—A State may limit the  
8 number of individuals who are eligible for such  
9 services and supports and may establish waiting  
10 lists for the receipt of such services and sup-  
11 ports.

12 “(D) CRITERIA BASED ON INDIVIDUAL AS-  
13 SESSMENT.—

14 “(i) IN GENERAL.—The criteria estab-  
15 lished by the State shall require an assess-  
16 ment of an individual’s support needs and  
17 capabilities, and may take into account the  
18 inability of the individual to perform 2 or  
19 more activities of daily living (as defined in  
20 section 7702B(c)(2)(B) of the Internal  
21 Revenue Code of 1986) or the need for sig-  
22 nificant assistance to perform such activi-  
23 ties, and such other risk factors as the  
24 State determines to be appropriate.

1           “(ii) ADJUSTMENT AUTHORITY.—The  
2 State plan amendment provides the State  
3 with the option to modify the criteria es-  
4 tablished under subparagraph (A) (without  
5 having to obtain prior approval from the  
6 Secretary) in the event that the enrollment  
7 of individuals eligible for services exceeds  
8 the projected enrollment, but only if—

9           “(I) the State provides at least  
10 60 days notice to the Secretary and  
11 the public of the proposed modifica-  
12 tion;

13           “(II) the State deems an indi-  
14 vidual receiving long-term care serv-  
15 ices and supports on the basis of the  
16 most recent version of the criteria in  
17 effect prior to the effective date of the  
18 modification to be eligible for such  
19 services and supports for a period of  
20 at least 12 months beginning on the  
21 date the individual first received med-  
22 ical assistance for such services and  
23 supports; and

24           “(III) after the effective date of  
25 such modification, the State, at a

1 minimum, applies the criteria for de-  
2 termining whether an individual re-  
3 quires the level of care provided in a  
4 facility or institutionalized setting  
5 which applied under the State plan  
6 immediately prior to the application of  
7 the modified criteria.

8 “(E) INDEPENDENT EVALUATION AND AS-  
9 SESSMENT.—

10 “(i) ELIGIBILITY DETERMINATION.—  
11 The State uses an independent evaluation  
12 for making the determinations described in  
13 subparagraph (A).

14 “(ii) ASSESSMENT.—In the case of an  
15 individual who is determined to be eligible  
16 for long-term care services and supports,  
17 the State uses an independent assessment,  
18 based on the needs of the individual to—

19 “(I) determine a necessary level  
20 of services and supports to be pro-  
21 vided, consistent with an individual’s  
22 physical and mental capacity;

23 “(II) prevent the provision of un-  
24 necessary or inappropriate care; and

1                   “(III) establish an individualized  
2                   care plan for the individual in accord-  
3                   ance with subparagraph (G).

4                   “(F) ASSESSMENT.—The independent as-  
5                   sessment required under subparagraph (E)(ii)  
6                   shall include the following:

7                   “(i) An objective evaluation of an in-  
8                   dividual’s inability to perform 2 or more  
9                   activities of daily living (as defined in sec-  
10                  tion 7702B(c)(2)(B) of the Internal Rev-  
11                  enue Code of 1986) or the need for signifi-  
12                  cant assistance to perform such activities.

13                  “(ii) A face-to-face evaluation of the  
14                  individual by an individual trained in the  
15                  assessment and evaluation of individuals  
16                  whose physical or mental conditions trigger  
17                  a potential need for long-term care services  
18                  and supports.

19                  “(iii) Where appropriate, consultation  
20                  with the individual’s family, spouse, guard-  
21                  ian, or other responsible individual.

22                  “(iv) Consultation with appropriate  
23                  treating and consulting health and support  
24                  professionals caring for the individual.

1           “(v) An examination of the individ-  
2           ual’s relevant history, medical records, and  
3           care and support needs, guided by best  
4           practices and research on effective strate-  
5           gies that result in improved health and  
6           quality of life outcomes.

7           “(vi) An evaluation of the ability of  
8           the individual or the individual’s represent-  
9           ative to self-direct the purchase of, or con-  
10          trol the receipt of, such services and sup-  
11          ports if the individual so elects.

12          “(G) INDIVIDUALIZED CARE PLAN.—

13           “(i) IN GENERAL.—In the case of an  
14           individual who is determined to be eligible  
15           for long-term care services and supports,  
16           the State uses the independent assessment  
17           required under subparagraph (E)(ii) to es-  
18           tablish a written individualized care plan  
19           for the individual.

20           “(ii) PLAN REQUIREMENTS.—The  
21           State ensures that the individualized care  
22           plan for an individual—

23                   “(I) is developed—

24                           “(aa) in consultation with  
25                           the individual, the individual’s

1 treating physician, health care or  
2 support professional, or other ap-  
3 propriate individuals, as defined  
4 by the State, and, where appro-  
5 priate the individual’s family,  
6 caregiver, or representative; and

7 “(bb) taking into account  
8 the extent of, and need for, any  
9 family or other supports for the  
10 individual;

11 “(II) identifies the long-term care  
12 services and supports to be furnished  
13 to the individual (or, if the individual  
14 elects to self-direct the purchase of, or  
15 control the receipt of, such services  
16 and supports, funded for the indi-  
17 vidual); and

18 “(III) is reviewed at least annu-  
19 ally and as needed when there is a  
20 significant change in the individual’s  
21 circumstances.

22 “(iii) STATE REQUIREMENT TO OFFER  
23 ELECTION FOR SELF-DIRECTED SERVICES  
24 AND SUPPORTS.—



1                   “(I) INDIVIDUAL CHOICE.—The  
2                   State shall allow an individual or the  
3                   individual’s representative the oppor-  
4                   tunity to elect to receive self-directed  
5                   long-term care services and supports  
6                   in a manner which gives them the  
7                   most control over such services and  
8                   supports consistent with the individ-  
9                   ual’s abilities and the requirements of  
10                  subclauses (II) and (III).

11                  “(II) SELF-DIRECTED.—The  
12                  term ‘self-directed’ means, with re-  
13                  spect to the long-term care services  
14                  and supports offered under the State  
15                  plan amendment, such services and  
16                  supports for the individual which are  
17                  planned and purchased under the di-  
18                  rection and control of such individual  
19                  or the individual’s authorized rep-  
20                  resentative, including the amount, du-  
21                  ration, scope, provider, and location of  
22                  such services and supports, under the  
23                  State plan consistent with the fol-  
24                  lowing requirements:

1                   “(aa) ASSESSMENT.—There  
2 is an assessment of the needs, ca-  
3 pabilities, and preferences of the  
4 individual with respect to such  
5 services and supports.

6                   “(bb) SERVICE PLAN.—  
7 Based on such assessment, there  
8 is developed jointly with such in-  
9 dividual or the individual’s au-  
10 thorized representative a plan for  
11 such services and supports for  
12 such individual that is approved  
13 by the State and that satisfies  
14 the requirements of subclause  
15 (III).

16                   “(III) PLAN REQUIREMENTS.—  
17 For purposes of subclause (II)(bb),  
18 the requirements of this subclause are  
19 that the plan—

20                   “(aa) specifies those services  
21 and supports which the individual  
22 or the individual’s authorized  
23 representative would be respon-  
24 sible for directing;

1           “(bb) identifies the methods  
2 by which the individual or the in-  
3 dividual’s authorized representa-  
4 tive will select, manage, and dis-  
5 miss providers of such services  
6 and supports;

7           “(cc) specifies the role of  
8 family members and others whose  
9 participation is sought by the in-  
10 dividual or the individual’s au-  
11 thorized representative with re-  
12 spect to such services and sup-  
13 ports;

14           “(dd) is developed through a  
15 person-centered process that is  
16 directed by the individual or the  
17 individual’s authorized represent-  
18 ative, builds upon the individual’s  
19 capacity to engage in activities  
20 that promote community life and  
21 that respects the individual’s  
22 preferences, choices, and abilities,  
23 and involves families, friends,  
24 and professionals as desired or  
25 required by the individual or the

1 individual's authorized represent-  
2 ative;

3 “(ee) includes appropriate  
4 risk management techniques that  
5 recognize the roles and sharing of  
6 responsibilities in obtaining serv-  
7 ices and supports in a self-di-  
8 rected manner and assure the ap-  
9 propriateness of such plan based  
10 upon the resources and capabili-  
11 ties of the individual or the indi-  
12 vidual's authorized representa-  
13 tive; and

14 “(ff) may include an individ-  
15 ualized budget which identifies  
16 the dollar value of the services  
17 and supports under the control  
18 and direction of the individual or  
19 the individual's authorized rep-  
20 resentative.

21 “(IV) BUDGET PROCESS.—With  
22 respect to individualized budgets de-  
23 scribed in subclause (III)(ff), the  
24 State plan amendment—

1                   “(aa) describes the method  
2                   for calculating the dollar values  
3                   in such budgets based on reliable  
4                   costs and service utilization;

5                   “(bb) defines a process for  
6                   making adjustments in such dol-  
7                   lar values to reflect changes in  
8                   individual assessments and serv-  
9                   ice plans; and

10                   “(cc) provides a procedure  
11                   to evaluate expenditures under  
12                   such budgets.

13                   “(H) QUALITY ASSURANCE; CONFLICT OF  
14                   INTEREST STANDARDS.—

15                   “(i) QUALITY ASSURANCE.—The  
16                   State ensures that the provision of long-  
17                   term care services and supports meets  
18                   Federal and State guidelines for quality  
19                   assurance.

20                   “(ii) CONFLICT OF INTEREST STAND-  
21                   ARDS.—The State establishes standards  
22                   for the conduct of the independent evalua-  
23                   tion and the independent assessment to  
24                   safeguard against conflicts of interest.

1           “(I) REDETERMINATIONS AND APPEALS.—  
2           The State allows for at least annual redeter-  
3           minations of eligibility, and appeals in accord-  
4           ance with the frequency of, and manner in  
5           which, redeterminations and appeals of eligi-  
6           bility are made under the State plan.

7           “(J) PRESUMPTIVE ELIGIBILITY FOR AS-  
8           SESSMENT.—The State, at its option, elects to  
9           provide for a period of presumptive eligibility  
10          (not to exceed a period of 60 days) only for  
11          those individuals that the State has reason to  
12          believe may be eligible for long-term care serv-  
13          ices and supports. Such presumptive eligibility  
14          shall be limited to medical assistance for car-  
15          rying out the independent evaluation and as-  
16          sessment under subparagraph (E) to determine  
17          an individual’s eligibility for such services and  
18          if the individual is so eligible, the specific long-  
19          term care services and supports that the indi-  
20          vidual will receive.

21          “(2) DEFINITION OF INDIVIDUAL’S REP-  
22          RESENTATIVE.—In this section, the term ‘individ-  
23          ual’s representative’ means, with respect to an indi-  
24          vidual, a parent, a family member, or a guardian of  
25          the individual, an advocate for the individual, or any

1 other individual who is authorized to represent the  
2 individual.

3 “(b) SELF-DIRECTED PERSONAL ASSISTANCE SERV-  
4 ICES.—If a State includes personal care or personal assist-  
5 ance services in the long-term care services and supports  
6 available under the State plan, the State shall comply with  
7 the requirements of old section 1915(j) in the case of an  
8 individual who elects to self-direct the receipt of such care  
9 or services.

10 **“SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR**  
11 **CERTAIN INSTITUTIONALIZED SPOUSES.**

12 “Old section 1924 (relating to treatment of income  
13 and resources for certain institutionalized spouses), other  
14 than paragraphs (2) and (4)(A) of subsection (a) of such  
15 section, shall apply under this part.

16 **“SEC. 1919. ANNUAL REPORTS.**

17 “(a) IN GENERAL.—Each State that receives pay-  
18 ments under this part shall submit an annual report to  
19 the Secretary, in such form and manner as the Secretary  
20 shall specify.

21 “(b) REQUIREMENTS.—The report shall include the  
22 following with respect to the most recent fiscal year ended:

23 “(1) The number of individuals served under  
24 the plan.

1           “(2) The number of individuals served by tier  
2           (preventive, emergency, low, medium, and high  
3           needs).

4           “(3) The number of individuals known to the  
5           State on waiting list for services (if any) and type  
6           of disability (physical, developmental, mental health)  
7           or aged.

8           “(4) Expenditures by service category.

9           **“PART C—GRANTS TO STATES FOR SURVEY AND**  
10           **CERTIFICATION OF MEDICAL FACILITIES**  
11           **AND OTHER REQUIREMENTS**

12           **“SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.**

13           “For the purpose of carrying our Federal activities  
14           and providing grants to States for expenses necessary to  
15           carry out this part, there is authorized to be appro-  
16           priated—

17           “(1) for fiscal year 2011, \$300,000,000; and

18           “(2) for each succeeding fiscal year, the amount  
19           authorized under this section for the preceding fiscal  
20           year, increased by 5 percent.

21           **“SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS**  
22           **UNDER PRE-MODERNIZED MEDICAID.**

23           “The following old provisions shall apply under this  
24           part:



1           “(1) Old section 1902(a)(9) (relating to health  
2 standards and applicable requirements for laboratory  
3 services).

4           “(2) Old section 1902(a)(28) (relating to nurs-  
5 ing facilities and nursing facility services).

6           “(3) Old sections 1902(a)(29) and 1908 (relat-  
7 ing to a State program for the licensing of adminis-  
8 trators of nursing homes).

9           “(4) Old section 1902(a)(33)(B) (relating to li-  
10 censing health institutions).

11           “(5) Old section 1902(d) (relating to medical or  
12 utilization review functions).

13           “(6) Old section 1902(i) (relating to inter-  
14 mediate care facilities for the mentally retarded).

15           “(7) Old section 1902(y) (relating to psy-  
16 chiatric hospitals).

17           “(8) Paragraphs (2) and (6) of old section  
18 1903(g) (relating to the Secretarial requirement to  
19 conduct sample onsite surveys of private and public  
20 institutions and recertifications for the need for cer-  
21 tain services).

22           “(9) Old section 1903(q)(4)(B) (relating to the  
23 definition of a board and care facility).

1           “(10) Old section 1910 (relating to certification  
2           and approval of rural health clinics and intermediate  
3           care facilities for the mentally retarded).

4           “(11) Old section 1911 (relating to Indian  
5           Health Service facilities).

6           “(12) Old section 1913 (relating to hospital  
7           providers of nursing facility services).

8           “(13) Old section 1919 (relating to require-  
9           ments for nursing facilities).

10       **“PART D—GRANTS TO STATES FOR PROGRAM**

11                               **INTEGRITY**

12       **“SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.**

13           “(a) IN GENERAL.—For the purpose of carrying out  
14           Federal activities under this part and providing grants to  
15           States for expenses necessary to carry out this part, there  
16           is authorized to be appropriated—

17                       “(1) for fiscal year 2011, \$100,000,000; and

18                       “(2) for each succeeding fiscal year, the amount  
19           authorized under this section for the preceding fiscal  
20           year, increased by 5 percent.

21           “(b) AVAILABILITY; AUTHORITY FOR USE OF  
22           FUNDS.—

23                       “(1) AVAILABILITY.—Amounts appropriated  
24           pursuant to subsection (a) shall remain available  
25           until expended.

1           “(2) AUTHORITY FOR USE OF FUNDS FOR  
2           TRANSPORTATION AND TRAVEL EXPENSES FOR  
3           ATTENDEES AT EDUCATION, TRAINING, OR CON-  
4           SULTATIVE ACTIVITIES.—

5           “(A) IN GENERAL.—The Secretary may  
6           use amounts appropriated pursuant to sub-  
7           section (a) to pay for transportation and the  
8           travel expenses, including per diem in lieu of  
9           subsistence, at rates authorized for employees  
10          of agencies under subchapter I of chapter 57 of  
11          title 5, United States Code, while away from  
12          their homes or regular places of business, of in-  
13          dividuals described in subsection (b)(4) who at-  
14          tend education, training, or consultative activi-  
15          ties conducted under the authority of that sub-  
16          section.

17          “(B) PUBLIC DISCLOSURE.—The Secretary  
18          shall make available on a website of the Centers  
19          for Medicare & Medicaid Services that is acces-  
20          sible to the public—

21                  “(i) the total amount of funds ex-  
22                  pended for each conference conducted  
23                  under the authority of subsection (b)(4);  
24                  and

1                   “(ii) the amount of funds expended  
2                   for each such conference that were for  
3                   transportation and for travel expenses.

4           “(c) ANNUAL REPORT.—Not later than 180 days  
5 after the end of each fiscal year, the Secretary shall sub-  
6 mit a report to Congress which identifies—

7                   “(1) the use of funds appropriated pursuant to  
8                   subsection (a); and

9                   “(2) the effectiveness of the use of such funds.

10 **“SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS**  
11 **UNDER PRE-MODERNIZED MEDICAID.**

12           “The following old provisions shall apply under this  
13 part:

14                   “(1) Old subsections (a)(25) (other than sub-  
15                   paragraph (E)) and (g) of section 1902 and section  
16                   1903(o) (relating to third party liability).

17                   “(2) Old section 1902(a)(30)(B) (relating to  
18                   hospital, intermediate care facility for the mentally  
19                   retarded, or hospital for mental diseases admission  
20                   screening and review requirements).

21                   “(3) Old section 1902(a)(32) (relating to cer-  
22                   tain payment requirements).

23                   “(4) Old section 1902(a)(35) (relating to dis-  
24                   closing entities under section 1124).

1           “(5) Old section 1902(a)(37) and the fifth sen-  
2           tence (relating to claims payment procedures).

3           “(6) Old section 1902(a)(44) (relating to pay-  
4           ment for inpatient hospital services, services in an  
5           intermediate care facility for the mentally retarded,  
6           or inpatient mental hospital services).

7           “(7) Old sections 1902(a)(45) and 1912 (relat-  
8           ing to assignment of rights of payment).

9           “(8) Old sections 1902(a)(49) and 1921 (relat-  
10          ing to information and access to information con-  
11          cerning sanctions taken by State licensing authori-  
12          ties against health care practitioners and providers).

13          “(9) Old sections 1902(a)(61) and 1903(q) (re-  
14          lating to requirements for a medicaid fraud and  
15          abuse control unit).

16          “(10) Old section 1902(a)(64) (relating to re-  
17          ports from beneficiaries and others and data com-  
18          pilation requirements concerning alleged instances of  
19          waste, fraud, and abuse).

20          “(11) Old section 1902(a)(65) (relating to pro-  
21          vider number and surety bond requirement for sup-  
22          pliers of durable medical equipment).

23          “(12) Old section 1902(a)(68) (relating to re-  
24          quirements for certain entities).

1           “(13) Old sections 1902(a)(69) and 1936 (re-  
2 relating to the Medicaid Integrity Program) other  
3 than paragraphs (1), (2)(A), and (3) of old section  
4 1936(e).

5           “(14) Old section 1902(a)(70)(B)(iv) (relating  
6 to prohibitions on referrals and conflict of interest  
7 for certain brokers of non-emergency medical trans-  
8 portation).

9           “(15) Old sections 1902(a)(71) and 1940 (re-  
10 relating to a required asset verification program).

11           “(16) Old section 1902(p) (relating to exclusion  
12 of certain individuals or entities).

13           “(17) Old section 1902(x) (relating to unique  
14 identifiers for physicians).

15           “(18) Old section 1903(p) (relating to inter-  
16 state collection of rights of support).

17           “(19) Old section 1903(r)(2) (relating to re-  
18 quirements for mechanized claims processing and in-  
19 formation retrieval systems).

20           “(20) Old section 1903(u) (relating to erro-  
21 neous excess payments), other than clause (v) of  
22 paragraph (1)(D).

23           “(21) Old section 1903(v) and the seventh sen-  
24 tence of old section 1902(a) (relating to limitations

1 on payments for services furnished to aliens), other  
2 than subparagraphs (A) and (B) of paragraph (4).

3 “(22) Old section 1903(x) (relating to citizen-  
4 ship documentation).

5 “(23) Old section 1909 (relating to State false  
6 claims act requirements for increased State share of  
7 recoveries).

8 “(24) Old section 1914 (relating to withholding  
9 of Federal share of payments for certain Medicare  
10 providers).

11 “(25) Old section 1917 (relating to liens, ad-  
12 justments and recoveries, and transfers of assets).

13 “(26) Old section 1922 (relating to correction  
14 and reduction plans for intermediate care facilities  
15 for the mentally retarded).

16 **“PART E—GRANTS TO STATES FOR**  
17 **ADMINISTRATION**

18 **“SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAY-**  
19 **MENTS TO STATES.**

20 “(a) IN GENERAL.—For the purpose of providing  
21 grants to States for administrative expenses necessary to  
22 carry out parts A and B, there is authorized to be appro-  
23 priated—

24 “(1) for fiscal year 2011, \$7,000,000,000; and

1           “(2) for each succeeding fiscal year, the amount  
2 authorized under this subsection for the preceding  
3 fiscal year, increased by 3 percent.

4           “(b) PAYMENTS TO STATES.—

5           “(1) IN GENERAL.—From the amount appro-  
6 priated pursuant to subsection (a) for a fiscal year,  
7 the Secretary shall pay each State with approved  
8 plans under parts A and B for the fiscal year an  
9 amount equal to the product of the amount appro-  
10 priated for the fiscal year and the ratio of the total  
11 amount of payments made to the State under para-  
12 graphs (2) through (7) of section 1903(a) for fiscal  
13 year 2008 (as such section was in effect for that fis-  
14 cal year) to the total amount of such payments made  
15 to all States for such fiscal year.

16           “(2) PRO RATA ADJUSTMENT.—The Secretary  
17 shall make pro rata adjustments to the amounts de-  
18 termined under paragraph (1) for a fiscal year as  
19 necessary so as to not exceed the amount appro-  
20 priated pursuant to subsection (a) for the fiscal  
21 year.

22 **“SEC. 1952. COST-SHARING PROTECTIONS.**

23           “(a) IN GENERAL.—A State may impose cost-sharing  
24 for individuals provided acute care medical assistance  
25 under a State plan under part A or long-term care services



1 and supports under a State plan under part B consistent  
2 with the following:

3 “(1) The State may (in a uniform manner) re-  
4 quire payment of monthly premiums or other cost-  
5 sharing set on a sliding scale based on family in-  
6 come.

7 “(2) A premium or other cost-sharing require-  
8 ment imposed under paragraph (1) may only apply  
9 to the extent that, in the case of an individual whose  
10 family income—

11 “(A) exceeds 150 percent of the poverty  
12 line, the aggregate annual amount of such pre-  
13 mium and other cost-sharing charges imposed  
14 under the plan does not exceed 5 percent of the  
15 individual’s annual income; and

16 “(B) exceeds 250 percent of the poverty  
17 line, the aggregate annual amount of such pre-  
18 mium and other cost-sharing charges do not ex-  
19 ceed 7.5 percent of the individual’s annual in-  
20 come.

21 “(3) A State shall not require prepayment of  
22 any premium or cost-sharing imposed pursuant to  
23 paragraph (1) and shall not terminate eligibility of  
24 an individual under the State plan on the basis of  
25 failure to pay any such premium or cost-sharing

1       until such failure continues for a period of at least  
2       60 days from the date on which the premium or  
3       cost-sharing became past due. The State may waive  
4       payment of any such premium or cost-sharing in any  
5       case where the State determines that requiring such  
6       payment would create an undue hardship.

7       “(b) APPLICATION TO INSTITUTIONALIZED INDIVID-  
8       UALS.—A State may impose cost-sharing consistent with  
9       subsection (a) to individuals who are patients in, or resi-  
10      dents of, a medical institution or nursing facility except  
11      that rules relating to the post-eligibility treatment of in-  
12      come (including a minimum monthly personal needs allow-  
13      ance) applicable to institutionalized individuals under old  
14      title XIX shall apply in the same manner to individuals  
15      eligible for long-term care services and supports under a  
16      State plan under part B.

17      “(c) POVERTY LINE DEFINED.—In this section, the  
18      term ‘poverty line’ has the meaning given such term in  
19      section 673(2) of the Community Services Block Grant  
20      Act (42 U.S.C. 9902(2)), including any revision required  
21      by such section.

22      **“SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS**  
23   **UNDER PRE-MODERNIZED MEDICAID.**

24      “The following old provisions shall apply to the State  
25      plans under this title:

1 “(1) OLD STATE PLAN REQUIREMENTS.—

2 “(A) Old section 1902(a)(1) (relating to  
3 the requirement for plans to be in effect in all  
4 political subdivisions of the State).

5 “(B) Old section 1902(a)(2) (relating to  
6 State financial participation).

7 “(C) Old section 1902(a)(3) (relating to  
8 opportunity for a fair hearing).

9 “(D) Old section 1902(a)(4) (relating to  
10 administration).

11 “(E) Old section 1902(a)(5) (relating to  
12 designation of a single State agency).

13 “(F) Old section 1902(a)(6) (relating to  
14 reporting requirements).

15 “(G) Old section 1902(a)(7) (relating to  
16 restrictions on the use or disclosure of informa-  
17 tion).

18 “(H) Old section 1902(a)(8) (relating to  
19 applications for assistance).

20 “(I) Old section 1902(a)(11) (relating to  
21 cooperative agreements with other State agen-  
22 cies).

23 “(J) Old section 1902(a)(12) (relating to  
24 determinations of blindness).

1           “(K) Old section 1902(a)(13) (relating to  
2           determination of rates of payment for certain  
3           services), other than clause (iv) of subpara-  
4           graph (A).

5           “(L) Subsections (a)(15) and (bb) of old  
6           section 1902(a) (relating to payment for serv-  
7           ices provided by rural health clinics and feder-  
8           ally qualified health centers).

9           “(M) Old section 1902(a)(16) (relating to  
10          furnishing services to individuals when absent  
11          from the State).

12          “(N) Old section 1902(a)(22) (relating to  
13          certain administrative provisions).

14          “(O) Paragraphs (23) and (25)(D) of old  
15          section 1902(a) (relating to any willing provider  
16          requirements).

17          “(P) Old section 1902(a)(24) (relating to  
18          consultative services by other agencies).

19          “(Q) Old section 1902(a)(26) (relating to  
20          review of need for inpatient mental hospital  
21          services and written plan of care requirements).

22          “(R) Old section 1902(a)(27) (relating to  
23          provider record keeping requirements).

24          “(S) Old section 1902(a)(30)(A) (relating  
25          to utilization review).

1           “(T) Old section 1902(a)(31) (relating to  
2 written plan of care for services and review for  
3 intermediate care facility for the mentally re-  
4 tarded services).

5           “(U) Old section 1902(a)(33)(A) (relating  
6 to quality review requirements).

7           “(V) Old section 1902(a)(36) (relating to  
8 public availability of facility surveys).

9           “(W) Old section 1902(a)(38) (relating to  
10 the provision of information described in section  
11 1128(b)(9) by certain entities).

12           “(X) Old section 1902(a)(39) (relating to  
13 the exclusion of certain entities).

14           “(Y) Old section 1902(a)(40) (relating to  
15 requirement for uniform reporting systems).

16           “(Z) Old section 1902(a)(41) (relating to  
17 notice to State medical licensing boards).

18           “(AA) Old section 1902(a)(42) (relating to  
19 certain audit requirements).

20           “(BB) Old section 1902(a)(48) (relating to  
21 eligibility cards).

22           “(CC) Old section 1902(a)(55) (relating to  
23 the receipt and initial processing of applica-  
24 tions, but only to the extent such section is con-

1           sistent with the policy embodied in the State  
2           plans under parts A and B).

3           “(DD) Subsections (a)(56) and (s) of old  
4           section 1902 (relating to adjusted payments for  
5           certain inpatient hospital services).

6           “(EE) Old section 1902(a)(59) (relating to  
7           maintenance of list of participating physicians).

8           “(FF) The second sentence of old section  
9           1902 (relating to designation of certain State  
10          agencies).

11          “(GG) Old section 1902(b) (relating to  
12          limitations on approval of plans).

13          “(HH) Old section 1902(j) (relating to ap-  
14          plication of requirements to American Samoa  
15          and the Northern Mariana Islands).

16          “(2) OTHER OLD TITLE XIX REQUIREMENTS.—

17               “(A) Old section 1903(b)(4) (relating to  
18               limitations on payments to enrollment brokers).

19               “(B) Old section 1903(e) (relating to fur-  
20               nishing of services included in a program or  
21               plan under part B or C of the Individuals with  
22               Disabilities Education Act).

23               “(C) Old section 1903(d) (relating to pay-  
24               ments).

1           “(D) Old section 1903(e) (relating to costs  
2 with respect to certain hospital services).

3           “(E) Old section 1903(i) (relating to limi-  
4 tations on payments).

5           “(F) Old section 1903(r) (relating to re-  
6 quirements for mechanized claims processing  
7 and information retrieval systems).

8           “(G) Subsections (b)(5) and (w) of old sec-  
9 tion 1903 (relating to limitations on payments  
10 related to provider taxes).

11           “(H) Old section 1904 (relating to oper-  
12 ation of State plans).

13           “(I) Old sections 1902(a)(60) and 1908A  
14 (relating to medical child support).

15           “(J) Paragraphs (32)(D) and (62) of old  
16 section 1902(a) and section 1928 (relating to  
17 program for distribution of pediatric vaccines).

18           **“PART F—OTHER PROVISIONS**

19           **“SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS**  
20           **UNDER PRE-MODERNIZED MEDICAID.**

21           “The following old provisions shall apply under this  
22 part:

23           “(1) The third sentence of old section 1902 (re-  
24 lating to nonapplication of certain old provisions to  
25 a religious nonmedical health care institution).

1           “(2) Old section 1918 (relating to application of  
2 provisions of title II relating to subpoenas).

3           “(3) Old section 1939 (relating to references to  
4 laws directly affecting the Medicaid program.”.

5           (b) REPEAL OF TITLE XXI.—Effective January 1,  
6 2011, title XXI of the Social Security Act (42 U.S.C.  
7 1397aa et seq.) is repealed.

8 **SEC. 402. OUTREACH.**

9           (a) AUTHORIZATION OF APPROPRIATIONS.—The fol-  
10 lowing amounts are authorized to be appropriated to the  
11 Secretary of Health and Human Services:

12           (1) For fiscal year 2009, \$100,000,000 for the  
13 design and implementation of a public outreach cam-  
14 paign to inform the public about the changes to the  
15 programs under such titles that take effect on Janu-  
16 ary 1, 2011, as a result of the amendment made by  
17 section 401.

18           (2) For each of fiscal years 2010 and 2011,  
19 \$200,000,000 to carry out such public outreach  
20 campaign.

21           (3) For fiscal year 2012, \$50,000,000 to carry  
22 out such public outreach campaign.

23           (b) AVAILABILITY.—Funds appropriated under sub-  
24 section (a) shall remain available for expenditure through  
25 September 30, 2012.



1 (c) AUTHORITY FOR USE OF FUNDS.—The Secretary  
2 may use funds made available under paragraphs (2) and  
3 (3) of subsection (a) to award grants to, or enter into con-  
4 tracts with, public or private entities, including States,  
5 local governments, schools, churches, and community  
6 groups.

7 **SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVI-**  
8 **SIONS.**

9 (a) IN GENERAL.—

10 (1) Not later than June 30, 2010, a State that  
11 is one of the 50 States or the District of Columbia  
12 shall inform all individuals enrolled in a State plan  
13 under title XIX or XXI of the Social Security Act  
14 on such date (and any new enrollees after such date)  
15 of the changes to the programs under such titles  
16 that take effect on January 1, 2011, as a result of  
17 the amendment made by section 401.

18 (2) No State that is one of the 50 States or the  
19 District of Columbia shall approve any applications  
20 for medical assistance or child health assistance  
21 under a State plan under title XIX or XXI (as in  
22 effect for fiscal year 2010) after December 31,  
23 2010.

24 (b) SUBMISSION OF LEGISLATIVE PROPOSAL FOR  
25 TECHNICAL AND CONFORMING AMENDMENTS.—Not later

1 than 6 months after the date of enactment of this Act,  
2 the Secretary of Health and Human Services shall submit  
3 to Congress a legislative proposal for such technical and  
4 conforming amendments as are necessary to carry out the  
5 amendments made by this Act.

6 **Subtitle B—Supplemental Health**  
7 **Care Assistance for Low-Income**  
8 **Families**

9 **SEC. 411. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR**  
10 **LOW-INCOME FAMILIES.**

11 Part D of title III of the Public Health Service Act  
12 (42 U.S.C. 254b et seq.) is amended by adding at the end  
13 the following:

14 **“Subpart XI—Health Care Assistance to Low-Income**  
15 **Families**

16 **“SEC. 340A-1. FINANCIAL ASSISTANCE TO LOW-INCOME**  
17 **FAMILIES.**

18 “(a) IN GENERAL.—The Secretary shall supplement  
19 the costs of private health insurance for eligible low-in-  
20 come families through the distribution of supplemental  
21 debit cards to eligible families, which may be used to pay  
22 for costs associated with health care for the members of  
23 such eligible families and provide direct support to such  
24 families in accessing health care.

25 “(b) ELIGIBILITY.—

1           “(1) ELIGIBLE FAMILIES.—To be eligible for fi-  
2 nancial assistance under this section—

3           “(A) a family shall—

4           “(i) consist of 2 or more individuals  
5 living together who are related by mar-  
6 riage, birth, adoption, or guardianship;

7           “(ii) have a gross income that does  
8 not exceed 200 percent of the poverty line,  
9 as applicable to a family of the size in-  
10 volved; and

11           “(iii) include at least 1 individual who  
12 is a dependent under the age of 19; and

13           “(B) no member of the family shall be cov-  
14 ered by private health insurance.

15           “(2) DETERMINATION OF GROSS INCOME.—The  
16 gross income of a family shall be determined by tak-  
17 ing the sum of the income of each family member  
18 who is at least age 21 but not older than age 65,  
19 except that the income of any member of the family  
20 who qualifies for coverage under Medicaid Part A or  
21 B shall not be counted.

22           “(3) LIMITATION ON INDIVIDUAL ELIGIBILITY;  
23 ASSISTANCE.—

24           “(A) IN GENERAL.—No individual who is a  
25 member of an eligible family under paragraph

1 (1) is eligible to qualify separately for financial  
2 assistance under this section.

3 “(B) ALIENS.—The Secretary shall ensure  
4 that financial assistance under this section is  
5 not provided for costs associated with health  
6 care for any member of an eligible family who  
7 is an alien individual who is not a lawful per-  
8 manent resident of the United States.

9 “(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH  
10 CARE EXPENDITURES.—

11 “(1) IN GENERAL.—The Secretary shall issue  
12 to each eligible family that enrolls in the program in  
13 accordance with subsection (f) a supplemental debit  
14 card with a dollar-amount value, in accordance with  
15 subsection (d), that may be used to pay for quali-  
16 fying health care expenses.

17 “(2) USE OF THE DEBIT CARD.—

18 “(A) QUALIFYING HEALTH CARE EX-  
19 PENSES.—A supplemental debit card issued  
20 under this section may be used by members of  
21 the eligible family to pay for—

22 “(i) the purchase of health care insur-  
23 ance for any member of the family;

24 “(ii) cost sharing expenses related to  
25 health care, including deductibles, copay-

1           ments, and coinsurance, for any member of  
2           the family; and

3           “(iii) the direct purchase of health  
4           care services and supplies for any member  
5           of the family.

6           “(B) GEOGRAPHIC RANGE.—Each supple-  
7           mental debit card may be used to pay for quali-  
8           fying health care expenses incurred anywhere in  
9           the 50 States or the District of Columbia.

10          “(C) LIMITATIONS.—No supplemental  
11          debit card shall be used to make a payment for  
12          any cost—

13                 “(i) incurred prior to the determina-  
14                 tion of the family’s eligibility for assistance  
15                 under this section; or

16                 “(ii) that is not a health-related ex-  
17                 pense.

18          “(3) ROLLOVER OF UNUSED AMOUNTS.—Not  
19          more than one-quarter of the annual dollar amount  
20          of a supplemental debit card that is unexpended at  
21          the end of each 12-month period may rollover—

22                 “(A) to the family’s supplemental debit  
23                 card for expenditure during the subsequent 12-  
24                 month period, provided that the family to which  
25                 the supplemental debit card was issued in the

1 previous 12-month period is eligible to receive a  
2 supplemental debit card in the subsequent 12-  
3 month period; or

4 “(B) to the family’s health savings account  
5 (as defined in section 223(g)(2) of the Internal  
6 Revenue Code of 1986).

7 “(4) MONTHLY STATEMENTS.—The Secretary  
8 shall issue a monthly statement to each family to  
9 which a supplemental debit card has been issued  
10 under this section, which shall state each payment  
11 made with the family’s supplemental debit card dur-  
12 ing the month covered by the statement, the dollar  
13 amount of each such payment, and the provider to  
14 which each such payment was made.

15 “(d) AMOUNT OF FINANCIAL ASSISTANCE.—

16 “(1) AMOUNTS FOR CALENDAR YEAR 2011.—  
17 Subject to paragraph (5), the amount of financial  
18 assistance available to each eligible family during the  
19 calendar year 2011 shall be determined as follows:

20 “(A) Each family whose annual income  
21 does not exceed 100 percent of the poverty  
22 level, as applicable to a family of the size in-  
23 volved, shall receive \$5,000.

24 “(B) Each family whose annual income ex-  
25 ceeds 100 percent, but does not exceed 200 per-

1 cent, of the poverty level, as applicable to a  
2 family of the size involved, shall receive an  
3 amount as follows:

4 “(i) For families whose annual income  
5 exceeds 100 percent but does not exceed  
6 120 percent, of the poverty level, \$4,000.

7 “(ii) For families whose annual in-  
8 come exceeds 120 percent but does not ex-  
9 ceed 140 percent, of the poverty level,  
10 \$3,500.

11 “(iii) For families whose annual in-  
12 come exceeds 140 percent but does not ex-  
13 ceed 160 percent, of the poverty level,  
14 \$3,000.

15 “(iv) For families whose annual in-  
16 come exceeds 160 percent but does not ex-  
17 ceed 180 percent, of the poverty level,  
18 \$2,500.

19 “(v) For families whose annual in-  
20 come exceeds 180 percent but does not ex-  
21 ceed 200 percent, of the poverty level,  
22 \$2,000.

23 “(2) ADDITIONAL AMOUNTS.—In addition to  
24 the amounts under paragraph (1), subject to para-

1 graph (5), the following amounts shall be added to  
2 the supplemental debit cards of qualifying families:

3 “(A) For each pregnancy during which a  
4 pregnant woman’s family is eligible for assist-  
5 ance under this section, an additional amount  
6 of \$1,000 shall be added to the family’s supple-  
7 mental debit card, except that no family shall  
8 receive such additional \$1,000 for any preg-  
9 nancy for which the family received such  
10 amount in the previous 12-month period.

11 “(B) For each member of an eligible fam-  
12 ily who is less than 1 year old on any day with-  
13 in the calendar year in which the family is eligi-  
14 ble for assistance, an additional amount of  
15 \$500 shall be added to the family’s supple-  
16 mental debit card.

17 “(3) COST OF LIVING ADJUSTMENTS.—In the  
18 case of any taxable year beginning in a calendar  
19 year after 2011, each dollar amount contained in  
20 paragraphs (1) and (2) shall be increased in the  
21 same manner as the dollar amounts specified in sec-  
22 tion 25E(b)(3) of the Internal Revenue Code of  
23 1986 are increased by the blended cost-of-living ad-  
24 justment determined under subsection (k)(2) of sec-



1       tion 25E of the Internal Revenue Code for the tax-  
2       able year involved.

3           “(4) STATE OPTION TO INCREASE AMOUNTS.—

4       At the option of each State, amounts in excess of  
5       the annual dollar amounts under paragraphs (1) and  
6       (2) may be provided through the supplemental debit  
7       card to eligible families in that State, but no Federal  
8       funds shall be paid to any State for any amount pro-  
9       vided in excess of such annual dollar amount.

10          “(5) RISK ADJUSTMENT.—The Secretary may

11       adjust the amount of financial assistance available to  
12       an eligible family for a calendar year under this sec-  
13       tion based on age, health indicators, and other fac-  
14       tors that represent distinct patterns of health care  
15       services utilization and costs.

16          “(e) CONTRIBUTIONS OF STATES.—

17          “(1) IN GENERAL.—As a condition for receiving

18       Federal funds under Part A or Part B of Medicaid,  
19       each State shall contribute 50 percent of the total  
20       amount expended under the supplemental debit card  
21       program by the participating families that reside  
22       within the State during the time that the family re-  
23       sides in that State. For purposes of this section, the  
24       residency of a family is determined by the residency  
25       the legally responsible head of the household.

1           “(2) PAYMENTS FROM STATES.—

2               “(A) BILLING NOTIFICATION.—

3                   “(i) TIMING.—On June 30th and De-  
4                   cember 31st of each year, the Secretary  
5                   shall send written notification to each  
6                   State of that State’s 50 percent share of  
7                   expenses, as described in paragraph (1),  
8                   for the 6-month period ending on the last  
9                   day of the month previous to such notifica-  
10                  tion.

11                  “(ii) CONTENTS.—Each such notifica-  
12                  tion to a State shall clearly state—

13                       “(I) the payment amount due  
14                       from the State;

15                       “(II) the name of each individual  
16                       for whom payment was made through  
17                       the supplemental debit card program;

18                       “(III) the health care provider to  
19                       whom each payment was made;

20                       “(IV) the amount of each pay-  
21                       ment; and

22                       “(V) any other information, as  
23                       the Secretary requires.

24                  “(B) PAYMENTS.—Each State shall make  
25                  a payment to the Secretary, in the amount

1 billed, not later than 30 days after the billing  
 2 notification date, in accordance with subpara-  
 3 graph (A)(i).

4 “(C) PENALTIES.—If a State fails to pay  
 5 to the Secretary an amount required under sub-  
 6 paragraph (B), interest shall accrue on such  
 7 amount at the rate provided under old section  
 8 1903(d)(5) of the Social Security Act. The  
 9 amount so owed and applicable interest shall be  
 10 immediately offset against amounts otherwise  
 11 payable to the State under this section, in ac-  
 12 cordance with the Federal Claims Collection Act  
 13 of 1996 and applicable regulations.

14 “(f) ENROLLMENT.—

15 “(1) IN GENERAL.—The Secretary shall estab-  
 16 lish procedures and times for enrollment in the sup-  
 17 plemental debit card program. Open enrollment shall  
 18 be available not less than 4 times per calendar year.

19 “(2) TRANSITION OF INDIVIDUALS ENROLLED  
 20 IN MEDICAID OR THE STATE CHILDREN’S HEALTH  
 21 INSURANCE PROGRAM.—

22 “(A) INFORMATION FROM THE STATES.—

23 Each State shall—

24 “(i) not later than June 30, 2010, in-  
 25 form all individuals then enrolled in Med-

1           icaid or the State Children’s Health Insur-  
2           ance Program (SCHIP), of the changes in  
3           effect beginning on January 1, 2011; and

4           “(ii) not later than October 31, 2010,  
5           redetermine the eligibility of each indi-  
6           vidual enrolled in Medicaid or SCHIP,  
7           other than those individuals who qualify  
8           for Medicaid or SCHIP as disabled, elder-  
9           ly, or a special population, for the supple-  
10          mental debit card program, according to  
11          the eligibility criteria under subsection (b).

12          “(B) AUTOMATIC ENROLLMENT.—The  
13          Secretary shall provide for the automatic enroll-  
14          ment in the supplemental debit card program of  
15          all individuals who are enrolled in Medicaid or  
16          SCHIP and who have been redetermined by a  
17          State under subparagraph (A) to be eligible for  
18          Medicaid or SCHIP. Any individual who is de-  
19          termined by a State not to qualify for the sup-  
20          plemental debit card program may retain cov-  
21          erage under Medicaid or SCHIP until June 30,  
22          2011.

23          “(3) ASSISTANCE WITH QUALIFIED HEALTH IN-  
24          SURANCE CREDIT.—Each State shall, to the extent  
25          practicable, provide individuals residing within the

1 State with information regarding the qualified health  
2 insurance credit described in section 25E of the In-  
3 ternal Revenue Code of 1986, including information  
4 regarding eligibility for, and how to claim, such  
5 credit.

6 “(g) ADMINISTRATION.—

7 “(1) NATIONAL SYSTEM.—The Secretary may  
8 enter into contracts or agreements with a State, a  
9 consortium of States, or a private entity, including  
10 a bank, enrollment broker, or similar entity, to es-  
11 tablish and maintain a unified national system to  
12 support the processes and transactions necessary to  
13 administer this section.

14 “(2) AUTOMATED SYSTEM.—The Secretary  
15 shall establish an automated means, such as an elec-  
16 tronic benefit transfer system, by which the benefits  
17 under this section shall be transferred to eligible  
18 families.

19 “(3) VERIFICATION OF APPLICANT INFORMA-  
20 TION.—The Secretary may verify information pro-  
21 vided by applicants with the appropriate Federal,  
22 State, and local agencies, including the Internal Rev-  
23 enue Service, the Social Security Administration, the  
24 Department of Labor, and child support enforce-  
25 ment agencies.

1           “(4) CHOICE COUNSELING.—The Secretary  
2           may enter into contracts or agreements with a State,  
3           a consortium of a State, or a private entity, includ-  
4           ing an enrollment broker or community organization  
5           or other organization, to educate eligible families  
6           about their options and to assist in their enrollment  
7           in the supplemental debit card plan.

8           “(5) APPEALS.—The Secretary shall establish  
9           an independent appeals process, to be administered  
10          by an entity separate from the entity that makes ini-  
11          tial eligibility determinations, which shall be avail-  
12          able to individuals who are denied benefits under the  
13          supplemental debit card program.

14          “(6) RESOLUTION OF ERRORS.—The Secretary  
15          shall provide for a reconciliation process with the  
16          States to resolve any errors and adjudicate disputes  
17          due to incomplete or false information in a family’s  
18          application or in the billing process described in sub-  
19          section (e).

20          “(7) PENALTIES FOR FALSE INFORMATION.—  
21          Any person who provides false information to qualify  
22          for the supplemental debit card program shall pay a  
23          penalty in the amount of 110 percent of the amount  
24          of assistance paid on behalf of such person and all  
25          members of such person’s family.

1       “(h) IMPLEMENTATION PLAN.—Not later than 6  
2 months after the date of enactment of this section, the  
3 Secretary shall submit to Congress a plan for imple-  
4 menting this program during fiscal years 2009–2012.

5       “(i) AUTHORIZATION OF APPROPRIATIONS.—

6           “(1) ADMINISTRATION OF THE SUPPLEMENTAL  
7 DEBIT CARD PROGRAM.—To administer the program  
8 under this section, there are authorized to be appro-  
9 priated—

10           “(A) for fiscal year 2009, \$300,000,000,  
11 for the design of a unified, national system of  
12 conducting the supplemental debit card pro-  
13 gram;

14           “(B) for fiscal year 2010, \$1,000,000,000  
15 for start-up costs, including, contracting, hiring  
16 and training employees, and testing the pro-  
17 gram; and

18           “(C) for fiscal year 2011 and each subse-  
19 quent fiscal year, \$3,000,000,000.

20       “(2) AUTHORIZATION OF BENEFITS UNDER  
21 THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To  
22 provide the supplemental debit card benefits de-  
23 scribed in this section, there are authorized to be ap-  
24 propriated—

1           “(A)     for     fiscal     year     2011,  
 2           \$24,020,000,000;  
 3           “(B)     for     fiscal     year     2012,  
 4           \$25,220,000,000;  
 5           “(C)     for     fiscal     year     2013,  
 6           \$26,480,000,000;  
 7           “(D)     for     fiscal     year     2014,  
 8           \$27,810,000,000; and  
 9           “(E)     for     fiscal     year     2015,  
 10          \$29,200,000,000.”.

11 **TITLE V—FIXING MEDICARE FOR**  
 12 **AMERICAN SENIORS**

13 **Subtitle     A—Increasing     Pro-**  
 14 **grammatic Efficiency, Economy,**  
 15 **and Accountability**

16 **SEC. 501. ELIMINATING INEFFICIENCIES AND INCREASING**  
 17 **CHOICE IN MEDICARE ADVANTAGE.**

18       Part C of title XVIII of the Social Security Act is  
 19 amended by adding at the end the following new section:

20       “MEDICARE ADVANTAGE COMPETITIVE BIDDING

21       “SEC. 1860C–2. (a) COMPETITIVE BIDDING.—

22           “(1) IN GENERAL.—In order to promote com-  
 23 petition among Medicare Advantage plans and to in-  
 24 crease the quality of care furnished under such  
 25 plans, the Secretary shall establish and implement a  
 26 competitive bidding mechanism under this part.



1           “(2) MECHANISM TO BEGIN IN 2011.—The  
2 mechanism established under paragraph (1) shall  
3 apply to all MA organizations and plans beginning  
4 in 2011.

5           “(3) NO EFFECT ON PART D BENEFITS.—The  
6 mechanism established under paragraph (1) shall  
7 not affect the provisions of this part relating to ben-  
8 efits under part D, including the bidding mechanism  
9 used for benefits under such part.

10          “(b) RULES FOR COMPETITIVE BIDDING MECHA-  
11 NISM.—Notwithstanding any other provision of this part,  
12 the following rules shall apply under the competitive bid-  
13 ding mechanism established under subsection (a).

14           “(1) BENCHMARK.—Benchmark amounts for  
15 an area for a year shall be established solely through  
16 the competitive bids of MA plans. The benchmark  
17 amount for each area for a year shall be the average  
18 bid of the plans in that area for that year. In estab-  
19 lishing the benchmark for an area for a year under  
20 the preceding sentence, the Secretary shall exclude  
21 the highest and lowest bid for that area and year.  
22 The benchmark amount for an area for a year may  
23 not exceed the benchmark amount for that area and  
24 year that would have applied if this section had not  
25 been enacted.

1           “(2) BIDS.—The MA plan bid shall reflect the  
2           per capita payments that the MA plan will accept  
3           for providing a benefit package that is actuarially  
4           equivalent to 106 percent of the value of the original  
5           Medicare fee-for-service program option. MA plan  
6           bid submissions shall include data on plan average  
7           provider network contract rates compared to the  
8           rates under the original Medicare fee-for-service pro-  
9           gram option for the top 5 most common claim sub-  
10          missions per provider type.

11          “(3) RISK ADJUSTMENT.—The benchmark  
12          under paragraph (1) and the MA plan bid shall be  
13          risk adjusted using the risk adjustment require-  
14          ments under this part.

15          “(4) BENEFICIARY PREMIUMS.—The MA  
16          monthly basic beneficiary premium for a beneficiary  
17          who enrolls in an MA plan whose plan bid is at or  
18          below the benchmark shall be zero and the bene-  
19          ficiary shall receive the full difference (if any) be-  
20          tween the bid and the benchmark in the form of ad-  
21          ditional benefits or as a rebate on their premiums  
22          under this title. The MA monthly basic beneficiary  
23          premium for a beneficiary who enrolls in an MA  
24          plan whose plan bid is above the benchmark shall be

1 equal to the amount by which the bid exceeds the  
2 benchmark.

3 “(5) BENCHMARK AMOUNTS FOR RURAL COUN-  
4 TIES.—The Secretary may adjust the benchmark  
5 amount established under paragraph (1) for any  
6 rural county (as identified by the Secretary after  
7 consultation with the Secretary of Commerce) to en-  
8 courage plan participation in such county.

9 “(6) EXISTING REQUIREMENTS.—Requirements  
10 relating to licensure, quality, and beneficiary protec-  
11 tions that would otherwise apply under this part  
12 shall apply under the competitive bidding mechanism  
13 established under subsection (a).

14 “(c) WAIVER.—In order to implement the competitive  
15 bidding mechanism under established subsection (a), the  
16 Secretary may waive or modify requirements under this  
17 part.”.

18 **SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION**

19 **DEMONSTRATION PROGRAM.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—In order to promote innova-  
22 tive care coordination and delivery that is cost-effec-  
23 tive, the Secretary of Health and Human Services  
24 (in this section referred to as the “Secretary”) shall

1       conduct a demonstration program under the Medi-  
2       care program under which—

3               (A) groups of providers meeting certain  
4               criteria may work together to manage and co-  
5               ordinate care for Medicare fee-for-service bene-  
6               ficiaries through an Accountable Care Organi-  
7               zation (in this section referred to as an  
8               “ACO”); and

9               (B) providers in participating ACOs are el-  
10              igible for bonuses based on performance.

11             (2) MEDICARE FEE-FOR-SERVICE BENEFICIARY  
12             DEFINED.—In this section, the term “Medicare fee-  
13             for-service beneficiary” means an individual who is  
14             enrolled in the original medicare fee-for-service pro-  
15             gram under parts A and B of title XVIII of the So-  
16             cial Security Act and not enrolled in an MA plan  
17             under part C of such title.

18             (b) ELIGIBLE ACOs.—

19               (1) IN GENERAL.—Subject to paragraph (2),  
20               the following provider groups are eligible to partici-  
21               pate as ACOs under the demonstration program  
22               under this section:

23                   (A) Physicians in group practice arrange-  
24                   ments.

1 (B) Networks of individual physician prac-  
2 tices.

3 (C) Partnerships or joint venture arrange-  
4 ments between hospitals and physicians.

5 (D) Partnerships or joint ventures, which  
6 may include pharmacists providing medication  
7 therapy management.

8 (E) Hospitals employing physicians.

9 (F) Integrated delivery systems.

10 (G) Community-based coalitions of pro-  
11 viders.

12 (2) REQUIREMENTS.—An ACO shall meet the  
13 following requirements:

14 (A) The ACO shall have a formal legal  
15 structure that would allow the organization to  
16 receive and distribute bonuses to participating  
17 providers.

18 (B) The ACO shall include the primary  
19 care providers of at least 5,000 Medicare fee-  
20 for-service beneficiaries.

21 (C) The ACO shall be willing to become  
22 accountable for the overall care of the Medicare  
23 fee-for-service beneficiaries.

24 (D) The ACO shall provide the Secretary  
25 with a list of primary care and specialist physi-

1 cians participating in the ACO to support the  
2 beneficiary assignment, implementation of per-  
3 formance measures, and the determination of  
4 bonus payments under the demonstration pro-  
5 gram.

6 (E) The ACO shall have in place contracts  
7 with a core group of key specialist physicians,  
8 a leadership and management structure, and  
9 processes to promote evidence-based medicine  
10 and to coordinate care.

11 (c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE  
12 BENEFICIARIES.—

13 (1) IN GENERAL.—Under the demonstration  
14 program under this section, each Medicare fee-for-  
15 service Medicare beneficiary shall be automatically  
16 assigned to a primary care provider. Such assign-  
17 ment shall be based on the physician from whom the  
18 beneficiary received the most primary care in the  
19 preceding year.

20 (2) BENEFICIARIES MAY CONTINUE TO SEE  
21 PROVIDERS OUTSIDE OF THE ACO.—Under the dem-  
22 onstration program under this section, a Medicare  
23 fee-for-service Medicare beneficiary may continue to  
24 see providers in and outside of the ACO to which  
25 they have been assigned.

1 (d) BONUS PAYMENTS.—

2 (1) IN GENERAL.—Under the demonstration  
3 program, Medicare payments shall continue to be  
4 made to providers under the original Medicare fee-  
5 for-service program in the same manner as they  
6 would otherwise be made except that a participating  
7 ACO is eligible for bonuses if—

8 (A) it meets certain quality performance  
9 measures; and

10 (B) spending for their Medicare fee-for-  
11 service beneficiaries meets the requirement  
12 under paragraph (3).

13 (2) QUALITY.—Under the demonstration pro-  
14 gram under this section, providers meet the require-  
15 ment under paragraph (1)(A) if they generally follow  
16 consensus-based guidelines established by non-gov-  
17 ernment professional medical societies. Patient satis-  
18 faction and risk-adjusted outcomes shall be deter-  
19 mined through an independent entity with medical  
20 expertise.

21 (3) REQUIREMENT RELATING TO SPENDING.—

22 (A) IN GENERAL.—An ACO shall only be  
23 eligible to receive a bonus payment if the aver-  
24 age Medicare expenditures under the ACO for  
25 Medicare fee-for-service beneficiaries over a

1 two-year period is at least 2 percent below the  
2 average benchmark for the corresponding two-  
3 year period. The benchmark for each ACO shall  
4 be set using the most recent three years of total  
5 per-beneficiary spending for Medicare fee-for-  
6 service beneficiaries assigned to the ACO. Such  
7 benchmark shall be updated by the projected  
8 rate of growth in national per capita spending  
9 for the original medicare fee-for-service pro-  
10 gram, as projected (using the most recent three  
11 years of data) by the Chief Actuary of the Cen-  
12 ters for Medicare & Medicaid Services.

13 (4) AMOUNT OF BONUS PAYMENTS.—The  
14 amount of the bonus payment to a participating  
15 ACO shall be one-half of the percentage point dif-  
16 ference between the two-year average of their pa-  
17 tients' Medicare expenditures and 98 percent of the  
18 two-year average benchmark. The bonus amount, in  
19 dollars, shall be equal to the bonus share multiplied  
20 by the benchmark for the most recent year.

21 (5) LIMITATION.—Bonus payments may only be  
22 made to an ACO if the primary care provider to  
23 which the Medicare fee-for-service beneficiary has  
24 been assigned under subsection (c) elects to partici-  
25 pate in such ACO.



1 (e) WAIVER AUTHORITY.—The Secretary may waive  
 2 such requirements of titles XI and XVIII of the Social  
 3 Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as  
 4 may be appropriate for the purpose of carrying out the  
 5 demonstration program under this section.

6 (f) REPORT.—Upon completion of the demonstration  
 7 program under this section, the Secretary shall submit to  
 8 Congress a report on the program together with such rec-  
 9 ommendations as the Secretary determines appropriate.

10 **SEC. 503. REDUCING GOVERNMENT HANDOUTS TO**  
 11 **WEALTHIER SENIORS.**

12 (a) ELIMINATION OF ANNUAL INDEXING OF INCOME  
 13 THRESHOLDS FOR REDUCED PART B PREMIUM SUB-  
 14 SIDIES.—

15 (1) IN GENERAL.—Paragraph (5) of section  
 16 1839(i) of the Social Security Act (42 U.S.C.  
 17 1395r(i)) is repealed.

18 (2) EFFECTIVE DATE.—The repeal made by  
 19 paragraph (1) shall apply to premiums for months  
 20 beginning after December 2010.

21 (b) INCOME-RELATED REDUCTION IN PART D PRE-  
 22 MIUM SUBSIDY.—

23 (1) INCOME-RELATED REDUCTION IN PART D  
 24 PREMIUM SUBSIDY.—

1           (A) IN GENERAL.—Section 1860D–13(a)  
2 of the Social Security Act (42 U.S.C. 1395w–  
3 113(a)) is amended by adding at the end the  
4 following new paragraph:

5           “(7) REDUCTION IN PREMIUM SUBSIDY BASED  
6 ON INCOME.—

7           “(A) IN GENERAL.—In the case of an indi-  
8 vidual whose modified adjusted gross income  
9 exceeds the threshold amount applicable under  
10 paragraph (2) of section 1839(i) (including ap-  
11 plication of paragraph (5) of such section) for  
12 the calendar year, the monthly amount of the  
13 premium subsidy applicable to the premium  
14 under this section for a month after December  
15 2010 shall be reduced (and the monthly bene-  
16 ficiary premium shall be increased) by the  
17 monthly adjustment amount specified in sub-  
18 paragraph (B).

19           “(B) MONTHLY ADJUSTMENT AMOUNT.—  
20 The monthly adjustment amount specified in  
21 this subparagraph for an individual for a month  
22 in a year is equal to the product of—

23                   “(i) the quotient obtained by divid-  
24 ing—

1           “(I) the applicable percentage de-  
2           termined under paragraph (3)(C) of  
3           section 1839(i) (including application  
4           of paragraph (5) of such section) for  
5           the individual for the calendar year  
6           reduced by 25.5 percent; by

7           “(II) 25.5 percent; and

8           “(ii) the base beneficiary premium (as  
9           computed under paragraph (2)).

10           “(C) MODIFIED ADJUSTED GROSS IN-  
11           COME.—For purposes of this paragraph, the  
12           term ‘modified adjusted gross income’ has the  
13           meaning given such term in subparagraph (A)  
14           of section 1839(i)(4), determined for the tax-  
15           able year applicable under subparagraphs (B)  
16           and (C) of such section.

17           “(D) DETERMINATION BY COMMISSIONER  
18           OF SOCIAL SECURITY.—The Commissioner of  
19           Social Security shall make any determination  
20           necessary to carry out the income-related reduc-  
21           tion in premium subsidy under this paragraph.

22           “(E) PROCEDURES TO ASSURE CORRECT  
23           INCOME-RELATED REDUCTION IN PREMIUM  
24           SUBSIDY.—

1           “(i) DISCLOSURE OF BASE BENE-  
2           FICIARY PREMIUM.—Not later than Sep-  
3           tember 15 of each year beginning with  
4           2010, the Secretary shall disclose to the  
5           Commissioner of Social Security the  
6           amount of the base beneficiary premium  
7           (as computed under paragraph (2)) for the  
8           purpose of carrying out the income-related  
9           reduction in premium subsidy under this  
10          paragraph with respect to the following  
11          year.

12          “(ii) ADDITIONAL DISCLOSURE.—Not  
13          later than October 15 of each year begin-  
14          ning with 2010, the Secretary shall dis-  
15          close to the Commissioner of Social Secu-  
16          rity the following information for the pur-  
17          pose of carrying out the income-related re-  
18          duction in premium subsidy under this  
19          paragraph with respect to the following  
20          year:

21                  “(I) The modified adjusted gross  
22                  income threshold applicable under  
23                  paragraph (2) of section 1839(i) (in-  
24                  cluding application of paragraph (5)  
25                  of such section).

1           “(II) The applicable percentage  
2           determined under paragraph (3)(C) of  
3           section 1839(i) (including application  
4           of paragraph (5) of such section).

5           “(III) The monthly adjustment  
6           amount specified in subparagraph  
7           (B).

8           “(IV) Any other information the  
9           Commissioner of Social Security de-  
10          termines necessary to carry out the  
11          income-related reduction in premium  
12          subsidy under this paragraph.

13          “(F) RULE OF CONSTRUCTION.—The for-  
14          mula used to determine the monthly adjustment  
15          amount specified under subparagraph (B) shall  
16          only be used for the purpose of determining  
17          such monthly adjustment amount under such  
18          subparagraph.”.

19          (B) COLLECTION OF MONTHLY ADJUST-  
20          MENT AMOUNT.—Section 1860D–13(c) of the  
21          Social Security Act (42 U.S.C. 1395w–113(c))  
22          is amended—

23                 (i) in paragraph (1), by striking “(2)  
24                 and (3)” and inserting “(2), (3), and (4)”;  
25                 and

1 (ii) by adding at the end the following  
2 new paragraph:

3 “(4) COLLECTION OF MONTHLY ADJUSTMENT  
4 AMOUNT.—

5 “(A) IN GENERAL.—Notwithstanding any  
6 provision of this subsection or section  
7 1854(d)(2), subject to subparagraph (B), the  
8 amount of the income-related reduction in pre-  
9 mium subsidy for an individual for a month (as  
10 determined under subsection (a)(7)) shall be  
11 paid through withholding from benefit pay-  
12 ments in the manner provided under section  
13 1840.

14 “(B) AGREEMENTS.—In the case where  
15 the monthly benefit payments of an individual  
16 that are withheld under subparagraph (A) are  
17 insufficient to pay the amount described in such  
18 subparagraph, the Commissioner of Social Se-  
19 curity shall enter into agreements with the Sec-  
20 retary, the Director of the Office of Personnel  
21 Management, and the Railroad Retirement  
22 Board as necessary in order to allow other  
23 agencies to collect the amount described in sub-  
24 paragraph (A) that was not withheld under  
25 such subparagraph.”.

1 (2) CONFORMING AMENDMENTS.—

2 (A) MEDICARE.—Part D of title XVIII of  
3 the Social Security Act (42 U.S.C. 1395w–101  
4 et seq.) is amended—

5 (i) in section 1860D–13(a)(1)—

6 (I) by redesignating subpara-  
7 graph (F) as subparagraph (G);

8 (II) in subparagraph (G), as re-  
9 designated by subparagraph (A), by  
10 striking “(D) and (E)” and inserting  
11 “(D), (E), and (F)”; and

12 (III) by inserting after subpara-  
13 graph (E) the following new subpara-  
14 graph:

15 “(F) INCREASE BASED ON INCOME.—The  
16 monthly beneficiary premium shall be increased  
17 pursuant to paragraph (7).”; and

18 (ii) in section 1860D–15(a)(1)(B), by  
19 striking “paragraph (1)(B)” and inserting  
20 “paragraphs (1)(B) and (1)(F)”.

21 (B) INTERNAL REVENUE CODE.—Section  
22 6103(l)(20) of the Internal Revenue Code of  
23 1986 (relating to disclosure of return informa-  
24 tion to carry out Medicare part B premium sub-  
25 sidy adjustment) is amended—

1 (i) in the heading, by striking “PART  
2 B PREMIUM SUBSIDY ADJUSTMENT” and  
3 inserting “PARTS B AND D PREMIUM SUB-  
4 SIDY ADJUSTMENTS”;

5 (ii) in subparagraph (A)—

6 (I) in the matter preceding clause  
7 (i), by inserting “or 1860D–13(a)(7)”  
8 after “1839(i)”; and

9 (II) in clause (vii), by inserting  
10 after “subsection (i) of such section”  
11 the following: “or under section  
12 1860D–13(a)(7) of such Act”;

13 (iii) in subparagraph (B)—

14 (I) by inserting “or such section  
15 1860D–13(a)(7)” before the period at  
16 the end;

17 (II) as amended by clause (i), by  
18 inserting “or for the purpose of re-  
19 solving tax payer appeals with respect  
20 to any such premium adjustment” be-  
21 fore the period at the end; and

22 (III) by adding at the end the  
23 following new sentence: “Officers, em-  
24 ployees, and contractors of the Social  
25 Security Administration may disclose



1 such return information to officers,  
2 employees, and contractors of the De-  
3 partment of Health and Human Serv-  
4 ices, the Office of Personnel Manage-  
5 ment, the Railroad Retirement Board,  
6 the Department of Justice, and the  
7 courts of the United States to the ex-  
8 tent necessary to carry out the pur-  
9 poses described in the preceding sen-  
10 tence.”; and

11 (iv) by adding at the end the following  
12 new subparagraph:

13 “(C) TIMING OF DISCLOSURE.—Return in-  
14 formation shall be disclosed to officers, employ-  
15 ees, and contractors of the Social Security Ad-  
16 ministration under subparagraph (A) not later  
17 than the date that is 90 days prior to the date  
18 on which the taxpayer first becomes entitled to  
19 benefits under part A of title XVIII of the So-  
20 cial Security Act or eligible to enroll for benefits  
21 under part B of such title.”.

22 **SEC. 504. REWARDING PREVENTION.**

23 Section 1839 of the Social Security Act (42 U.S.C.  
24 1395r) is amended—

1           (1) in subsection (a)(2), by striking “and (i)”  
2           and inserting “(i), and (j)”; and

3           (2) by adding at the end the following new sub-  
4           section:

5           “(j)(1) With respect to the monthly premium amount  
6 for months after December 2010, the Secretary may ad-  
7 just (under procedures established by the Secretary) the  
8 amount of such premium for an individual based on  
9 whether or not the individual participates in certain  
10 healthy behaviors, such as weight management, exercise,  
11 nutrition counseling, refraining from tobacco use, desig-  
12 nating a health home, and other behaviors determined ap-  
13 propriate by the Secretary.

14          “(2) In making the adjustments under paragraph (1)  
15 for a month, the Secretary shall ensure that the total  
16 amount of premiums to be paid under this part for the  
17 month is equal to the total amount of premiums that  
18 would have been paid under this part for the month if  
19 no such adjustments had been made, as estimated by the  
20 Secretary.”.

21 **SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANS-**  
22 **PARENCY.**

23          (a) **TRANSPARENCY.**—Title XVIII of the Social Secu-  
24 rity Act is amended by adding at the end the following  
25 new section:

1           “PRICE TRANSPARENCY REQUIREMENTS

2           “SEC. 1899. (a) PRE-TREATMENT DISCLOSURE.—A  
3 provider of services (as defined in section 1861(u)) and  
4 a supplier (as defined in section 1861(d)) shall provide  
5 to each individual (regardless of whether or not the indi-  
6 vidual is a beneficiary under this title) who is scheduled  
7 to receive a treatment (or to begin a course of treatment)  
8 that is not for an emergency medical condition the esti-  
9 mated price that the provider of services or supplier will  
10 charge for the treatment (or course of treatment). Such  
11 price shall be determined at the time of scheduling.

12          “(b) POST-TREATMENT DISCLOSURE.—A provider of  
13 services (as so defined) and a supplier (as so defined) shall  
14 include with any bill that includes the charges for a treat-  
15 ment with respect to an individual (regardless of whether  
16 or not the individual is a beneficiary under this title), an  
17 itemized list of component charges for such treatment, in-  
18 cluding charges for drugs and medical equipment involved,  
19 as determined at the time of billing. With respect to each  
20 item included on such list, the provider of services or sup-  
21 plier shall include the price charged for the item.”.

22          (b) EFFECTIVE DATE.—The amendment made by  
23 subsection (a) shall apply to providers of services and sup-  
24 pliers on and after January 1, 2011.

1 **SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID**  
2 **CLAIMS AND PATIENT ENCOUNTER DATA.**

3 (a) PUBLIC AVAILABILITY.—Not later than 1 year  
4 after the date of enactment of this Act (and annually  
5 thereafter), the Secretary of Health and Human Services  
6 (in this section referred to as the “Secretary”), shall make  
7 available to the public (including through an Internet  
8 website) data on claims and patient encounters under ti-  
9 tles XVIII and XIX of the Social Security Act during the  
10 preceding calendar year. Such data shall be appropriately  
11 disaggregated and patient deidentified, as determined nec-  
12 essary by the Secretary in order to comply with the Fed-  
13 eral regulations (concerning the privacy of individually  
14 identifiable health information) promulgated under section  
15 264(c) of the Health Insurance Portability and Account-  
16 ability Act of 1996.

17 (b) PROVISION OF DATA TO STATE EXCHANGES AND  
18 HEALTH INSURANCE ISSUERS UNDER THE STATE EX-  
19 CHANGE.—The Secretary shall submit such data directly  
20 to a State Exchange under title II and health insurance  
21 issuers under such Exchange (in a form and manner de-  
22 termined appropriate by the Secretary).

23 (c) MATCHING OF DATA.—The Secretary shall en-  
24 sure that the total amount of claims under such titles dur-  
25 ing the preceding year for which data is made available  
26 under subsection (a) is equal to the reported outlays from

1 the Federal government and the States under such titles  
2 during the preceding years.

3 **Subtitle B—Reducing Fraud and**  
4 **Abuse**

5 **SEC. 511. REQUIRING THE SECRETARY OF HEALTH AND**  
6 **HUMAN SERVICES TO CHANGE THE MEDI-**  
7 **CARE BENEFICIARY IDENTIFIER USED TO**  
8 **IDENTIFY MEDICARE BENEFICIARIES UNDER**  
9 **THE MEDICARE PROGRAM.**

10 (a) PROCEDURES.—

11 (1) IN GENERAL.—Not later than 1 year after  
12 the date of enactment of this Act, in order to protect  
13 beneficiaries from identity theft, the Secretary of  
14 Health and Human Services (in this section referred  
15 to as the “Secretary”) shall establish and implement  
16 procedures to change the Medicare beneficiary iden-  
17 tifier used to identify individuals entitled to benefits  
18 under part A of title XVIII of the Social Security  
19 Act or enrolled under part B of such title so that  
20 such an individual’s social security account number  
21 is not used. Such procedures shall provide that the  
22 new Medicare beneficiary identifier includes biomet-  
23 ric identification protections.

24 (2) MAINTAINING EXISTING HICN STRUC-  
25 TURE.—In order to minimize the impact of the

1 change under paragraph (1) on systems that com-  
2 municate with Medicare beneficiary eligibility sys-  
3 tems, the procedures under paragraph (1) shall pro-  
4 vide that the new Medicare beneficiary identifier  
5 maintain the existing Health Insurance Claim Num-  
6 ber structure.

7 (3) PROTECTION AGAINST FRAUD.—The proce-  
8 dures under paragraph (1) shall provide for a proc-  
9 ess for changing the Medicare beneficiary identifier  
10 for an individual to a different identifier in the case  
11 of the discovery of fraud, including identity theft.

12 (4) PHASE-IN AUTHORITY.—

13 (A) IN GENERAL.—Subject to subpara-  
14 graphs (B) and (C), the Secretary may phase in  
15 the change under paragraph (1) in such man-  
16 ner as the Secretary determines appropriate.

17 (B) LIMIT.—The phase-in period under  
18 subparagraph (A) shall not exceed 10 years.

19 (C) NEWLY ENTITLED AND ENROLLED IN-  
20 DIVIDUALS.—The Secretary shall ensure that  
21 the change under paragraph (1) is implemented  
22 not later than January 1, 2010, with respect to  
23 any individual who first becomes entitled to  
24 benefits under part A of title XVIII of the So-

1           cial Security Act or enrolled under part B of  
2           such title on or after such date.

3           (b) EDUCATION AND OUTREACH.—The Secretary  
4 shall establish a program of education and outreach for  
5 individuals entitled to, or enrolled for, benefits under part  
6 A of title XVIII of the Social Security Act or enrolled  
7 under part B of such title, providers of services (as defined  
8 in subsection (u) of section 1861 of such Act (42 U.S.C.  
9 1395x)), and suppliers (as defined in subsection (d) of  
10 such section) on the change under paragraph (1).

11          (c) DATA MATCHING.—

12           (1) ACCESS TO CERTAIN INFORMATION.—Sec-  
13 tion 205(r) of the Social Security Act (42 U.S.C.  
14 405(r)) is amended by adding at the end the fol-  
15 lowing new paragraph:

16           “(9)(A) The Commissioner of Social Security  
17 shall, upon the request of the Secretary—

18           “(i) enter into an agreement with the Sec-  
19 retary for the purpose of matching data in the  
20 system of records of the Commissioner with  
21 data in the system of records of the Secretary,  
22 so long as the requirements of subparagraphs  
23 (A) and (B) of paragraph (3) are met, in order  
24 to determine—

1           “(I) whether a beneficiary under the  
2           program under title XVIII, XIX, or XXI is  
3           dead, imprisoned, or otherwise not eligible  
4           for benefits under such program; and

5           “(II) whether a provider of services or  
6           a supplier under the program under title  
7           XVIII, XIX, or XXI is dead, imprisoned,  
8           or otherwise not eligible to furnish or re-  
9           ceive payment for furnishing items and  
10          services under such program; and

11          “(ii) include in such agreement safeguards  
12          to assure the maintenance of the confidentiality  
13          of any information disclosed and procedures to  
14          permit the Secretary to use such information  
15          for the purpose described in clause (i).

16          “(B) Information provided pursuant to an  
17          agreement under this paragraph shall be provided at  
18          such time, in such place, and in such manner as the  
19          Commissioner determines appropriate.

20          “(C) Information provided pursuant to an  
21          agreement under this paragraph shall include infor-  
22          mation regarding whether—

23                 “(i) the name (including the first name  
24                 and any family name or surname), the date of  
25                 birth (including the month, day, and year), and



1 social security number of an individual provided  
 2 to the Commissioner match the information  
 3 contained in the Commissioner's records, and

4 “(ii) such individual is shown on the  
 5 records of the Commissioner as being de-  
 6 ceased.”.

7 (2) INVESTIGATION BASED ON CERTAIN INFOR-  
 8 MATION.—Title XI of the Social Security Act (42  
 9 U.S.C. 1301 et seq.) is amended by inserting after  
 10 section 1128F the following new section:

11 **“SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGA-**  
 12 **TION OF CLAIMS INVOLVING INDIVIDUALS**  
 13 **WHO ARE NOT ELIGIBLE FOR BENEFITS OR**  
 14 **ARE NOT ELIGIBLE PROVIDERS OF SERVICES**  
 15 **OR SUPPLIERS.**

16 “(a) DATA AGREEMENT.—The Secretary shall enter  
 17 into an agreement with the Commissioner of Social Secu-  
 18 rity pursuant to section 205(r)(9).

19 “(b) INVESTIGATION OF CLAIMS INVOLVING CER-  
 20 TAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENE-  
 21 FITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR  
 22 SUPPLIERS.—

23 “(1) IN GENERAL.—The Secretary shall, in the  
 24 case where a provider of services or a supplier under  
 25 the program under title XVIII, XIX, or XXI sub-

1 mits a claim for payment for items or services fur-  
2 nished to an individual who the Secretary deter-  
3 mines, as a result of information provided pursuant  
4 to such agreement, is not eligible for benefits under  
5 such program, or where the Secretary determines, as  
6 a result of such information, that such provider of  
7 services or supplier is not eligible to furnish or re-  
8 ceive payment for furnishing such items or services,  
9 conduct an investigation with respect to the provider  
10 of services or supplier. If the Secretary determines  
11 further action is appropriate, the Secretary shall  
12 refer the investigation to the Inspector General of  
13 the Department of Health and Human Services as  
14 soon as practicable.

15 “(2) ASSESSMENT OF IMPLEMENTATION AND  
16 EFFECTIVENESS BY THE OIG.—The Inspector Gen-  
17 eral of the Department of Health and Human Serv-  
18 ices shall test the implementation of the provisions  
19 of this section (including the implementation of the  
20 agreement under section 205(r)(9)) and conduct  
21 such period assessments of such implementation as  
22 the Inspector General determines necessary to deter-  
23 mine the effectiveness of such implementation.”.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There  
 2 are authorized to be appropriated such sums as may be  
 3 necessary to carry out this section.

4 **SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA RE-**  
 5 **VIEW.**

6 Title XVIII of the Social Security Act, as amended  
 7 by this Act, is amended by adding at the end the following  
 8 new section:

9 “USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

10 “SEC. 1899A. (a) IN GENERAL.—The Secretary shall  
 11 establish procedures for the use of technology (including  
 12 front-end, pre-payment technology similar to that used by  
 13 hedge funds, investment funds, and banks) to provide real-  
 14 time data analysis of claims for payment under this title  
 15 to identify and investigate unusual billing or order prac-  
 16 tices under this title that could indicate fraud or abuse.

17 “(b) COMPETITIVE BIDDING.—The procedures estab-  
 18 lished under subsection (a) shall ensure that the imple-  
 19 mentation of such technology is conducted through a com-  
 20 petitive bidding process.”.

21 **SEC. 513. DETECTION OF MEDICARE FRAUD AND ABUSE.**

22 (a) IN GENERAL.—Section 1893 of the Social Secu-  
 23 rity Act (42 U.S.C. 1395ddd) is amended—

24 (1) in subsection (b), by adding at the end the  
 25 following new paragraph:

1           “(7) Implementation of fraud and abuse detec-  
2           tion methods under subsection (i).”;

3           (2) in subsection (c), by adding at the end of  
4           the flush matter following paragraph (4), the fol-  
5           lowing new sentence “In the case of an activity de-  
6           scribed in subsection (b)(8), an entity shall only be  
7           eligible to enter into a contract under the Program  
8           to carry out the activity if the entity is selected  
9           through a competitive bidding process in accordance  
10          with subsection (i)(3).”; and

11          (3) by adding at the end the following new sub-  
12          section:

13          “(i) DETECTION OF MEDICARE FRAUD AND  
14 ABUSE.—

15               “(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY  
16               COUNTIES MOST VULNERABLE TO FRAUD.—Not  
17               later than 6 months after the date of enactment of  
18               this subsection, the Secretary shall establish a sys-  
19               tem to identify the 50 counties most vulnerable to  
20               fraud with respect to items and services furnished by  
21               providers of services (other than hospitals and crit-  
22               ical access hospitals) and suppliers based on the de-  
23               gree of county-specific reimbursement and analysis  
24               of payment trends under this title. The Secretary

1 shall designate the counties identified under the pre-  
2 ceding sentence as ‘high risk areas’.

3 “(2) FRAUD AND ABUSE DETECTION.—

4 “(A) INITIAL IMPLEMENTATION.—The  
5 Secretary shall establish procedures for the im-  
6 plementation of fraud and abuse detection  
7 methods under this title with respect to items  
8 and services furnished by such providers of  
9 services and suppliers in high risk areas des-  
10 ignated under paragraph (1) (and, beginning  
11 not later than 18 months after the date of en-  
12 actment of this subsection, with respect to  
13 items and services furnished by such providers  
14 of services and suppliers in areas not so des-  
15 ignated) including the following:

16 “(i) Data analysis to establish prepay-  
17 ment claim edits designed to target the  
18 claims for payment under this title for  
19 such items and services that are most like-  
20 ly to be fraudulent.

21 “(ii) Prepayment benefit integrity re-  
22 views for claims for payment under this  
23 title for such items and services that are  
24 suspended as a result of such edits.

1           “(B) REQUIREMENT FOR PARTICIPA-  
2           TION.—In no case may a provider of services or  
3           supplier who does not meet the requirements  
4           under subparagraph (A) participate in the pro-  
5           gram under this title.

6           “(C) EXPANDED IMPLEMENTATION.—Not  
7           later than 24 months after the date of enact-  
8           ment of this subsection, the Secretary shall es-  
9           tablish procedures for the implementation of  
10          such fraud and abuse detection methods under  
11          this title with respect to items and services fur-  
12          nished by all providers of services and suppliers,  
13          including those not in high risk areas des-  
14          ignated under paragraph (1).

15          “(3) COMPETITIVE BIDDING.—In selecting enti-  
16          ties to carry out this subsection, the Secretary shall  
17          use a competitive bidding process.

18          “(4) REPORT TO CONGRESS.—The Secretary  
19          shall submit to Congress an annual report on the ef-  
20          fectiveness of activities conducted under this sub-  
21          section, including a description of any savings to the  
22          program under this title as a result of such activities  
23          and the overall administrative cost of such activities  
24          and a determination as to the amount of funding  
25          needed to carry out this subsection for subsequent

1 fiscal years, together with recommendations for such  
2 legislation and administrative action as the Sec-  
3 retary determines appropriate.”.

4 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry  
5 out the amendments made by this section, there are au-  
6 thorized to be appropriated—

7 (1) such sums as may be necessary, not to ex-  
8 ceed \$50,000,000, for each of fiscal years 2010  
9 through 2014; and

10 (2) such sums as may be necessary, not to ex-  
11 ceed an amount the Secretary determines appro-  
12 priate in the most recent report submitted to Con-  
13 gress under section 1893(j)(4) of the Social Security  
14 Act, as added by subsection (a), for each subsequent  
15 fiscal year.

16 **SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLI-**  
17 **CATION AND EXEMPTION OF PHARMACISTS**  
18 **FROM SURETY BOND REQUIREMENT.**

19 (a) EDITS ON 855S MEDICARE ENROLLMENT APPLI-  
20 CATION.—Section 1834(a) of the Social Security Act (42  
21 U.S.C. 1395m(a)) is amended by adding at the end the  
22 following new paragraphs:

23 “(22) CONFIRMATION WITH NATIONAL SUP-  
24 PLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

1           “(A) IN GENERAL.—Not later than 1 year  
2 after the date of enactment of this paragraph,  
3 the Secretary shall establish procedures to re-  
4 quire carriers, prior to paying a claim for pay-  
5 ment for durable medical equipment, pros-  
6 thetics, orthotics, and supplies under this title,  
7 to confirm with the National Supplier Clearing-  
8 house—

9           “(i) that the National Provider Identifi-  
10 fier of the physician or practitioner pre-  
11 scribing or ordering the item or service is  
12 valid and active;

13           “(ii) that the Medicare identification  
14 number of the supplier is valid and active;  
15 and

16           “(iii) that the item or service for  
17 which the claim for payment is submitted  
18 was properly identified on the CMS–855S  
19 Medicare enrollment application.

20           “(B) ONLINE DATABASE FOR IMPLEMEN-  
21 TATION.—Not later than 18 months after the  
22 date of enactment of this paragraph, the Sec-  
23 retary shall establish an online database similar  
24 to that used for the National Provider Identifier  
25 to enable providers of services, accreditors, car-



1 riers, and the National Supplier Clearinghouse  
2 to view information on specialties and the types  
3 of items and services each supplier has indi-  
4 cated on the CMS–855S Medicare enrollment  
5 application submitted by the supplier.

6 “(C) NOTIFICATION OF CLAIM DENIAL  
7 AND RESUBMISSION.—In the case where a claim  
8 for payment for durable medical equipment,  
9 prosthetics, orthotics, and supplies under this  
10 title is denied because the item or service fur-  
11 nished does not correctly match up with the in-  
12 formation on file with the National Supplier  
13 Clearinghouse—

14 “(i) the National Supplier Clearing-  
15 house shall—

16 “(I) provide the supplier written  
17 notification of the reason for such de-  
18 nial; and

19 “(II) allow the supplier 60 days  
20 to provide the National Supplier  
21 Clearinghouse with appropriate certifi-  
22 cation, licensing, or accreditation; and

23 “(ii) the Secretary shall waive applica-  
24 ble requirements relating to the time frame  
25 for the submission of claims for payment

1 under this title in order to permit the re-  
2 submission of such claim if payment of  
3 such claim would otherwise be allowed  
4 under this title.

5 “(D) IMPROVEMENTS TO MEDICARE EN-  
6 ROLLMENT APPLICATION.—The Secretary shall  
7 establish procedures under which a prospective  
8 supplier of durable medical equipment, pros-  
9 thetics, orthotics, and supplies under this title  
10 shall certify, as part of the CMS–855S Medi-  
11 care enrollment application submitted by such  
12 supplier, under penalty of perjury, that the in-  
13 formation provided by the supplier on such ap-  
14 plication is accurate to the best of the supplier’s  
15 knowledge.

16 “(23) TERMINATION OF PARTICIPATION FOR  
17 SUBMISSION OF FRAUDULENT CLAIMS.—If the Sec-  
18 retary finds that a supplier of durable medical  
19 equipment, prosthetics, orthotics, and supplies under  
20 this title has submitted fraudulent claims for pay-  
21 ment under this title, the Secretary shall terminate  
22 the suppliers participation under this title. Not later  
23 than 1 year after the date of enactment of this para-  
24 graph, the Secretary shall establish a process under  
25 which a supplier whose participation has been termi-

1 nated under the preceding sentence may appeal such  
2 termination and such appeal shall be resolved not  
3 later than 60 days after the date on which the ap-  
4 peal was made.”.

5 (b) EXEMPTION OF PHARMACISTS FROM SURETY  
6 BOND REQUIREMENT.—Section 1834(a)(16) of the Social  
7 Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the  
8 second sentence, by inserting “and shall waive such re-  
9 quirement in the case of a pharmacist” before the period  
10 at the end.

11 **SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS OF**  
12 **SURETY BOND REQUIREMENTS FOR SUP-**  
13 **PLIERS OF DURABLE MEDICAL EQUIPMENT**  
14 **IN COMBATING FRAUD.**

15 (a) STUDY.—The Comptroller General of the United  
16 States shall conduct a study on the effectiveness of the  
17 surety bond requirement under section 1834(a)(16) of the  
18 Social Security Act (42 U.S.C. 1395m(a)(16)) in com-  
19 bating fraud.

20 (b) REPORT.—Not later than 1 year after the date  
21 of enactment of this Act, the Comptroller General shall  
22 submit to Congress a report containing the results of the  
23 study conducted under subsection (a), together with rec-  
24 ommendations for such legislation and administrative ac-  
25 tion as the Comptroller General determines appropriate.

1           **TITLE VI—ENDING LAWSUIT**  
2                                   **ABUSE**

3   **SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLU-**  
4                                   **TIONS.**

5           Part P of title III of the Public Health Service Act  
6 (42 U.S.C. 280g et seq.) is amended by adding at the end  
7 the following:

8   **“SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SO-**  
9                                   **LUTIONS.**

10           “(a) **IN GENERAL.**—The Secretary may award grants  
11 to States for the development, implementation, and eval-  
12 uation of alternatives to current tort litigation that comply  
13 with this section, for the resolution of disputes concerning  
14 injuries allegedly caused by health care providers or health  
15 care organizations.

16           “(b) **CONDITIONS FOR DEMONSTRATION GRANTS.**—

17                   “(1) **APPLICATION.**—To be eligible to receive a  
18 grant under this section, a State shall submit to the  
19 Secretary an application at such time, in such man-  
20 ner, and containing such information as may be re-  
21 quired by the Secretary. A grant shall be awarded  
22 under this section on such terms and conditions as  
23 the Secretary determines appropriate.

24                   “(2) **STATE REQUIREMENTS.**—To be eligible to  
25 receive a grant under this section, a State shall—

1           “(A) develop and implement an alternative  
2           to current tort litigation for resolving disputes  
3           over injuries allegedly caused by health care  
4           providers or health care organizations based on  
5           one or more of the models described in sub-  
6           section (d); and

7           “(B) implement policies that provide for a  
8           reduction in health care errors through the col-  
9           lection and analysis by organizations that en-  
10          gage in voluntary efforts to improve patient  
11          safety and the quality of health care delivery, of  
12          patient safety data related to disputes resolved  
13          under the alternatives under subparagraph (A).

14          “(3) DEMONSTRATION OF EFFECTIVENESS.—  
15          To be eligible to receive a grant under subsection  
16          (a), a State shall demonstrate how the proposed al-  
17          ternative to be implemented under paragraph (2)(A)  
18          will—

19                 “(A) make the medical liability system of  
20                 the State more reliable through the prompt and  
21                 fair resolution of disputes;

22                 “(B) encourage the early disclosure of  
23                 health care errors;

24                 “(C) enhance patient safety; and

1           “(D) maintain access to medical liability  
2 insurance.

3           “(4) SOURCES OF COMPENSATION.—To be eligi-  
4 ble to receive a grant under subsection (a), a State  
5 shall identify the sources from, and methods by  
6 which, compensation would be paid for medical li-  
7 ability claims resolved under the proposed alter-  
8 native to current tort litigation implemented under  
9 paragraph (2)(A). Funding methods shall, to the ex-  
10 tent practicable, provide financial incentives for ac-  
11 tivities that improve patient safety.

12           “(5) SCOPE.—

13           “(A) IN GENERAL.—To be eligible to re-  
14 ceive a grant under subsection (a), a State shall  
15 utilize the proposed alternative identified under  
16 paragraph (2)(A) for the resolution of all types  
17 of disputes concerning injuries allegedly caused  
18 by health care providers or health care organi-  
19 zations.

20           “(B) CURRENT STATE EFFORTS TO ESTAB-  
21 LISH ALTERNATIVE TO TORT LITIGATION.—

22           “(i) IN GENERAL.—Nothing in this  
23 section shall be construed to limit the ef-  
24 forts that any State has made prior to the

1 date of enactment of this section to estab-  
2 lish any alternative to tort litigation.

3 “(ii) ALTERNATIVE FOR PRACTICE  
4 AREAS OR INJURIES.—In the case of a  
5 State that has established an alternative to  
6 tort litigation for a certain area of health  
7 care practice or a category of injuries, the  
8 alternative selected as provided for in this  
9 section shall supplement not replace or in-  
10 validate such established alternative unless  
11 the State intends otherwise.

12 “(6) NOTIFICATION OF PATIENTS.—To be eligi-  
13 ble to receive a grant under subsection (a), the State  
14 shall demonstrate how patients will be notified when  
15 they are receiving health care services that fall with-  
16 in the scope of the alternative selected under this  
17 section by the State to current tort litigation.

18 “(c) REPRESENTATION BY COUNSEL.—A State that  
19 receives a grant under this section may not preclude any  
20 party to a dispute that falls within the jurisdiction of the  
21 alternative to current tort litigation that is implemented  
22 under the grant from obtaining legal representation at any  
23 point during the consideration of the claim under such al-  
24 ternative.

25 “(d) MODELS.—

1           “(1) IN GENERAL.—The models in this section  
2 are the following:

3           “(2) EXPERT PANEL REVIEW AND EARLY  
4 OFFER GUIDELINES.—

5           “(A) IN GENERAL.—A State may use  
6 amounts received under a grant under this sec-  
7 tion to develop and implement an expert panel  
8 and early offer review system that meets the re-  
9 quirements of this paragraph.

10           “(B) ESTABLISHMENT OF PANEL.—Under  
11 the system under this paragraph, the State  
12 shall establish an expert panel to review any  
13 disputes concerning injuries allegedly caused by  
14 health care providers or health care organiza-  
15 tions according to the guidelines described in  
16 this paragraph.

17           “(C) COMPOSITION.—

18           “(i) IN GENERAL.—An expert panel  
19 under this paragraph shall be composed of  
20 3 medical experts (either physicians or  
21 health care professionals) and 3 attorneys  
22 to be appointed by the head of the State  
23 agency responsible for health.

24           “(ii) LICENSURE AND EXPERTISE.—  
25 Each physician or health care professional



1 appointed to an expert panel under clause  
2 (i) shall—

3 “(I) be appropriately credentialed  
4 or licensed in the State in which the  
5 dispute takes place to deliver health  
6 care services; and

7 “(II) typically treat the condi-  
8 tion, make the diagnosis, or provide  
9 the type of treatment that is under re-  
10 view.

11 “(iii) INDEPENDENCE.—

12 “(I) IN GENERAL.—Subject to  
13 subclause (II), each individual ap-  
14 pointed to an expert panel under this  
15 paragraph shall—

16 “(aa) not have a material  
17 familial, financial, or professional  
18 relationship with a party involved  
19 in the dispute reviewed by the  
20 panel; and

21 “(bb) not otherwise have a  
22 conflict of interest with such a  
23 party.

24 “(II) EXCEPTION.—Nothing in  
25 subclause (I) shall be construed to

1 prohibit an individual who has staff  
2 privileges at an institution where the  
3 treatment involved in the dispute was  
4 provided from serving as a member of  
5 an expert panel merely on the basis of  
6 such affiliation, if the affiliation is  
7 disclosed to the parties and neither  
8 party objects.

9 “(iv) PRACTICING HEALTH CARE PRO-  
10 FESSIONAL IN SAME FIELD.—

11 “(I) IN GENERAL.—In a dispute  
12 before an expert panel that involves  
13 treatment, or the provision of items or  
14 services—

15 “(aa) by a physician, the  
16 medical experts on the expert  
17 panel shall be practicing physi-  
18 cians (allopathic or osteopathic)  
19 of the same or similar specialty  
20 as a physician who typically  
21 treats the condition, makes the  
22 diagnosis, or provides the type of  
23 treatment under review; or

24 “(bb) by a health care pro-  
25 fessional other than a physician,

1 at least two medical experts on  
2 the expert panel shall be prac-  
3 ticing physicians (allopathic or  
4 osteopathic) of the same or simi-  
5 lar specialty as the health care  
6 professional who typically treats  
7 the condition, makes the diag-  
8 nosis, or provides the type of  
9 treatment under review, and, if  
10 determined appropriate by the  
11 State agency, the third medical  
12 expert shall be a practicing  
13 health care professional (other  
14 than such a physician) of such a  
15 same or similar specialty.

16 “(II) PRACTICING DEFINED.—In  
17 this paragraph, the term ‘practicing’  
18 means, with respect to an individual  
19 who is a physician or other health  
20 care professional, that the individual  
21 provides health care services to indi-  
22 vidual patients on average at least 2  
23 days a week.

24 “(V) PEDIATRIC EXPERTISE.—In the  
25 case of dispute relating to a child, at least

1           1 medical expert on the expert panel shall  
2           have expertise described in clause (iv)(I) in  
3           pediatrics.

4           “(D) DETERMINATION.—After a review,  
5           an expert panel shall make a determination as  
6           to the liability of the parties involved and com-  
7           pensation based on a schedule of compensation  
8           that is developed by the panel. Such a schedule  
9           shall at least include—

10                   “(i) payment for the net economic loss  
11                   incurred by the patient, on a periodic  
12                   basis, reduced by any payments received by  
13                   the patient under—

14                           “(I) any health or accident insur-  
15                           ance;

16                           “(II) any wage or salary continu-  
17                           ation plan; or

18                           “(III) any disability income in-  
19                           surance;

20                   “(ii) payment for the non-economic  
21                   damages incurred by the patient, if appro-  
22                   priate for the injury, based on a defined  
23                   payment schedule developed by the State,  
24                   in consultation with relevant experts and  
25                   with the Secretary;

1 “(iii) reasonable attorney’s fees; and

2 “(iv) regular updates of the schedule  
3 under clause (ii) as necessary.

4 “(E) ACCEPTANCE.—If the parties to a  
5 dispute who come before an expert panel under  
6 this paragraph accept the determination of the  
7 expert panel concerning liability and compensa-  
8 tion, such compensation shall be paid to the  
9 claimant and the claimant shall agree to forgo  
10 any further action against the health care pro-  
11 viders or health care organizations involved.

12 “(F) FAILURE TO ACCEPT.—If any party  
13 decides not to accept the expert panel’s deter-  
14 mination under this paragraph, the State may  
15 choose whether to allow the panel to review the  
16 determination de novo, with deference, or to  
17 provide an opportunity for parties to reject the  
18 determination of the panel.

19 “(G) REVIEW BY STATE COURT AFTER EX-  
20 HAUSTION OF ADMINISTRATIVE REMEDIES.—

21 “(i) RIGHT TO FILE.—If the State  
22 elects not to permit the expert panel under  
23 this paragraph to conduct its own reviews  
24 of determinations, or if the State elects to  
25 permit such reviews but a party is not sat-

1 isfied with the final decision of the panel  
2 after such a review, the party shall have  
3 the right to file a claim relating to the in-  
4 jury involved in a State court of competent  
5 jurisdiction.

6 “(ii) FORFEIT OF AWARDS.—Any  
7 party filing an action in a State court  
8 under clause (i) shall forfeit any compensa-  
9 tion award made under subparagraph (C).

10 “(iii) ADMISSIBILITY.—The deter-  
11 minations of the expert panel pursuant to  
12 a review under subparagraph (C) shall be  
13 admissible into evidence in any State court  
14 proceeding under this subparagraph.

15 “(3) ADMINISTRATIVE HEALTH CARE TRIBU-  
16 NALS.—

17 “(A) IN GENERAL.—A State may use  
18 amounts received under a grant under this sec-  
19 tion to develop and implement an administra-  
20 tive health care tribunal system under which  
21 the parties involved shall have the right to re-  
22 quest a hearing to review any dispute con-  
23 cerning injuries allegedly caused by health care  
24 providers or health care organizations before an

1 administrative health care tribunal established  
2 by the State involved.

3 “(B) REQUIREMENTS.—In establishing an  
4 administrative health care tribunal under this  
5 paragraph, a State shall—

6 “(i) ensure that such tribunals are  
7 presided over by special judges with health  
8 care expertise who meet applicable State  
9 standards for judges and who agree to pre-  
10 side over such court voluntarily;

11 “(ii) provide authority to such judges  
12 to make binding rulings, rendered in writ-  
13 ten decisions, on standards of care, causa-  
14 tion, compensation, and related issues with  
15 reliance on independent expert witnesses  
16 commissioned by the tribunal;

17 “(iii) establish a legal standard for  
18 the tribunal that shall be the same as the  
19 standard that would apply in the State  
20 court of competent jurisdiction which  
21 would otherwise handle the claim; and

22 “(iv) provide for an appeals process to  
23 allow for review of decisions by State  
24 courts.

1           “(C) DETERMINATION.—After a tribunal  
2           conducts a review under this paragraph, the tri-  
3           bunal shall make a determination as to the li-  
4           ability of the parties involved and the amount  
5           of compensation that should be paid based on  
6           a schedule of compensation developed by the  
7           tribunal. Such a schedule shall at a minimum  
8           include—

9                   “(i) payment for the net economic loss  
10                  incurred by the patient, on a periodic  
11                  basis, reduced by any payments received by  
12                  the patient under—

13                           “(I) any health or accident insur-  
14                           ance;

15                           “(II) any wage or salary continu-  
16                           ation plan; or

17                           “(III) any disability income in-  
18                           surance;

19                   “(ii) payment for the non-economic  
20                  damages incurred by the patient, if appro-  
21                  priate for the injury, based on a defined  
22                  payment schedule developed by the State  
23                  in consultation with relevant experts and  
24                  with the Secretary;

25                   “(iii) reasonable attorney’s fees; and



1           “(iv) regular updates of the schedule  
2           under clause (ii) as necessary.

3           “(D) REVIEW BY STATE COURT AFTER EX-  
4           HAUSTION OF ADMINISTRATIVE REMEDIES.—

5           “(i) RIGHT TO FILE.—Nothing in this  
6           paragraph shall be construed to prohibit  
7           any individual who is not satisfied with the  
8           determinations of a tribunal under this  
9           paragraph, from filing a claim for the in-  
10          jury involved in a State court of competent  
11          jurisdiction.

12          “(ii) FORFEIT OF AWARD.—Any party  
13          filing an action in a State court under  
14          clause (i) shall forfeit any compensation  
15          award made under subparagraph (C).

16          “(iii) ADMISSIBILITY.—The deter-  
17          minations of the tribunal under subpara-  
18          graph (C) shall be admissible into evidence  
19          in any State court proceeding under this  
20          subparagraph.

21          “(4) EXPERT PANEL REVIEW AND ADMINISTRA-  
22          TIVE HEALTH CARE TRIBUNAL COMBINATION  
23          MODEL.—

24          “(A) IN GENERAL.—A State may use  
25          amounts received under a grant under this sec-

1           tion to develop and implement an expert panel  
2           review and administrative health care tribunal  
3           combination system to review any dispute con-  
4           cerning injuries allegedly caused by health care  
5           providers or health care organizations. Under  
6           such system, a dispute concerning injuries al-  
7           legedly caused by health care providers or  
8           health care organizations shall proceed through  
9           the procedures described in this subparagraph  
10          prior to the submission of such dispute to a  
11          State court.

12                   “(B) GENERAL PROCEDURE.—

13                           “(i) ESTABLISHMENT OF EXPERT  
14                           PANEL.—Prior to submitting any dispute  
15                           described in subparagraph (A) to an ad-  
16                           ministrative health care tribunal under the  
17                           system established under this paragraph,  
18                           the State shall establish an expert panel  
19                           (in accordance with subparagraph (C)) to  
20                           review the allegations involved in such dis-  
21                           pute.

22                           “(ii) REFERRAL TO TRIBUNAL.—If ei-  
23                           ther party to a dispute described in clause  
24                           (i) fails to accept the determination of the  
25                           expert panel, the dispute shall then be re-

1           ferred to an administrative health care tri-  
2           bunal (in accordance with subparagraph  
3           (D)).

4           “(C) EXPERT REVIEW PANEL.—

5                 “(i) IN GENERAL.—The provisions of  
6           paragraph (2) shall apply with respect to  
7           the establishment and operation of an ex-  
8           pert review panel under this subparagraph,  
9           except that the subparagraphs (F) and (G)  
10          of such paragraph shall not apply.

11                 “(ii) FAILURE TO ACCEPT DETER-  
12          MINATION OF PANEL.—If any party to a  
13          dispute before an expert panel under this  
14          subparagraph refuses to accept the panel’s  
15          determination, the dispute shall be referred  
16          to an administrative health care tribunal  
17          under subparagraph (D).

18           “(D) ADMINISTRATIVE HEALTH CARE TRI-  
19          BUNALS.—

20                 “(i) IN GENERAL.—Upon the failure  
21          of any party to accept the determination of  
22          an expert panel under subparagraph (C),  
23          the parties shall request a hearing con-  
24          cerning the liability or compensation in-  
25          volved by an administrative health care tri-

1           bunal established by the State involved  
2           under this subparagraph.

3           “(ii) REQUIREMENTS.—The provisions  
4           of paragraph (3) shall apply with respect  
5           to the establishment and operation of an  
6           administrative health care tribunal under  
7           this subparagraph.

8           “(iii) FORFEIT OF AWARDS.—Any  
9           party proceeding to the second step-admin-  
10          istrative health care tribunal-under this  
11          model shall forfeit any compensation  
12          awarded by the expert panel.

13          “(iv) ADMISSIBILITY.—The deter-  
14          minations of the expert panel under sub-  
15          paragraph (C) shall be admissible into evi-  
16          dence in any administrative health care tri-  
17          bunal proceeding under this subparagraph.

18          “(E) RIGHT TO FILE.—Nothing in this  
19          paragraph shall be construed to prohibit any in-  
20          dividual who is not satisfied with the deter-  
21          mination of the tribunal (after having proceeded  
22          through both the expert panel under subpara-  
23          graph (C) and the tribunal under subparagraph  
24          (D)) from filing a claim for the injury involved  
25          in a State court of competent jurisdiction.

1           “(F) ADMISSIBILITY.—The determinations  
2           of both the expert panel and the tribunal under  
3           this paragraph shall be admissible into evidence  
4           in any State court proceeding under this para-  
5           graph.

6           “(G) FORFEIT OF AWARDS.—Any party fil-  
7           ing an action in State court under subpara-  
8           graph (E) shall forfeit any compensation award  
9           made by both the expert panel and the adminis-  
10          trative health care tribunal under this para-  
11          graph.

12          “(e) DEFINITIONS.—In this section:

13           “(1) CURRENT TORT LITIGATION.—The term  
14           ‘current tort litigation’ means the tort litigation sys-  
15           tem existing in the State on the date on which the  
16           State submits an application under subsection  
17           (b)(1), for the resolution of disputes concerning inju-  
18           ries allegedly caused by health care providers or  
19           health care organizations.

20           “(2) HEALTH CARE ORGANIZATION.—The term  
21           ‘health care organization’ means any individual or  
22           entity that is obligated to provide, pay for, or admin-  
23           ister health benefits under any health plan.

24           “(3) NET ECONOMIC LOSS.—The term ‘net eco-  
25           nomic loss’ means—

1           “(A) reasonable expenses incurred for  
2 products, services and accommodations needed  
3 for health care, training and other remedial  
4 treatment and care of an injured individual;

5           “(B) reasonable and appropriate expenses  
6 for rehabilitation treatment and occupational  
7 training;

8           “(C) 100 percent of the loss of income  
9 from work that an injured individual would  
10 have performed if not injured, reduced by any  
11 income from substitute work actually per-  
12 formed; and

13           “(D) reasonable expenses incurred in ob-  
14 taining ordinary and necessary services to re-  
15 place services an injured individual would have  
16 performed for the benefit of the individual or  
17 the family of such individual if the individual  
18 had not been injured.

19           “(4) NON-ECONOMIC DAMAGES.—The term  
20 ‘non-economic damages’ means losses for physical  
21 and emotional pain, suffering, inconvenience, phys-  
22 ical impairment, mental anguish, disfigurement, loss  
23 of enjoyment of life, loss of society and compan-  
24 ship, loss of consortium (other than loss of domestic  
25 service), injury to reputation, and all other non-pe-

1 cuniary losses of any kind or nature, to the extent  
2 permitted under State law.

3 “(f) FUNDING.—

4 “(1) ONE-TIME INCREASE IN MEDICAID PAY-  
5 MENT.—In the case of a State awarded a grant to  
6 carry out this section, the total amount of the Fed-  
7 eral payment determined for the State under section  
8 1913 of the Social Security Act (as amended by sec-  
9 tion 401) for fiscal year 2011 (in addition to the any  
10 increase applicable for that fiscal year under section  
11 203(b) but determined without regard to any such  
12 increase) shall be increased by an amount equal to  
13 1 percent of the total amount of payments made to  
14 the State for fiscal year 2010 under section 1903(a)  
15 of the Social Security Act (42 U.S.C. 1396b(a)) for  
16 purposes of carrying out a grant awarded under this  
17 section. Amounts paid to a State pursuant to this  
18 subsection shall remain available until expended.

19 “(2) AUTHORIZATION OF APPROPRIATIONS.—

20 There are authorized to be appropriated for any fis-  
21 cal year such sums as may be necessary for purposes  
22 of making payments to States pursuant to para-  
23 graph (1).”.

1 **TITLE VII—PROMOTING HEALTH**  
2 **INFORMATION TECHNOLOGY**  
3 **Subtitle A—Assisting the Develop-**  
4 **ment of Health Information**  
5 **Technology**

6 **SEC. 701. PURPOSE.**

7 It is the purpose of this subtitle to promote the utili-  
8 zation of health record banking by improving the coordina-  
9 tion of health information through an infrastructure for  
10 the secure and authorized exchange and use of healthcare  
11 information.

12 **SEC. 702. HEALTH RECORD BANKING.**

13 (a) **ESTABLISHMENT.**—Not later than 1 year after  
14 the date of enactment of this Act, the Secretary of Health  
15 and Human Services shall promulgate regulations to pro-  
16 vide for the certification and auditing of the banking of  
17 electronic medical records.

18 (b) **GENERAL RIGHTS.**—An individual who has a  
19 health record contained in a health record bank shall  
20 maintain ownership over the health record and shall have  
21 the right to review the contents of the record.

22 **SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY**  
23 **AND CONFIDENTIALITY STANDARDS.**

24 (a) **IN GENERAL.**—Current Federal security and con-  
25 fidentiality standards and State security and confiden-



1 tiality laws shall apply to this subtitle until such time as  
2 Congress acts to amend such standards.

3 (b) DEFINITIONS.—In this section:

4 (1) CURRENT FEDERAL SECURITY AND CON-  
5 FIDENTIALITY STANDARDS.—The term “current  
6 Federal security and confidentiality standards”  
7 means the Federal privacy standards established  
8 pursuant to section 264(c) of the Health Insurance  
9 Portability and Accountability Act of 1996 (42  
10 U.S.C. 1320d–2 note) and security standards estab-  
11 lished under section 1173(d) of the Social Security  
12 Act (42 U.S.C. 1320d–2(d)).

13 (2) STATE SECURITY AND CONFIDENTIALITY  
14 LAWS.—The term “State security and confidentiality  
15 laws” means State laws and regulations relating to  
16 the privacy and confidentiality of individually identi-  
17 fiable health information or to the security of such  
18 information.

19 (3) STATE.—The term “State” has the mean-  
20 ing given such term for purposes of title XI of the  
21 Social Security Act, as provided under section  
22 1101(a) of such Act (42 U.S.C. 1301(a)).

1 **Subtitle B—Removing Barriers to**  
2 **the Use of Health Information**  
3 **Technology to Better Coordi-**  
4 **nate Health Care**

5 **SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**  
6 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**  
7 **VISION OF HEALTH INFORMATION TECH-**  
8 **NOLOGY AND TRAINING SERVICES.**

9 (a) FOR CIVIL PENALTIES.—Section 1128A of the  
10 Social Security Act (42 U.S.C. 1320a–7a) is amended—

11 (1) in subsection (b), by adding at the end the  
12 following new paragraph:

13 “(4) For purposes of this subsection, inducements to  
14 reduce or limit services described in paragraph (1) shall  
15 not include the practical or other advantages resulting  
16 from health information technology or related installation,  
17 maintenance, support, or training services.”; and

18 (2) in subsection (i), by adding at the end the  
19 following new paragraph:

20 “(8) The term ‘health information technology’  
21 means hardware, software, license, right, intellectual  
22 property, equipment, or other information tech-  
23 nology (including new versions, upgrades, and  
24 connectivity) designed or provided primarily for the  
25 electronic creation, maintenance, or exchange of

1 health information to better coordinate care or im-  
2 prove health care quality, efficiency, or research.”.

3 (b) FOR CRIMINAL PENALTIES.—Section 1128B of  
4 such Act (42 U.S.C. 1320a–7b) is amended—

5 (1) in subsection (b)(3)—

6 (A) in subparagraph (G), by striking  
7 “and” at the end;

8 (B) in the subparagraph (H) added by sec-  
9 tion 237(d) of the Medicare Prescription Drug,  
10 Improvement, and Modernization Act of 2003  
11 (Public Law 108–173; 117 Stat. 2213)—

12 (i) by moving such subparagraph 2  
13 ems to the left; and

14 (ii) by striking the period at the end  
15 and inserting a semicolon;

16 (C) in the subparagraph (H) added by sec-  
17 tion 431(a) of such Act (117 Stat. 2287)—

18 (i) by redesignating such subpara-  
19 graph as subparagraph (I);

20 (ii) by moving such subparagraph 2  
21 ems to the left; and

22 (iii) by striking the period at the end  
23 and inserting “; and”; and

24 (D) by adding at the end the following new  
25 subparagraph:

1           “(J) any nonmonetary remuneration (in the  
2 form of health information technology, as defined in  
3 section 1128A(i)(8), or related installation, mainte-  
4 nance, support or training services) made to a per-  
5 son by a specified entity (as defined in subsection  
6 (g)) if—

7           “(i) the provision of such remuneration is  
8 without an agreement between the parties or  
9 legal condition that—

10           “(I) limits or restricts the use of the  
11 health information technology to services  
12 provided by the physician to individuals re-  
13 ceiving services at the specified entity;

14           “(II) limits or restricts the use of the  
15 health information technology in conjunc-  
16 tion with other health information tech-  
17 nology; or

18           “(III) conditions the provision of such  
19 remuneration on the referral of patients or  
20 business to the specified entity;

21           “(ii) such remuneration is arranged for in  
22 a written agreement that is signed by the par-  
23 ties involved (or their representatives) and that  
24 specifies the remuneration solicited or received  
25 (or offered or paid) and states that the provi-

1           sion of such remuneration is made for the pri-  
2           mary purpose of better coordination of care or  
3           improvement of health quality, efficiency, or re-  
4           search; and

5           “(iii) the specified entity providing the re-  
6           muneration (or a representative of such entity)  
7           has not taken any action to disable any basic  
8           feature of any hardware or software component  
9           of such remuneration that would permit inter-  
10          operability.”; and

11          (2) by adding at the end the following new sub-  
12          section:

13          “(g) SPECIFIED ENTITY DEFINED.—For purposes of  
14          subsection (b)(3)(J), the term ‘specified entity’ means an  
15          entity that is a hospital, group practice, prescription drug  
16          plan sponsor, a Medicare Advantage organization, or any  
17          other such entity specified by the Secretary, considering  
18          the goals and objectives of this section, as well as the goals  
19          to better coordinate the delivery of health care and to pro-  
20          mote the adoption and use of health information tech-  
21          nology.”.

22          (c) EFFECTIVE DATE AND EFFECT ON STATE  
23          LAWS.—

24          (1) EFFECTIVE DATE.—The amendments made  
25          by subsections (a) and (b) shall take effect on the

1 date that is 120 days after the date of the enact-  
2 ment of this Act.

3 (2) PREEMPTION OF STATE LAWS.—No State  
4 (as defined in section 1101(a) of the Social Security  
5 Act (42 U.S.C. 1301(a)) for purposes of title XI of  
6 such Act) shall have in effect a State law that im-  
7 poses a criminal or civil penalty for a transaction de-  
8 scribed in section 1128A(b)(4) or section  
9 1128B(b)(3)(J) of such Act, as added by subsections  
10 (a)(1) and (b), respectively, if the conditions de-  
11 scribed in the respective provision, with respect to  
12 such transaction, are met.

13 (d) STUDY AND REPORT TO ASSESS EFFECT OF  
14 SAFE HARBORS ON HEALTH SYSTEM.—

15 (1) IN GENERAL.—The Secretary of Health and  
16 Human Services shall conduct a study to determine  
17 the impact of each of the safe harbors described in  
18 paragraph (3). In particular, the study shall examine  
19 the following:

20 (A) The effectiveness of each safe harbor  
21 in increasing the adoption of health information  
22 technology.

23 (B) The types of health information tech-  
24 nology provided under each safe harbor.

1           (C) The extent to which the financial or  
2 other business relationships between providers  
3 under each safe harbor have changed as a re-  
4 sult of the safe harbor in a way that adversely  
5 affects or benefits the health care system or  
6 choices available to consumers.

7           (D) The impact of the adoption of health  
8 information technology on health care quality,  
9 cost, and access under each safe harbor.

10          (2) REPORT.—Not later than 3 years after the  
11 effective date described in subsection (c)(1), the Sec-  
12 retary of Health and Human Services shall submit  
13 to Congress a report on the study under paragraph  
14 (1).

15          (3) SAFE HARBORS DESCRIBED.—For purposes  
16 of paragraphs (1) and (2), the safe harbors de-  
17 scribed in this paragraph are—

18           (A) the safe harbor under section  
19 1128A(b)(4) of such Act (42 U.S.C. 1320a-  
20 7a(b)(4)), as added by subsection (a)(1); and

21           (B) the safe harbor under section  
22 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-  
23 7b(b)(3)(J)), as added by subsection (b).

1 **SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**  
2 **CIAN REFERRALS (UNDER STARK) FOR PRO-**  
3 **VISION OF HEALTH INFORMATION TECH-**  
4 **NOLOGY AND TRAINING SERVICES TO**  
5 **HEALTH CARE PROFESSIONALS.**

6 (a) IN GENERAL.—Section 1877(b) of the Social Se-  
7 curity Act (42 U.S.C. 1395nn(b)) is amended by adding  
8 at the end the following new paragraph:

9 “(6) INFORMATION TECHNOLOGY AND TRAIN-  
10 ING SERVICES.—

11 “(A) IN GENERAL.—Any nonmonetary re-  
12 munerated (in the form of health information  
13 technology or related installation, maintenance,  
14 support or training services) made by a speci-  
15 fied entity to a physician if—

16 “(i) the provision of such remunera-  
17 tion is without an agreement between the  
18 parties or legal condition that—

19 “(I) limits or restricts the use of  
20 the health information technology to  
21 services provided by the physician to  
22 individuals receiving services at the  
23 specified entity;

24 “(II) limits or restricts the use of  
25 the health information technology in



1 conjunction with other health informa-  
2 tion technology; or

3 “(III) conditions the provision of  
4 such remuneration on the referral of  
5 patients or business to the specified  
6 entity;

7 “(ii) such remuneration is arranged  
8 for in a written agreement that is signed  
9 by the parties involved (or their represent-  
10 atives) and that specifies the remuneration  
11 made and states that the provision of such  
12 remuneration is made for the primary pur-  
13 pose of better coordination of care or im-  
14 provement of health quality, efficiency, or  
15 research; and

16 “(iii) the specified entity (or a rep-  
17 resentative of such entity) has not taken  
18 any action to disable any basic feature of  
19 any hardware or software component of  
20 such remuneration that would permit  
21 interoperability.

22 “(B) HEALTH INFORMATION TECHNOLOGY  
23 DEFINED.—For purposes of this paragraph, the  
24 term ‘health information technology’ means  
25 hardware, software, license, right, intellectual

1 property, equipment, or other information tech-  
2 nology (including new versions, upgrades, and  
3 connectivity) designed or provided primarily for  
4 the electronic creation, maintenance, or ex-  
5 change of health information to better coordi-  
6 nate care or improve health care quality, effi-  
7 ciency, or research.

8 “(C) SPECIFIED ENTITY DEFINED.—For  
9 purposes of this paragraph, the term ‘specified  
10 entity’ means an entity that is a hospital, group  
11 practice, prescription drug plan sponsor, a  
12 Medicare Advantage organization, or any other  
13 such entity specified by the Secretary, consid-  
14 ering the goals and objectives of this section, as  
15 well as the goals to better coordinate the deliv-  
16 ery of health care and to promote the adoption  
17 and use of health information technology.”.

18 (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

19 (1) EFFECTIVE DATE.—The amendment made  
20 by subsection (a) shall take effect on the date that  
21 is 120 days after the date of the enactment of this  
22 Act.

23 (2) PREEMPTION OF STATE LAWS.—No State  
24 (as defined in section 1101(a) of the Social Security  
25 Act (42 U.S.C. 1301(a)) for purposes of title XI of

1 such Act) shall have in effect a State law that im-  
2 poses a criminal or civil penalty for a transaction de-  
3 scribed in section 1877(b)(6) of such Act, as added  
4 by subsection (a), if the conditions described in such  
5 section, with respect to such transaction, are met.

6 (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-  
7 CEPTION ON HEALTH SYSTEM.—

8 (1) IN GENERAL.—The Secretary of Health and  
9 Human Services shall conduct a study to determine  
10 the impact of the exception under section 1877(b)(6)  
11 of such Act (42 U.S.C. 1395m(b)(6)), as added by  
12 subsection (a). In particular, the study shall examine  
13 the following:

14 (A) The effectiveness of the exception in  
15 increasing the adoption of health information  
16 technology.

17 (B) The types of health information tech-  
18 nology provided under the exception.

19 (C) The extent to which the financial or  
20 other business relationships between providers  
21 under the exception have changed as a result of  
22 the exception in a way that adversely affects or  
23 benefits the health care system or choices avail-  
24 able to consumers.

1 (D) The impact of the adoption of health  
2 information technology on health care quality,  
3 cost, and access under the exception.

4 (2) REPORT.—Not later than 3 years after the  
5 effective date described in subsection (b)(1), the Sec-  
6 retary of Health and Human Services shall submit  
7 to Congress a report on the study under paragraph  
8 (1).

9 **SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF**  
10 **CONSORTIA.**

11 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL  
12 PENALTIES.—Section 1128B(b)(3) of the Social Security  
13 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding  
14 after and below subparagraph (J), as added by section  
15 711(b)(1), the following: “For purposes of subparagraph  
16 (J), nothing in such subparagraph shall be construed as  
17 preventing a specified entity, consistent with the specific  
18 requirements of such subparagraph, from forming a con-  
19 sortium composed of health care providers, payers, em-  
20 ployers, and other interested entities to collectively pur-  
21 chase and donate health information technology, or from  
22 offering health care providers a choice of health informa-  
23 tion technology products in order to take into account the  
24 varying needs of such providers receiving such products.”.

1 (b) APPLICATION TO STARK EXCEPTION.—Para-  
2 graph (6) of section 1877(b) of the Social Security Act  
3 (42 U.S.C. 1395m(b)), as added by section 712(a), is  
4 amended by adding at the end the following new subpara-  
5 graph:

6 “(D) RULE OF CONSTRUCTION.—For pur-  
7 poses of subparagraph (A), nothing in such  
8 subparagraph shall be construed as preventing  
9 a specified entity, consistent with the specific  
10 requirements of such subparagraph, from—

11 “(i) forming a consortium composed  
12 of health care providers, payers, employers,  
13 and other interested entities to collectively  
14 purchase and donate health information  
15 technology; or

16 “(ii) offering health care providers a  
17 choice of health information technology  
18 products in order to take into account the  
19 varying needs of such providers receiving  
20 such products.”.

1           **TITLE VIII—HEALTH CARE**  
2           **SERVICES COMMISSION**  
3           **Subtitle A—Establishment and**  
4           **General Duties**

5 **SEC. 801. ESTABLISHMENT.**

6           (a) IN GENERAL.—There is hereby established a  
7 Health Care Services Commission (in this title, referred  
8 to as the “Commission”) to be composed of 5 commis-  
9 sioners (in this title referred to as the “Commissioners”)  
10 to be appointed by the President by and with the advice  
11 and consent of the Senate. Not more than 3 of such Com-  
12 missioners shall be members of the same political party,  
13 and in making appointments members of different political  
14 parties shall be appointed alternately as nearly as may be  
15 practicable. No Commissioner shall engage in any other  
16 business, vocation, or employment than that of serving as  
17 Commissioner. Each Commissioner shall hold office for a  
18 term of 5 years and until a successor is appointed and  
19 has qualified, except that—

20           (1) such Commissioner shall not so continue to  
21           serve beyond the expiration of the next session of  
22           Congress subsequent to the expiration of said fixed  
23           term of office;

24           (2) any Commissioner appointed to fill a va-  
25           cancy occurring prior to the expiration of the term

1 for which a predecessor was appointed shall be ap-  
2 pointed for the remainder of such term; and

3 (3) the terms of office of the Commissioners  
4 first taking office after the date of the enactment of  
5 this Act shall expire as designated by the President  
6 at the time of nomination, 1 at the end of 1 year,  
7 1 at the end of 2 years, 1 at the end of 3 years, 1  
8 at the end of 4 years, and 1 at the end of 5 years,  
9 after the date of the enactment of this Act.

10 (b) PURPOSE.—The purpose of the Commission is to  
11 enhance the quality, appropriateness, and effectiveness of  
12 health care services, and access to such services, through  
13 the establishment of a broad base of scientific research  
14 and through the promotion of improvements in clinical  
15 practice and in the organization, financing, and delivery  
16 of health care services.

17 (c) APPOINTMENT OF CHAIRMAN.—The President  
18 shall, from among the Commissioners appointed under  
19 subsection (a), designate an individual to serve as the  
20 Chairman of the Commission.

21 **SEC. 802. GENERAL AUTHORITIES AND DUTIES.**

22 (a) IN GENERAL.—In carrying out section 801(b),  
23 the Commissioners shall conduct and support research,  
24 demonstration projects, evaluations, training, guideline de-  
25 velopment, and the dissemination of information, on

1 health care services and on systems for the delivery of  
2 such services, including activities with respect to—

3           (1) the effectiveness, efficiency, and quality of  
4 health care services;

5           (2) the outcomes of health care services and  
6 procedures;

7           (3) clinical practice, including primary care and  
8 practice-oriented research;

9           (4) health care technologies, facilities, and  
10 equipment;

11           (5) health care costs, productivity, and market  
12 forces;

13           (6) health promotion and disease prevention;

14           (7) health statistics and epidemiology; and

15           (8) medical liability.

16       (b) REQUIREMENTS WITH RESPECT TO RURAL  
17 AREAS AND UNDERSERVED POPULATIONS.—In carrying  
18 out subsection (a), the Commissioners shall undertake and  
19 support research, demonstration projects, and evaluations  
20 with respect to—

21           (1) the delivery of health care services in rural  
22 areas (including frontier areas); and

23           (2) the health of low-income groups, minority  
24 groups, and the elderly.



1 **SEC. 803. DISSEMINATION.**

2 (a) IN GENERAL.—The Commissioners shall—

3 (1) promptly publish, make available, and oth-  
4 erwise disseminate, in a form understandable and on  
5 as broad a basis as practicable so as to maximize its  
6 use, the results of research, demonstration projects,  
7 and evaluations conducted or supported under this  
8 title and the guidelines, standards, and review cri-  
9 teria developed under this title;

10 (2) promptly make available to the public data  
11 developed in such research, demonstration projects,  
12 and evaluations; and

13 (3) as appropriate, provide technical assistance  
14 to State and local government and health agencies  
15 and conduct liaison activities to such agencies to fos-  
16 ter dissemination.

17 (b) PROHIBITION AGAINST RESTRICTIONS.—Except  
18 as provided in subsection (c), the Commissioners may not  
19 restrict the publication or dissemination of data from, or  
20 the results of, projects conducted or supported under this  
21 title.

22 (c) LIMITATION ON USE OF CERTAIN INFORMA-  
23 TION.—No information, if an establishment or person sup-  
24 plying the information or described in it is identifiable,  
25 obtained in the course of activities undertaken or sup-  
26 ported under this title may be used for any purpose other

1 than the purpose for which it was supplied unless such  
 2 establishment or person has consented (as determined  
 3 under regulations of the Secretary) to its use for such  
 4 other purpose. Such information may not be published or  
 5 released in other form if the person who supplied the infor-  
 6 mation or who is described in it is identifiable unless such  
 7 person has consented (as determined under regulations of  
 8 the Secretary) to its publication or release in other form.

9 (d) CERTAIN INTERAGENCY AGREEMENT.—The  
 10 Commissioners and the Director of the National Library  
 11 of Medicine shall enter into an agreement providing for  
 12 the implementation of subsection (a)(1).

## 13 **Subtitle B—Forum for Quality and** 14 **Effectiveness in Health Care**

### 15 **SEC. 811. ESTABLISHMENT OF OFFICE.**

16 There is established within the Commission an office  
 17 to be known as the Office of the Forum for Quality and  
 18 Effectiveness in Health Care. The office shall be headed  
 19 by a director (referred to in this title as the “Director”)  
 20 who shall be appointed by the Commissioners.

### 21 **SEC. 812. MEMBERSHIP.**

22 (a) IN GENERAL.—The Office of the Forum for Qual-  
 23 ity and Effectiveness in Health Care shall be composed  
 24 of 15 individuals nominated by private sector health care

1 organizations and appointed by the Commission and shall  
2 include representation from at least the following:

3 (1) Health insurance industry.

4 (2) Health care provider groups.

5 (3) Non-profit organizations.

6 (4) Rural health organizations.

7 (b) TERMS.—

8 (1) IN GENERAL.—Except as provided in para-  
9 graph (2), members of the Office of the Forum for  
10 Quality and Effectiveness in Health Care shall serve  
11 for a term of 5 years.

12 (2) STAGGERED ROTATION.—Of the members  
13 first appointed to the Office of the Forum for Qual-  
14 ity and Effectiveness in Health Care, the Commis-  
15 sion shall appoint 5 members to serve for a term of  
16 2 years, 5 members to serve for a term of 3 years,  
17 and 5 members to serve for a term of 4 years.

18 (c) TREATMENT OF OTHER EMPLOYMENT.—Each  
19 member of the Office of the Forum for Quality and Effec-  
20 tiveness in Health Care shall serve the Office independ-  
21 ently from any other position of employment.

22 **SEC. 813. DUTIES.**

23 (a) ESTABLISHMENT OF FORUM PROGRAM.—The  
24 Commissioners, acting through the Director, shall estab-  
25 lish a program to be known as the Forum for Quality and

1 Effectiveness in Health Care. For the purpose of pro-  
2 moting transparency in price, quality, appropriateness,  
3 and effectiveness of health care, the Director, using the  
4 process set forth in section 814, shall arrange for the de-  
5 velopment and periodic review and updating of standards  
6 of quality, performance measures, and medical review cri-  
7 teria through which health care providers and other appro-  
8 priate entities may assess or review the provision of health  
9 care and assure the quality of such care.

10 (b) CERTAIN REQUIREMENTS.—Guidelines, stand-  
11 ards, performance measures, and review criteria under  
12 subsection (a) shall—

13 (1) be based on the best available research and  
14 professional judgment regarding the effectiveness  
15 and appropriateness of health care services and pro-  
16 cedures; and

17 (2) be presented in formats appropriate for use  
18 by physicians, health care practitioners, providers,  
19 medical educators, and medical review organizations  
20 and in formats appropriate for use by consumers of  
21 health care.

22 (c) AUTHORITY FOR CONTRACTS.—In carrying out  
23 this subtitle, the Director may enter into contracts with  
24 public or nonprofit private entities.

1 (d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—  
2 For each fiscal year beginning with 2010, the Director  
3 shall make publicly available the following:

4 (1) Quarterly reports for public comment that  
5 include proposed recommendations for guidelines,  
6 standards, performance measures, and review cri-  
7 teria under subsection (a) and any updates to such  
8 guidelines, standards, performance measures, and  
9 review criteria.

10 (2) After consideration of such comments, a  
11 final report that contains final recommendations for  
12 such guidelines, standards, performance measures,  
13 review criteria, and updates.

14 (e) DATE CERTAIN FOR INITIAL GUIDELINES AND  
15 STANDARDS.—The Commissioners, by not later than Jan-  
16 uary 1, 2012, shall assure the development of an initial  
17 set of guidelines, standards, performance measures, and  
18 review criteria under subsection (a).

19 **SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES**  
20 **AND STANDARDS.**

21 (a) ADOPTION OF RECOMMENDATIONS OF FORUM  
22 FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—  
23 For each fiscal year, the Commissioners shall adopt the  
24 recommendations made for such year in the final report  
25 under subsection (d)(2) of section 813 for guidelines,

1 standards, performance measures, and review criteria de-  
2 scribed in subsection (a) of such section.

3 (b) ENFORCEMENT AUTHORITY.—The Commis-  
4 sioners, in consultation with the Secretary of Health and  
5 Human Services, have the authority to make recommenda-  
6 tions to the Secretary to enforce compliance of health care  
7 providers with the guidelines, standards, performance  
8 measures, and review criteria adopted under subsection  
9 (a). Such recommendations may include the following,  
10 with respect to a health care provider who is not in compli-  
11 ance with such guidelines, standards, measures, and cri-  
12 teria:

13 (1) Exclusion from participation in Federal  
14 health care programs (as defined in section  
15 1128B(f) of the Social Security Act (42 U.S.C.  
16 1320a–7b(f))).

17 (2) Imposition of a civil money penalty on such  
18 provider.

19 **SEC. 815. ADDITIONAL REQUIREMENTS.**

20 (a) PROGRAM AGENDA.—The Commissioners shall  
21 provide for an agenda for the development of the guide-  
22 lines, standards, performance measures, and review cri-  
23 teria described in section 813(a), including with respect  
24 to the standards, performance measures, and review cri-  
25 teria, identifying specific aspects of health care for which

1 the standards, performance measures, and review criteria  
2 are to be developed and those that are to be given priority  
3 in the development of the standards, performance meas-  
4 ures, and review criteria.

## 5 **Subtitle C—General Provisions**

### 6 **SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.**

7 The Commissioners, in carrying out this title, may  
8 accept voluntary and uncompensated services.

### 9 **SEC. 822. FUNDING.**

10 For the purpose of carrying out this title, there are  
11 authorized to be appropriated such sums as may be nec-  
12 essary for fiscal years 2010 through 2014.

### 13 **SEC. 823. DEFINITIONS.**

14 For purposes of this title:

15 (1) The term “Commissioners” means the Com-  
16 missioners of the Health Care Services Commission.

17 (2) The term “Commission” means the Health  
18 Care Services Commission.

19 (3) The term “Director” means the Director of  
20 the Office of the Forum for Quality and Effective-  
21 ness in Health Care.

22 (4) The term “Secretary” means the Secretary  
23 of Health and Human Services.

1           **Subtitle D—Terminations and**  
2                           **Transition**

3   **SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RE-**  
4                           **SEARCH AND QUALITY.**

5           As of the date of the enactment of this Act, the Agen-  
6   cy for Healthcare Research and Quality is terminated, and  
7   title IX of the Public Health Service Act is repealed.

8   **SEC. 832. TRANSITION.**

9           All orders, grants, contracts, privileges, and other de-  
10   terminations or actions of the Agency for Healthcare Re-  
11   search and Quality that are effective as of the date before  
12   the date of the enactment of this Act, shall be transferred  
13   to the Secretary and shall continue in effect according to  
14   their terms unless changed pursuant to law.

15           **Subtitle E—Independent Health**  
16                           **Record Trust**

17   **SEC. 841. SHORT TITLE.**

18           This subtitle may be cited as the “Independent  
19   Health Record Trust Act of 2009”.

20   **SEC. 842. PURPOSE.**

21           It is the purpose of this subtitle to provide for the  
22   establishment of a nationwide health information tech-  
23   nology network that—

24                   (1) improves health care quality, reduces med-  
25                   ical errors, increases the efficiency of care, and ad-



1 vances the delivery of appropriate, evidence-based  
2 health care services;

3 (2) promotes wellness, disease prevention, and  
4 the management of chronic illnesses by increasing  
5 the availability and transparency of information re-  
6 lated to the health care needs of an individual;

7 (3) ensures that appropriate information nec-  
8 essary to make medical decisions is available in a us-  
9 able form at the time and in the location that the  
10 medical service involved is provided;

11 (4) produces greater value for health care ex-  
12 penditures by reducing health care costs that result  
13 from inefficiency, medical errors, inappropriate care,  
14 and incomplete information;

15 (5) promotes a more effective marketplace,  
16 greater competition, greater systems analysis, in-  
17 creased choice, enhanced quality, and improved out-  
18 comes in health care services;

19 (6) improves the coordination of information  
20 and the provision of such services through an effec-  
21 tive infrastructure for the secure and authorized ex-  
22 change and use of health information; and

23 (7) ensures that the health information privacy,  
24 security, and confidentiality of individually identifi-  
25 able health information is protected.

1 **SEC. 843. DEFINITIONS.**

2 In this subtitle:

3 (1) **ACCESS.**—The term “access” means, with  
4 respect to an electronic health record, entering infor-  
5 mation into such account as well as retrieving infor-  
6 mation from such account.

7 (2) **ACCOUNT.**—The term “account” means an  
8 electronic health record of an individual contained in  
9 an independent health record trust.

10 (3) **AFFIRMATIVE CONSENT.**—The term “af-  
11 firmative consent” means, with respect to an elec-  
12 tronic health record of an individual contained in an  
13 IHRT, express consent given by the individual for  
14 the use of such record in response to a clear and  
15 conspicuous request for such consent or at the indi-  
16 vidual’s own initiative.

17 (4) **AUTHORIZED EHR DATA USER.**—The term  
18 “authorized EHR data user” means, with respect to  
19 an electronic health record of an IHRT participant  
20 contained as part of an IHRT, any entity (other  
21 than the participant) authorized (in the form of af-  
22 firmative consent) by the participant to access the  
23 electronic health record.

24 (5) **CONFIDENTIALITY.**—The term “confiden-  
25 tiality” means, with respect to individually identifi-  
26 able health information of an individual, the obliga-

1       tion of those who receive such information to respect  
2       the health information privacy of the individual.

3           (6) ELECTRONIC HEALTH RECORD.—The term  
4       “electronic health record” means a longitudinal col-  
5       lection of information concerning a single individual,  
6       including medical records and personal health infor-  
7       mation, that is stored electronically.

8           (7) HEALTH INFORMATION PRIVACY.—The  
9       term “health information privacy” means, with re-  
10      spect to individually identifiable health information  
11      of an individual, the right of such individual to con-  
12      trol the acquisition, uses, or disclosures of such in-  
13      formation.

14          (8) HEALTH PLAN.—The term “health plan”  
15      means a group health plan (as defined in section  
16      2208(1) of the Public Health Service Act (42 U.S.C.  
17      300bb–8(1))) as well as a plan that offers health in-  
18      surance coverage in the individual market.

19          (9) HIPAA PRIVACY REGULATIONS.—The term  
20      “HIPAA privacy regulations” means the regulations  
21      promulgated under section 264(c) of the Health In-  
22      surance Portability and Accountability Act of 1996  
23      (42 U.S.C. 1320d–2 note).

24          (10) INDEPENDENT HEALTH RECORD TRUST;  
25      IHRT.—The terms “independent health record trust”

1 and “IHRT” mean a legal arrangement under the  
2 administration of an IHRT operator that meets the  
3 requirements of this subtitle with respect to elec-  
4 tronic health records of individuals participating in  
5 the trust or IHRT.

6 (11) IHRT OPERATOR.—The term “IHRT op-  
7 erator” means, with respect to an IHRT, the organi-  
8 zation that is responsible for the administration and  
9 operation of the IHRT in accordance with this sub-  
10 title.

11 (12) IHRT PARTICIPANT.—The term “IHRT  
12 participant” means, with respect to an IHRT, an in-  
13 dividual who has a participation agreement in effect  
14 with respect to the maintenance of the individual’s  
15 electronic health record by the IHRT.

16 (13) INDIVIDUALLY IDENTIFIABLE HEALTH IN-  
17 FORMATION.—The term “individually identifiable  
18 health information” has the meaning given such  
19 term in section 1171(6) of the Social Security Act  
20 (42 U.S.C. 1320d(6)).

21 (14) SECURITY.—The term “security” means,  
22 with respect to individually identifiable health infor-  
23 mation of an individual, the physical, technological,  
24 or administrative safeguards or tools used to protect

1 such information from unwarranted access or dislo-  
2 sure.

3 **SEC. 844. ESTABLISHMENT, CERTIFICATION, AND MEMBER-**  
4 **SHIP OF INDEPENDENT HEALTH RECORD**  
5 **TRUSTS.**

6 (a) ESTABLISHMENT.—Not later than one year after  
7 the date of the enactment of this Act, the Federal Trade  
8 Commission, in consultation with the National Committee  
9 on Vital and Health Statistics, shall prescribe standards  
10 for the establishment, certification, operation, and inter-  
11 operability of IHRTs to carry out the purposes described  
12 in section 842 in accordance with the provisions of this  
13 subtitle.

14 (b) CERTIFICATION.—

15 (1) CERTIFICATION BY FTC.—The Federal  
16 Trade Commission shall provide for the certification  
17 of IHRTs. No IHRT may be certified unless the  
18 IHRT is determined to meet the standards for cer-  
19 tification established under subsection (a).

20 (2) DECERTIFICATION.—The Federal Trade  
21 Commission shall establish a process for the revoca-  
22 tion of certification of an IHRT under this section  
23 in the case that the IHRT violates the standards es-  
24 tablished under subsection (a).

25 (c) MEMBERSHIP.—

1           (1) IN GENERAL.—To be eligible to be a partic-  
2           ipant in an IHRT, an individual shall—

3                   (A) submit to the IHRT information as re-  
4                   quired by the IHRT to establish an electronic  
5                   health record with the IHRT; and

6                   (B) enter into a privacy protection agree-  
7                   ment described in section 846(b)(1) with the  
8                   IHRT.

9           The process to determine eligibility of an individual  
10           under this subsection shall allow for the establish-  
11           ment by such individual of an electronic health  
12           record as expeditiously as possible if such individual  
13           is determined so eligible.

14           (2) NO LIMITATION ON MEMBERSHIP.—Nothing  
15           in this subsection shall be construed to permit an  
16           IHRT to restrict membership, including on the basis  
17           of health condition.

18 **SEC. 845. DUTIES OF IHRT TO IHRT PARTICIPANTS.**

19           (a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR  
20           VIOLATIONS OF FIDUCIARY DUTY.—

21                   (1) FIDUCIARY DUTY.—With respect to the  
22                   electronic health record of an IHRT participant  
23                   maintained by an IHRT, the IHRT shall have a fi-  
24                   duciary duty to act for the benefit and in the inter-  
25                   ests of such participant and of the IHRT as a whole.

1 Such duty shall include obtaining the affirmative  
 2 consent of such participant prior to the release of in-  
 3 formation in such participant's electronic health  
 4 record in accordance with the requirements of this  
 5 subtitle.

6 (2) PENALTIES.—If the IHRT knowingly or  
 7 recklessly breaches the fiduciary duty described in  
 8 paragraph (1), the IHRT shall be subject to the fol-  
 9 lowing penalties:

10 (A) Loss of certification of the IHRT.

11 (B) A fine that is not in excess of \$50,000.

12 (C) A term of imprisonment for the indi-  
 13 viduals involved of not more than 5 years.

14 (b) ELECTRONIC HEALTH RECORD DEEMED TO BE  
 15 HELD IN TRUST BY IHRT.—With respect to an indi-  
 16 vidual, an electronic health record maintained by an IHRT  
 17 shall be deemed to be held in trust by the IHRT for the  
 18 benefit of the individual and the IHRT shall have no legal  
 19 or equitable interest in such electronic health record.

20 **SEC. 846. AVAILABILITY AND USE OF INFORMATION FROM**  
 21 **RECORDS IN IHRT CONSISTENT WITH PRI-**  
 22 **VACY PROTECTIONS AND AGREEMENTS.**

23 (a) PROTECTED ELECTRONIC HEALTH RECORDS  
 24 USE AND ACCESS.—

1           (1) GENERAL RIGHTS REGARDING USES OF IN-  
2           FORMATION.—

3           (A) IN GENERAL.—With respect to the  
4           electronic health record of an IHRT participant  
5           maintained by an IHRT, subject to paragraph  
6           (2)(C), primary uses and secondary uses (de-  
7           scribed in subparagraphs (B) and (C), respec-  
8           tively) of information within such record (other  
9           than by such participant) shall be permitted  
10          only upon the authorization of such use, prior  
11          to such use, by such participant.

12          (B) PRIMARY USES.—For purposes of sub-  
13          paragraph (A) and with respect to an electronic  
14          health record of an individual, a primary use is  
15          a use for purposes of the individual's self-care  
16          or care by health care professionals.

17          (C) SECONDARY USES.—For purposes of  
18          subparagraph (B) and with respect to an elec-  
19          tronic health record of an individual, a sec-  
20          ondary use is any use not described in subpara-  
21          graph (B) and includes a use for purposes of  
22          public health research or other related activi-  
23          ties. Additional authorization is required for a  
24          secondary use extending beyond the original  
25          purpose of the secondary use authorized by the



1 IHRT participant involved. Nothing in this  
2 paragraph shall be construed as requiring au-  
3 thorization for every secondary use that is with-  
4 in the authorized original purpose.

5 (2) RULES FOR PRIMARY USE OF RECORDS FOR  
6 HEALTH CARE PURPOSES.—With respect to the elec-  
7 tronic health record of an IHRT participant (or  
8 specified parts of such electronic health record)  
9 maintained by an IHRT standards for access to  
10 such record shall provide for the following:

11 (A) ACCESS BY IHRT PARTICIPANTS TO  
12 THEIR ELECTRONIC HEALTH RECORDS.—

13 (i) OWNERSHIP.—The participant  
14 maintains ownership over the entire elec-  
15 tronic health record (and all portions of  
16 such record) and shall have the right to  
17 electronically access and review the con-  
18 tents of the entire record (and any portion  
19 of such record) at any time, in accordance  
20 with this subparagraph.

21 (ii) ADDITION OF PERSONAL INFOR-  
22 MATION.—The participant may add per-  
23 sonal health information to the health  
24 record of that participant, except that such  
25 participant shall not alter information that

1 is entered into the electronic health record  
2 by any authorized EHR data user. Such  
3 participant shall have the right to propose  
4 an amendment to information that is en-  
5 tered by an authorized EHR data user  
6 pursuant to standards prescribed by the  
7 Federal Trade Commission for purposes of  
8 amending such information.

9 (iii) IDENTIFICATION OF INFORMA-  
10 TION ENTERED BY PARTICIPANT.—Any ad-  
11 ditions or amendments made by the partic-  
12 ipant to the health record shall be identi-  
13 fied and disclosed within such record as  
14 being made by such participant.

15 (B) ACCESS BY ENTITIES OTHER THAN  
16 IHRT PARTICIPANT.—

17 (i) AUTHORIZED ACCESS ONLY.—Ex-  
18 cept as provided under subparagraph (C)  
19 and paragraph (4), access to the electronic  
20 health record (or any portion of the  
21 record)—

22 (I) may be made only by author-  
23 ized EHR data users and only to such  
24 portions of the record as specified by  
25 the participant; and

1 (II) may be limited by the partic-  
2 ipant for purposes of entering infor-  
3 mation into such record, retrieving in-  
4 formation from such record, or both.

5 (ii) IDENTIFICATION OF ENTITY THAT  
6 ENTERS INFORMATION.—Any information  
7 that is added by an authorized EHR data  
8 user to the health record shall be identified  
9 and disclosed within such record as being  
10 made by such user.

11 (iii) SATISFACTION OF HIPAA PRIVACY  
12 REGULATIONS.—In the case of a record of  
13 a covered entity (as defined for purposes of  
14 HIPAA privacy regulations), with respect  
15 to an individual, if such individual is an  
16 IHRT participant with an independent  
17 health record trust and such covered entity  
18 is an authorized EHR data user, the re-  
19 quirement under the HIPAA privacy regu-  
20 lations for such entity to provide the  
21 record to the participant shall be deemed  
22 met if such entity, without charge to the  
23 IHRT or the participant—

24 (I) forwards to the trust an ap-  
25 propriately formatted electronic copy

1 of the record (and updates to such  
2 records) for inclusion in the electronic  
3 health record of the participant main-  
4 tained by the trust;

5 (II) enters such record into the  
6 electronic health record of the partici-  
7 pant so maintained; or

8 (III) otherwise makes such  
9 record available for electronic access  
10 by the IHRT or the individual in a  
11 manner that permits such record to  
12 be included in the account of the indi-  
13 vidual contained in the IHRT.

14 (iv) NOTIFICATION OF SENSITIVE IN-  
15 FORMATION.—Any information, with re-  
16 spect to the participant, that is sensitive  
17 information, as specified by the Federal  
18 Trade Commission, shall not be forwarded  
19 or entered by an authorized EHR data  
20 user into the electronic health record of the  
21 participant maintained by the trust unless  
22 the user certifies that the participant has  
23 been notified of such information.

24 (C) DEEMED AUTHORIZATION FOR ACCESS  
25 FOR EMERGENCY HEALTH CARE.—

1 (i) FINDINGS.—Congress finds that—

2 (I) given the size and nature of  
3 visits to emergency departments in  
4 the United States, readily available  
5 health information could make the dif-  
6 ference between life and death; and

7 (II) because of the case mix and  
8 volume of patients treated, emergency  
9 departments are well positioned to  
10 provide information for public health  
11 surveillance, community risk assess-  
12 ment, research, education, training,  
13 quality improvement, and other uses.

14 (ii) USE OF INFORMATION.—With re-  
15 spect to the electronic health record of an  
16 IHRT participant (or specified parts of  
17 such electronic health record) maintained  
18 by an IHRT, the participant shall be  
19 deemed as providing authorization (in the  
20 form of affirmative consent) for health  
21 care providers to access, in connection with  
22 providing emergency care services to the  
23 participant, a limited, authenticated infor-  
24 mation set concerning the participant for  
25 emergency response purposes, unless the

1 participant specifies that such information  
2 set (or any portion of such information  
3 set) may not be so accessed. Such limited  
4 information set may include information—

5 (I) patient identification data, as  
6 determined appropriate by the partici-  
7 pant;

8 (II) provider identification that  
9 includes the use of unique provider  
10 identifiers;

11 (III) payment information;

12 (IV) information related to the  
13 individual's vitals, allergies, and medi-  
14 cation history;

15 (V) information related to exist-  
16 ing chronic problems and active clin-  
17 ical conditions of the participant; and

18 (VI) information concerning  
19 physical examinations, procedures, re-  
20 sults, and diagnosis data.

21 (3) RULES FOR SECONDARY USES OF RECORDS  
22 FOR RESEARCH AND OTHER PURPOSES.—

23 (A) IN GENERAL.—With respect to the  
24 electronic health record of an IHRT participant  
25 (or specified parts of such electronic health

1 record) maintained by an IHRT, the IHRT  
2 may sell such record (or specified parts of such  
3 record) only if—

4 (i) the transfer is authorized by the  
5 participant pursuant to an agreement be-  
6 tween the participant and the IHRT and is  
7 in accordance with the privacy protection  
8 agreement described in subsection (b)(1)  
9 entered into between such participant and  
10 such IHRT;

11 (ii) such agreement includes param-  
12 eters with respect to the disclosure of in-  
13 formation involved and a process for the  
14 authorization of the further disclosure of  
15 information in such record;

16 (iii) the information involved is to be  
17 used for research or other activities only as  
18 provided for in the agreement;

19 (iv) the recipient of the information  
20 provides assurances that the information  
21 will not be further transferred or reused in  
22 violation of such agreement; and

23 (v) the transfer otherwise meets the  
24 requirements and standards prescribed by  
25 the Federal Trade Commission.

1           (B) TREATMENT OF PUBLIC HEALTH RE-  
2           PORTING.—Nothing in this paragraph shall be  
3           construed as prohibiting or limiting the use of  
4           health care information of an individual, includ-  
5           ing an individual who is an IHRT participant,  
6           for public health reporting (or other research)  
7           purposes prior to the inclusion of such informa-  
8           tion in an electronic health record maintained  
9           by an IHRT.

10          (4) LAW ENFORCEMENT CLARIFICATION.—  
11          Nothing in this subtitle shall prevent an IHRT from  
12          disclosing information contained in an electronic  
13          health record maintained by the IHRT when re-  
14          quired for purposes of a lawful investigation or offi-  
15          cial proceeding inquiring into a violation of, or fail-  
16          ure to comply with, any criminal or civil statute or  
17          any regulation, rule, or order issued pursuant to  
18          such a statute.

19          (5) RULE OF CONSTRUCTION.—Nothing in this  
20          section shall be construed to require a health care  
21          provider that does not utilize electronic methods or  
22          appropriate levels of health information technology  
23          on the date of the enactment of this Act to adopt  
24          such electronic methods or technology as a require-



1       ment for participation or compliance under this sub-  
2       title.

3       (b) PRIVACY PROTECTION AGREEMENT; TREATMENT  
4 OF STATE PRIVACY AND SECURITY LAWS.—

5           (1) PRIVACY PROTECTION AGREEMENT.—A pri-  
6       vacy protection agreement described in this sub-  
7       section is an agreement, with respect to an electronic  
8       health record of an IHRT participant to be main-  
9       tained by an independent health record trust, be-  
10      tween the participant and the trust—

11           (A) that is consistent with the standards  
12      described in subsection (a)(2);

13           (B) under which the participant specifies  
14      the portions of the record that may be accessed,  
15      under what circumstances such portions may be  
16      accessed, any authorizations for indicated au-  
17      thorized EHR data users to access information  
18      contained in the record, and the purposes for  
19      which the information (or portions of the infor-  
20      mation) in the record may be used;

21           (C) which provides a process for the au-  
22      thorization of the transfer of information con-  
23      tained in the record to a third party, including  
24      for the sale of such information for purposes of  
25      research, by an authorized EHR data user and

1 reuse of such information by such third party,  
2 including a provision requiring that such trans-  
3 fer and reuse is not in violation of any privacy  
4 or transfer restrictions placed by the partici-  
5 pant on the independent health record of such  
6 participant; and

7 (D) under which the trust provides assur-  
8 ances that the trust will not transfer, disclose,  
9 or provide access to the record (or any portion  
10 of the record) in violation of the parameters es-  
11 tablished in the agreement or to any person or  
12 entity who has not agreed to use and transfer  
13 such record (or portion of such record) in ac-  
14 cordance with such agreement.

15 (2) TREATMENT OF STATE LAWS.—

16 (A) IN GENERAL.—Except as provided  
17 under subparagraph (B), the provisions of a  
18 privacy protection agreement entered into be-  
19 tween an IHRT and an IHRT participant shall  
20 preempt any provision of State law (or any  
21 State regulation) relating to the privacy and  
22 confidentiality of individually identifiable health  
23 information or to the security of such health in-  
24 formation.

1 (B) EXCEPTION FOR PRIVILEGED INFOR-  
2 MATION.—The provisions of a privacy protec-  
3 tion agreement shall not preempt any provision  
4 of State law (or any State regulation) that rec-  
5 ognizes privileged communications between phy-  
6 sicians, health care practitioners, and patients  
7 of such physicians or health care practitioners,  
8 respectively.

9 (C) STATE DEFINED.—For purposes of  
10 this section, the term “State” has the meaning  
11 given such term when used in title XI of the  
12 Social Security Act, as provided under section  
13 1101(a) of such Act (42 U.S.C. 1301(a)).

14 **SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION**  
15 **AND INFORMATION SHARING.**

16 (a) IN GENERAL.—Participation in an independent  
17 health record trust, or authorizing access to information  
18 from such a trust, is voluntary. No employer, health insur-  
19 ance issuer, group health plan, health care provider, or  
20 other person may require, as a condition of employment,  
21 issuance of a health insurance policy, coverage under a  
22 group health plan, the provision of health care services,  
23 payment for such services, or otherwise, that an individual  
24 participate in, or authorize access to information from, an  
25 independent health record trust.

1 (b) ENFORCEMENT.—The penalties provided for in  
2 subsection (a) of section 1177 of the Social Security Act  
3 (42 U.S.C. 1320d–6) shall apply to a violation of sub-  
4 section (a) in the same manner as such penalties apply  
5 to a person in violation of subsection (a) of such section.

6 **SEC. 848. FINANCING OF ACTIVITIES.**

7 (a) IN GENERAL.—Except as provided in subsection  
8 (b), an IHRT may generate revenue to pay for the oper-  
9 ations of the IHRT through—

10 (1) charging IHRT participants account fees  
11 for use of the trust;

12 (2) charging authorized EHR data users for ac-  
13 cessing electronic health records maintained in the  
14 trust;

15 (3) the sale of information contained in the  
16 trust (as provided for in section 846(a)(3)(A)); and

17 (4) any other activity determined appropriate  
18 by the Federal Trade Commission.

19 (b) PROHIBITION AGAINST ACCESS FEES FOR  
20 HEALTH CARE PROVIDERS.—For purposes of providing  
21 incentives to health care providers to access information  
22 maintained in an IHRT, as authorized by the IHRT par-  
23 ticipants involved, the IHRT may not charge a fee for  
24 services specified by the IHRT. Such services shall include  
25 the transmittal of information from a health care provider

1 to be included in an independent electronic health record  
2 maintained by the IHRT (or permitting such provider to  
3 input such information into the record), including the  
4 transmission of or access to information described in sec-  
5 tion 846(a)(2)(C)(ii) by appropriate emergency respond-  
6 ers.

7 (c) **REQUIRED DISCLOSURES.**—The sources and  
8 amounts of revenue derived under subsection (a) for the  
9 operations of an IHRT shall be fully disclosed to each  
10 IHRT participant of such IHRT and to the public.

11 (d) **TREATMENT OF INCOME.**—For purposes of the  
12 Internal Revenue Code of 1986, any revenue described in  
13 subsection (a) shall not be included in gross income of any  
14 IHRT, IHRT participant, or authorized EHR data user.

15 **SEC. 849. REGULATORY OVERSIGHT.**

16 (a) **IN GENERAL.**—In carrying out this subtitle, the  
17 Federal Trade Commission shall promulgate regulations  
18 for independent health record trusts.

19 (b) **ESTABLISHMENT OF INTERAGENCY STEERING**  
20 **COMMITTEE.**—

21 (1) **IN GENERAL.**—The Secretary of Health and  
22 Human Services shall establish an Interagency  
23 Steering Committee in accordance with this sub-  
24 section.

1           (2) CHAIRPERSON.—The Secretary of Health  
2 and Human Services shall serve as the chairperson  
3 of the Interagency Steering Committee.

4           (3) MEMBERSHIP.—The members of the Inter-  
5 agency Steering Committee shall consist of the At-  
6 torney General, the Chairperson of the Federal  
7 Trade Commission, the Chairperson for the National  
8 Committee for Vital and Health Statistics, a rep-  
9 resentative of the Federal Reserve, and other Fed-  
10 eral officials determined appropriate by the Sec-  
11 retary of Health and Human Services.

12           (4) DUTIES.—The Interagency Steering Com-  
13 mittee shall coordinate the implementation of this  
14 title, including the implementation of policies de-  
15 scribed in subsection (d) based upon the rec-  
16 ommendations provided under such subsection, and  
17 regulations promulgated under this subtitle.

18           (c) FEDERAL ADVISORY COMMITTEE.—

19           (1) IN GENERAL.—The National Committee for  
20 Vital and Health Statistics shall serve as an advisory  
21 committee for the IHRTs. The membership of such  
22 advisory committee shall include a representative  
23 from the Federal Trade Commission and the chair-  
24 person of the Interagency Steering Committee. Not  
25 less than 60 percent of such membership shall con-

1       sist of representatives of nongovernment entities, at  
2       least one of whom shall be a representative from an  
3       organization representing health care consumers.

4               (2) DUTIES.—The National Committee for  
5       Vital and Health Statistics shall issue periodic re-  
6       ports and review policies concerning IHRTs based  
7       on each of the following factors:

8                       (A) Privacy and security policies.

9                       (B) Economic progress.

10                      (C) Interoperability standards.

11       (d) POLICIES RECOMMENDED BY FEDERAL TRADE  
12       COMMISSION.—The Federal Trade Commission, in con-  
13       sultation with the National Committee for Vital and  
14       Health Statistics, shall recommend policies to—

15               (1) provide assistance to encourage the growth  
16       of independent health record trusts;

17               (2) track economic progress as it pertains to  
18       operators of independent health records trusts and  
19       individuals receiving nontaxable income with respect  
20       to accounts;

21               (3) conduct public education activities regarding  
22       the creation and usage of the independent health  
23       records trusts;

24               (4) establish standards for the interoperability  
25       of health information technology to ensure that in-

1 formation contained in such record may be shared  
2 between the trust involved, the participant, and au-  
3 thorized EHR data users, including for the stand-  
4 ardized collection and transmission of individual  
5 health records (or portions of such records) to au-  
6 thorized EHR data users through a common inter-  
7 face and for the portability of such records among  
8 independent health record trusts; and

9 (5) carry out any other activities determined  
10 appropriate by the Federal Trade Commission.

11 (e) REGULATIONS PROMULGATED BY FEDERAL  
12 TRADE COMMISSION.—The Federal Trade Commission  
13 shall promulgate regulations based on, at a minimum, the  
14 following factors:

15 (1) Requiring that an IHRT participant, who  
16 has an electronic health record that is maintained by  
17 an IHRT, be notified of a security breach with re-  
18 spect to such record, and any corrective action taken  
19 on behalf of the participant.

20 (2) Requiring that information sent to, or re-  
21 ceived from, an IHRT that has been designated as  
22 high-risk should be authenticated through the use of  
23 methods such as the periodic changing of passwords,  
24 the use of biometrics, the use of tokens or other  
25 technology as determined appropriate by the council.



1           (3) Requiring a delay in releasing sensitive  
2 health care test results and other similar informa-  
3 tion to patients directly in order to give physicians  
4 time to contact the patient.

5           (4) Recommendations for entities operating  
6 IHRTs, including requiring analysis of the potential  
7 risk of health transaction security breeches based on  
8 set criteria.

9           (5) The conduct of audits of IHRTs to ensure  
10 that they are in compliance with the requirements  
11 and standards established under this subtitle.

12           (6) Disclosure to IHRT participants of the  
13 means by which such trusts are financed, including  
14 revenue from the sale of patient data.

15           (7) Prevention of certification of an entity seek-  
16 ing independent health record trust certification  
17 based on—

18                 (A) the potential for conflicts between the  
19 interests of such entity and the security of the  
20 health information involved; and

21                 (B) the involvement of the entity in any  
22 activity that is contrary to the best interests of  
23 a patient.

24           (8) Prevention of the use of revenue sources  
25 that are contrary to a patient's interests.

1           (9) Public disclosure of audits in a manner  
2 similar to financial audits required for publicly trad-  
3 ed stock companies.

4           (10) Requiring notification to a participating  
5 entity that the information contained in such record  
6 may not be representative of the complete or accu-  
7 rate electronic health record of such account holder.

8           (f) COMPLIANCE REPORT.—Not later than 1 year  
9 after the date of the enactment of this Act, and annually  
10 thereafter, the Commission shall submit to the Committee  
11 on Health, Education, Labor, and Pensions and the Com-  
12 mittee on Finance of the Senate and the Committee on  
13 Energy and Commerce and the Committee on Ways and  
14 Means of the House of Representatives, a report on com-  
15 pliance by and progress of independent health record  
16 trusts with this subtitle. Such report shall describe the fol-  
17 lowing:

18           (1) The number of complaints submitted about  
19 independent health record trusts, which shall be di-  
20 vided by complaints related to security breaches, and  
21 complaints not related to security breaches, and may  
22 include other categories as the Interagency Steering  
23 Committee established under subsection (b) deter-  
24 mines appropriate.

1           (2) The number of enforcement actions under-  
2 taken by the Commission against independent health  
3 record trusts in response to complaints under para-  
4 graph (1), which shall be divided by enforcement ac-  
5 tions related to security breaches and enforcement  
6 actions not related to security breaches and may in-  
7 clude other categories as the Interagency Steering  
8 Committee established under subsection (b) deter-  
9 mines appropriate.

10           (3) The economic progress of the individual  
11 owner or institution operator as achieved through  
12 independent health record trust usage and existing  
13 barriers to such usage.

14           (4) The progress in security auditing as pro-  
15 vided for by the Interagency Steering Committee  
16 council under subsection (b).

17           (5) The other core responsibilities of the Com-  
18 mission as described in subsection (a).

19           (g) INTERAGENCY MEMORANDUM OF UNDER-  
20 STANDING.—The Interagency Steering Committee shall  
21 ensure, through the execution of an interagency memo-  
22 randum of understanding, that—

23           (1) regulations, rulings, and interpretations  
24 issued by Federal officials relating to the same mat-  
25 ter over which 2 or more such officials have respon-

1 sibility under this subtitle are administered so as to  
2 have the same effect at all times; and

3 (2) the memorandum provides for the coordina-  
4 tion of policies related to enforcing the same require-  
5 ments through such officials in order to have coordi-  
6 nated enforcement strategy that avoids duplication  
7 of enforcement efforts and assigns priorities in en-  
8 forcement.

## 9 **TITLE IX—MISCELLANEOUS**

### 10 **SEC. 901. HEALTH CARE CHOICE FOR VETERANS.**

11 Beginning not later than 2 years after the date of  
12 the enactment of this Act, the Secretary of Veterans Af-  
13 fairs may—

14 (1) permit veterans, and survivors and depend-  
15 ents of veterans, who are eligible for health care and  
16 services under the laws administered by the Sec-  
17 retary to receive such care and services through such  
18 non-Department of Veterans Affairs providers and  
19 facilities as the Secretary may approve for purposes  
20 of this section; and

21 (2) pursuant to such procedures as the Sec-  
22 retary of Veteran Affairs shall prescribe for purposes  
23 of this section, make payments to such providers  
24 and facilities for the provision of such care and serv-  
25 ices to veterans, and such survivors and dependents,

1 at such rates as the Secretary may specify in such  
2 procedures and in such manner so that the Sec-  
3 retary ensures that the aggregate payments made by  
4 the Secretary to such providers and facilities do not  
5 exceed the aggregate amounts which the Secretary  
6 would have paid for such care and services if this  
7 section had not been enacted.

8 **SEC. 902. HEALTH CARE CHOICE FOR INDIANS.**

9 (a) IN GENERAL.—Beginning not later than 2 years  
10 after the date of enactment of this Act, the Secretary of  
11 Health and Human Services shall—

12 (1) permit Indians who are eligible for health  
13 care and services under a health care program oper-  
14 ated or financed by the Indian Health Service or by  
15 an Indian Tribe, Tribal Organization, or Urban In-  
16 dian Organization (and any such other individuals  
17 who are so eligible as the Secretary may specify), to  
18 receive such care and services through such non- In-  
19 dian Health Service, Indian Tribe, Tribal Organiza-  
20 tion, or Urban Indian Organization providers and  
21 facilities as the Secretary shall approve for purposes  
22 of this section; and

23 (2) pursuant to such procedures as the Sec-  
24 retary of Health and Human Services shall prescribe  
25 for purposes of this section, make payments to such

1 providers and facilities for the provision of such care  
2 and services to Indians and individuals described in  
3 paragraph (1), at such rates as the Secretary shall  
4 specify in such procedures and in such manner so  
5 that the Secretary ensures that the aggregate pay-  
6 ments made by the Secretary to such providers and  
7 facilities do not exceed the aggregate amounts which  
8 the Secretary would have paid for such care and  
9 services if this section had not been enacted.

10 (b) DEFINITIONS.—In this section, the terms “In-  
11 dian”, “Indian Health Program”, “Indian Tribe”, “Tribal  
12 Organization”, and “Urban Indian Organization” have  
13 the meanings given those terms in section 4 of the Indian  
14 Health Care Improvement Act.

15 **SEC. 903. TERMINATION OF FEDERAL COORDINATING**  
16 **COUNCIL FOR COMPARATIVE EFFECTIVE-**  
17 **NESS RESEARCH.**

18 The Federal Coordinating Council for Comparative  
19 Effectiveness Research is hereby terminated and section  
20 804 of the American Recovery and Reinvestment Act of  
21 2009 establishing and funding such Council is hereby re-  
22 pealed.

1 **SEC. 904. HHS AND GAO JOINT STUDY AND REPORT ON**  
2 **COSTS OF THE 5 MEDICAL CONDITIONS THAT**  
3 **HAVE THE GREATEST IMPACT.**

4 (a) **STUDY.**—The Secretary of Health and Human  
5 Services (in this section referred to as the “Secretary”)  
6 and the Comptroller General of the United States (in this  
7 section referred to as the “Comptroller General”) shall  
8 jointly conduct a study on the costs of the top 5 medical  
9 conditions facing the public which have the greatest im-  
10 pact in terms of morbidity, mortality, and financial cost.  
11 Such study shall include—

12 (1) current estimates as well as a “generational  
13 score” to capture the financial cost and health toll  
14 certain medical conditions will inflict on the baby  
15 boomer generation and on other individuals; and

16 (2) a careful review of certain medical condi-  
17 tions, including heart disease, obesity, diabetes,  
18 stroke, cancer, Alzheimers, and other medical condi-  
19 tions the Secretary and Comptroller General deter-  
20 mine appropriate.

21 (b) **REPORT.**—Not later than 1 year after the date  
22 of enactment of this Act, the Secretary and the Comp-  
23 troller General shall jointly submit to Congress a report  
24 containing the results of the study conducted under sub-  
25 section (a), together with recommendations for such legis-

1 lation and administrative action as the Secretary and the  
2 Comptroller General determine appropriate.

3 (c) TARGETING OF PREVENTION AND WELLNESS EF-  
4 FORTS.—The Secretary shall target prevention and  
5 wellness efforts conducted under the provisions of and  
6 amendments made by this Act in order to combat medical  
7 conditions identified in the report submitted under sub-  
8 section (b), including such medical conditions identified as  
9 the top 5 medical conditions facing the public which have  
10 the greatest impact in terms of morbidity, mortality, and  
11 financial cost as of or after the date of enactment of this  
12 Act.

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