111TH CONGRESS
1ST SESSION

S. 1099

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

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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Choice Act''.

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

TITLE I—INVESTING IN PREVENTION

SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall convene an interagency coordinating committee to develop a national strategic plan for prevention. The Secretary shall serve as the chairperson of the committee.

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

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

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

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

(D) the Administrator of the Substance Abuse and Mental Health Services Administration;

(E) the Administrator of the Health Resources and Services Administration;

(F) the Secretary of Agriculture;

(G) the Director of the Centers for Medicare & Medicaid Services;

(H) the Administrator of the Environmental Protection Agency;

(I) the Director of the Indian Health Service;

(J) the Administrator of the Administration on Aging;

(K) the Secretary of Veterans Affairs;

(L) the Secretary of Defense;

(M) the Secretary of Education; and

(N) the Secretary of Labor.

(3) REPORT AND PLAN.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the coordinating committee

convened under paragraph (1), shall submit to Congress a report concerning the recommendation of the committee for health promotion and disease prevention activities. Such report shall include a specific strategic plan that shall include—

(A) a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, and appropriate exercise) and the prevention measures for the 5 leading disease killers in the United States;

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

(C) specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010), that include transferring the nutrition guideline development responsibility from the Secretary of Ag-

riculture to the Director of the Centers for Disease Control and Prevention;

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

(E) specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under subparagraph (D); and

(F) a list of new non-Federal and non-government partners identified by the committee to build Federal capacity in health promotion and disease prevention efforts.

(4) ANNUAL REQUEST TO GIVE TESTIMONY.—The Secretary shall annually request an opportunity to testify before Congress concerning the progress made by the United States in meeting the outcome-based standards of Healthy People 2010 with respect to disease prevention and measurable outcomes and effectiveness of Federal programs related to this goal.

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

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

(1) MEDIA CAMPAIGNS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

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

(i) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and sec-

ondary prevention through disease screening promotion;

(ii) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(iii) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

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

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

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under subparagraph (A) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

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

into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(3) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and the Medicare and Medicaid Programs.

(4) PERSONALIZED PREVENTION PLANS.—

(A) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development

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

(B) USE.—The website developed under subparagraph (A) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVENTION EFFORT.

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

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a strategic plan that shall—

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

(2) include a list of the barriers that exist within the State to meeting specific goals of Healthy People 2010;

(3) include targeted demographic indicators and measurable objectives with respect to health promotion and disease prevention;

(4) contain a set of process outcomes and milestones, based on the process outcomes and milestones developed by the Secretary, for measuring the effectiveness of activities carried out under the grant in the State; and

(5) outline the manner in which interventions to be carried out under this grant will reduce morbidity and mortality within the State over a 5-year period (or over a 10-year period, if the Secretary determines such period appropriate for adequately measuring progress).

(c) PROCESS OUTCOMES AND MILESTONES.—

(1) IN GENERAL.—The Secretary shall develop process outcomes and milestones to be used to measure the effectiveness of activities carried out under a grant under this section by a State.

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

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

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

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

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

(f) INNOVATIVE INCENTIVE STRUCTURES.—The Secretary may award grants to States for the purposes of developing innovative incentive structures to encourage individuals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

(g) WELLNESS BONUSES.—

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

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

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

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

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

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

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

(i) STATE.—In this section, the term ''State'' means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

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

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

SEC. 103. FOCUSING THE FOOD STAMP PROGRAM ON NUTRITION.

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

(b) LIMITATIONS ON FOOD STAMP PURCHASES.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Agriculture shall, based on scientific, peer-reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program. Such list shall be updated on an annual basis to ensure the most current science-

based recommendations are applied to the food stamp program.

(2) AUTOMATED ENFORCEMENT.—The Secretary of Agriculture shall, through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program's automated system.

(3) IMPLEMENTATION.—The Secretary of Agriculture shall promulgate the regulations described in paragraph (2) by the date that is not later than 1 year after the date of enactment of this section.

SEC. 104. IMMUNIZATIONS.

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

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

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

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

(d) AUTHORIZATION OF APPROPRIATIONS.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, there shall be made available to carry out this section, $50,000,000 for each fiscal year.

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

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall establish a process for the review of applications submitted by States for the establishment and implementation of State-based health care Exchanges (referred to in this title as a ''State Exchange'') and for the certification of such Exchanges. The Secretary shall certify a

State Exchange if the Secretary determines that such Exchange meets the requirements of this title.

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

SEC. 202. REQUIREMENTS.

(a) GENERAL REQUIREMENTS FOR CERTIFICATION.—An application for certification under section 201(a) shall demonstrate compliance with the following:

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

(2) ADMINISTRATION.—A State shall ensure the operation of the State Exchange through direct contracts with the health insurance plans that are participating in the State Exchange or through a contract with a third party administrator for the operation of the Exchange.

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

long as the health insurance issuers involved are duly licensed under State insurance laws applicable to all health insurance issuers in the State and otherwise comply with the requirements of this title.

(4) PREMIUMS.—

(A) AMOUNT.—A State shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange.

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

(b) BENEFIT PARITY WITH MEMBERS OF CONGRESS.—With respect to health insurance issuers offering health insurance coverage through the State Exchange, the State shall not impose any requirement that such issuers provide coverage that includes benefits different than requirements on plans offered to Members of Congress under chapter 89 of title 5, United States Code.

(c) FACILITATING UNIVERSAL COVERAGE FOR AMERICANS.—

(1) AUTOMATIC ENROLLMENT.—The State Exchange shall ensure that health insurance coverage

offered through the Exchange provides for the application of uniform mechanisms that are designed to encourage and facilitate the enrollment of all eligible individuals in Exchange-based health insurance coverage. Such mechanisms shall include automatic enrollment through various venues, which may include emergency rooms, the submission of State tax forms, places of employment in the State, and State departments of motor vehicles.

(2) OTHER ENROLLMENT OPPORTUNITIES.—

(A) IN GENERAL.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits enrollment, and changes in enrollment, of individuals at the time such individuals become eligible individuals in the State.

(B) ANNUAL OPEN ENROLLMENT PERIODS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits eligible individuals to annually change enrollment among the coverage offered through the Exchange, subject to subparagraph (A).

(C) INCENTIVES FOR CONTINUOUS ANNUAL COVERAGE.—The State Exchange shall

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

(3) GUARANTEED ACCESS FOR INDIVIDUALS.—The State Exchange shall ensure that, with respect to health insurance coverage offered through the Exchange, all eligible individuals are able to enroll in the coverage of their choice provided that such individuals agree to make applicable premium and cost sharing payments.

(4) LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange meets the requirements of section 9801 of the Internal Revenue Code of 1986 in the same manner as if such coverage was a group health plan.

(5) OPT-OUT.—Nothing in this title shall be construed to require that an individual be enrolled in health insurance coverage.

(d) LIMITATION ON EXORBITANT PREMIUMS.—

(1) ESTABLISHMENT OF MECHANISM.—With respect to health insurance coverage offered through the State Exchange, the Exchange shall establish a mechanisms to protect enrollees from the imposition

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

(2) MECHANISM OPTIONS.—The mechanisms referred to in paragraph (1) may include the following:

(A) INDEPENDENT RISK ADJUSTMENT.—The implementation of risk-adjustment among health insurance coverage offered through the State Exchange through a contract entered into with a private, independent board. Such board shall include representation of health insurance issuers and State officials but shall be independently controlled. The State Exchange shall ensure that risk-adjustment implemented under this subparagraph shall be based on a blend of patient diagnoses and estimated costs.

(B) HEALTH SECURITY POOLS.—The establishment (or continued operation under section 2745 of the Public Health Service Act) of a health security pool to guarantee high-risk individuals access to affordable, quality health care.

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

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

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

(f) DISSEMINATION OF COVERAGE INFORMATION.—The State Exchange shall ensure that each health insurance issuer that provides health insurance coverage through the Exchange disseminate to eligible individuals and employers within the State information concerning health insurance coverage options, including the plans offered and premiums and benefits for such plans.

(g) REGIONAL OPTIONS.—

(1) INTERSTATE COMPACTS.—Two or more States that establish a State Exchange may enter into interstate compacts providing for the regulations of health insurance coverage offered within such States.

(2) MODEL LEGISLATION.—States adopting model legislation as developed by the National Association of Insurance Commissioners shall be eligible

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

(3) MULTI-STATE POOLING ARRANGEMENTS.—State Exchanges may implement a multi-state health care coverage pooling arrangement under this title.

(h) ELIGIBLE INDIVIDUAL.—In this title, the term ''eligible individual'' means an individual who is—

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

(2) a resident of the State involved;

(3) not incarcerated; and

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

SEC. 203. STATE EXCHANGE INCENTIVES.

(a) GRANTS.—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and to provide more options and choice for individuals purchasing health insurance coverage.

(b) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment deter-

mined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

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

SEC. 300. REFERENCE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

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

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

(a) ADVANCEABLE CREDIT.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

"SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

"(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents.

"(b) MONTHLY LIMITATION.—

"(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is 1/12th of—

"(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer's spouse,

"(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

"(C) the applicable child amount, in the case that the eligible individual is a child dependent.

"(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer's spouse and dependents for any month shall not exceed 1/12th of the applicable aggregate amount.

"(3) NO CREDIT FOR INELIGIBLE MONTHS.—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

"(4) APPLICABLE AMOUNT.—

"(A) IN GENERAL.—For purposes of this section—

"(i) APPLICABLE ADULT AMOUNT.—The applicable adult amount is $2,290.

"(ii) APPLICABLE CHILD AMOUNT.—The applicable child amount is $1,710.

"(iii) APPLICABLE AGGREGATE AMOUNT.—The applicable aggregate amount is $5,710.

''(B) COST-OF-LIVING ADJUSTMENTS.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

''(ii) BLENDED COST-OF-LIVING ADJUSTMENT.—For purposes of clause (i), the blended cost-of-living adjustment means one-half of the sum of—

''(I) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2010' for 'calendar year 1992' in subparagraph (B) thereof, plus

''(II) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting '2010' for '1996' in subclause (II) thereof.

"(iii) ROUNDING.—Any increase determined under clause (i) shall be rounded to the nearest multiple of $10.

"(C) REVENUE NEUTRALITY ADJUSTMENTS.—

"(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A), as adjusted under subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 303 and 401 of the Patients' Choice Act for such taxable year as estimated by the Secretary.

"(ii) DATE OF ADJUSTMENT.—The Secretary shall announce the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

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

''(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

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

''(d) EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.—If—

''(1) the credit which would be allowable under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

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

such excess shall be paid by the Secretary into the designated account of the taxpayer.

''(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible individual' means, with respect to any month, an individual who—

"(A) is the taxpayer, the taxpayer's spouse, or the taxpayer's dependent, and

"(B) is covered under qualified health insurance as of the 1st day of such month.

"(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—The term 'eligible individual' shall not include any individual who for any month is—

"(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual is not a participant or beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

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

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

"(3) IDENTIFICATION REQUIREMENTS.—The term 'eligible individual' shall not include any individual for any month unless the policy number associated with the qualified health insurance and the

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

''(4) PRISONERS.—The term 'eligible individual' shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

''(5) ALIENS.—The term 'eligible individual' shall not include any alien individual who is not a lawful permanent resident of the United States.

''(f) HEALTH INSURANCE.—For purposes of this section—

''(1) QUALIFIED HEALTH INSURANCE.—The term 'qualified health insurance' means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary)—

''(A) has a reasonable annual and lifetime benefit maximum, and

''(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

''(2) QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.—The term 'qualified refund eligible health insurance' means any qualified health insurance which is coverage under a group health plan (as defined in section 5000(b)(1)).

''(g) DESIGNATED ACCOUNTS.—

''(1) DESIGNATED ACCOUNT.—For purposes of this section, the term 'designated account' means any specified account established and maintained by the provider of the taxpayer's qualified refund eligible health insurance—

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

''(B) which, under the terms of the account, accepts the payment described in subsection (d) on behalf of the taxpayer, and

''(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

''(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term 'specified account' means—

"(A) any health savings account under section 223 or Archer MSA under section 220, or

"(B) any health insurance reserve account.

"(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term 'health insurance reserve account' means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

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

"(h) OTHER DEFINITIONS.—For purposes of this section—

''(1) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

''(2) ADULT.—The term 'adult' means an individual who is not a child.

''(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c)).

''(i) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(l).

''(2) COORDINATION WITH HEALTH CARE TAX CREDIT.—No credit shall be allowed under subsection (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a

credit under section 35 is allowed for such taxable year.

''(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

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

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary

may require) is verified in such manner as the Secretary may prescribe.

''(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

''(j) COORDINATION WITH ADVANCE PAYMENTS.—

''(1) REDUCTION IN CREDIT FOR ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(2) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

''(A) such excess, plus

''(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established. The Secretary may rescind or waive all or any portion of any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer.''.

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

''SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

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

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

''(b) LIMITATION.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer and taxpayer's spouse and dependents for such month.''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

''SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

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

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

''(1) is in such form as the Secretary may prescribe, and

''(2) contains, with respect to each individual referred to in subsection (a)—

''(A) the name, address, and TIN of each such individual,

''(B) the months for which amounts payments under section 7527A were received,

''(C) the amount of each such payment,

''(D) the type of insurance coverage provided by such person with respect to such individual and the policy number associated with such coverage,

''(E) the name, address, and TIN of the spouse and each dependent covered under such coverage, and

''(F) such other information as the Secretary may prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name

is required to be set forth in such return a written statement showing—

''(1) the contact information of the person required to make such return, and

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

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by inserting after clause (xxiii) the following new clause:

"(xxiv) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance), and".

(B) Paragraph (2) of section 6724(d) is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or" and by inserting after subparagraph (FF) the following new subparagraph:

"(GG) section 6050X (relating to returns relating to credit for qualified refund eligible health insurance).".

(d) CONFORMING AMENDMENTS.—

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

(2)(A) Section 24(b)(3)(B) is amended by inserting ", 25E," after "25D".

(B) Section 25(e)(1)(C)(ii) is amended by inserting "25E," after "25D,".

(C) Section 25B(g)(2) is amended by inserting "25E," after "25D,".

(D) Section 26(a)(1) is amended by inserting "25E," after "25D,".

(E) Section 30(c)(2)(B)(ii) is amended by inserting ''25E,'' after ''25D,''.

(F) Section 30D(c)(2)(B)(ii) is amended by striking ''and 25D'' and inserting '', 25D, and 25E''.

(G) Section 904(i) is amended by inserting ''25E,'' after ''25B,''.

(H) Section 1400C(d)(2) is amended by inserting ''25E,'' after ''25D,''.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Qualified health insurance credit.''.

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:

''Sec. 7527A. Advance payment of credit for qualified refund eligible health insurance.''.

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

''Sec. 6050X. Returns relating to credit for qualified refund eligible health insurance.''.

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

SEC. 302. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYEE BENEFITS.

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

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

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

SEC. 303. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.

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

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

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

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

(B) Section 106(d)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

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

''(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

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

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

(d) EARNED INCOME CREDIT UNAFFECTED BY REPEALED EXCLUSIONS.—Subparagraph (B) of section 32(c)(2) is amended by redesignating clauses (v) and (vi)

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

''(v) the earned income of an individual shall be computed without regard to sections 105(f) and 106(f),''.

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

''(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.''.

(f) REPORTING REQUIREMENT.—Subsection (a) of section 6051 is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ''and'', and by inserting after paragraph (13) the following new paragraph:

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

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

lowing: ''Such term shall not include any premium for coverage by an accident or health insurance plan for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

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

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

Subtitle B—Health Savings Accounts

SEC. 311. IMPROVEMENTS TO HEALTH SAVINGS ACCOUNTS.

(a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

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

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—In the case of an eligible individual who has coverage under a high deductible health plan, the monthly limitation for any month of such coverage is 1/12 of the sum of—

"(i) the greater of—

"(I) the sum of the annual deductible and the other annual out-of-pocket expenses (other than for premiums) required to be paid under the plan by the eligible individual for covered benefits, or

"(II) in the case of an eligible individual who has—

"(aa) self-only coverage under a high deductible health plan as of the first day of such month, $3,000, or

"(bb) family coverage under a high deductible health plan as of the first day of such month, $5,950, and

"(ii) in the case of an eligible individual who has coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)), the lesser of—

"(I) the annual premium for such coverage, or

"(II) $1,000.

''(B) SPECIAL RULES RELATING TO OUT-OF-POCKET EXPENSES.—

''(i) REDUCTION FOR SEPARATE PLAN.—The annual out-of-pocket expenses taken into account under subparagraph (A)(i)(I) with respect to any eligible individual shall be reduced by any out-of-pocket expense payable under a separate plan covering the individual.

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

(2) APPLICATION OF SPECIAL RULES FOR MARRIED INDIVIDUALS.—Paragraph (5) of section 223(b) (relating to limitations) is amended to read as follows:

''(5) SPECIAL RULES FOR MARRIED INDIVIDUALS.—

''(A) IN GENERAL.—In the case of individuals who are married to each other and who are both eligible individuals, the limitation under

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

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

"(i) the lesser of—

"(I) subject to subparagraph (C), the sum of the limitations computed separately under paragraph (1) for each spouse (including any additional contribution amount under paragraph (3)), or

"(II) the dollar amount in effect under subsection (c)(2)(A)(ii)(II), over

"(ii) the aggregate amount paid to Archer MSAs of such spouses for the taxable year.

"(C) SPECIAL RULE WHERE BOTH SPOUSES HAVE FAMILY COVERAGE.—For purposes of subparagraph (B)(i)(I), if either spouse has family coverage which covers both spouses, both spouses shall be treated as having only such coverage (and if both spouses each have

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

''(D) APPLICABLE SHARE.—For purposes of subparagraph (A), a spouse's applicable share is ½ of the combined marital limit unless both spouses agree on a different division.

''(E) COUPLES NOT MARRIED ENTIRE YEAR.—The Secretary shall prescribe rules for the application of this paragraph in the case of any taxable year for which the individuals were not married to each other during all months included in the taxable year, including rules which allow individuals in appropriate cases to take into account coverage prior to marriage in computing the combined marital limit for purposes of this paragraph.''.

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

''(4) COVERAGE.—

''(A) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

"(B) SELF-ONLY COVERAGE.—If more than 1 individual is covered by a high deductible health plan but only 1 of the individuals is an eligible individual, the coverage shall be treated as self-only coverage.".

(4) CONFORMING AMENDMENTS.—

(A) Section 223(b)(3)(A) is amended by striking "subparagraphs (A) and (B) of".

(B) Section 223(c)(2)(A) is amended—

(i) by striking "$1,000" in clause (i)(I) and inserting "$1,150", and

(ii) by striking "$5,000" in clause (ii)(I) and inserting "$5,800".

(C) Section 223(d)(1)(A)(ii)(I) is amended by striking "subsection (b)(2)(B)(ii)" and inserting "subsection (c)(2)(A)(ii)(II)".

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

"(ii) CERTAIN ITEMS DISREGARDED IN COMPUTING MONTHLY LIMITATION.—Such plan's annual deductible, and such plan's annual out-of-pocket limitation, for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2)."

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

''(g) COST-OF-LIVING ADJUSTMENTS.—

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

''(2) BLENDED COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the blended cost-of-living adjustment means one-half of the sum of—

''(A) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof, plus

''(B) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting '2008' for '1996' in subclause (II) thereof.

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

(b) USE OF ACCOUNT FOR INDIVIDUAL HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.—Section 223(d)(2)(C) (relating to exceptions) is amended by striking ''or'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', or'', and by adding at the end the following new clause:

''(v) a high deductible health plan, but only if—

''(I) the plan is not a group health plan (as defined in section 5000(b)(1) without regard to section 5000(d)), and

''(II) the expenses are for coverage for a month with respect to which the account beneficiary is an eligible individual by reason of the coverage under the plan.

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

ganization negotiates the cost of benefits of such arrangement.''.

(c) SAFE HARBOR FOR ABSENCE OF MAINTENANCE OF CHRONIC DISEASE.—Section 223(c)(2)(C) (safe harbor for absence of preventive care deductible) is amended—

(1) by inserting ''or maintenance of chronic disease, or both'' after ''the Secretary)'', and

(2) by inserting ''OR MAINTENANCE OF CHRONIC DISEASE'' in the heading after ''PREVENTIVE CARE''.

(d) CLARIFICATION OF TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MEDICAL CARE.—Section 213(d) (relating to definitions) is amended by adding at the end the following new paragraph:

''(12) TREATMENT OF CAPITATED PRIMARY CARE PAYMENTS.—Capitated primary care payments shall be treated as amounts paid for medical care.''.

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

''(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR VETERANS OR INDIAN HEALTH BEN-

EFITS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services under any law administered by the Secretary of Veterans Affairs or the Bureau of Indian Affairs.''.

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

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

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

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

(g) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2009.

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

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

SEC. 312. EXCEPTION TO REQUIREMENT FOR EMPLOYERS TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

(a) GREATER EMPLOYER-PROVIDED CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES TREATED AS MEETING COMPARABILITY REQUIREMENTS.—Subsection (b) of section 4980G (relating to failure of employer to make comparable health savings account contributions) is amended to read as follows:

''(b) RULES AND REQUIREMENTS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

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

''(A) IN GENERAL.—Any contribution by an employer to a health savings account of an employee who is (or the spouse or any dependent of the employee who is) a chronically ill individual in an amount which is greater than a contribution to a health savings account of a

comparable participating employee who is not a chronically ill individual shall not fail to be considered a comparable contribution.

''(B) NONDISCRIMINATION REQUIREMENT.—Subparagraph (A) shall not apply unless the excess employer contributions described in subparagraph (A) are the same for all chronically ill individuals who are similarly situated.

''(C) CHRONICALLY ILL INDIVIDUAL.—For purposes of this paragraph, the term 'chronically ill individual' means any individual whose qualified medical expenses for any taxable year are more than 50 percent greater than the average qualified medical expenses of all employees of the employer for such year.''.

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

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

SEC. 401. MEDICAID MODERNIZATION.

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

"TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

"TABLE OF CONTENTS OF TITLE

''SEC. 1900. REFERENCES TO PRE-MODERNIZED MEDICAID PROVISIONS; CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.

''(a) IN GENERAL.—In this title, if a reference to this title or to a provision of this title is prefaced by the term 'old', such reference is to this title or a provision of this title as in effect on December 31, 2010.

''(b) REGULATIONS.—The Secretary shall promulgate regulations to bring requirements imposed under an old provision of this title that applies under this title after December 31, 2010, into conformity with the policies embodied in this title as in effect on and after January 1, 2011.

''(c) CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.—In the case of Puerto Rico, the United States Virgin Islands, Guam, the Northen Mariana Islands, and American Samoa, this title as in effect on and after January 1, 2011, shall not apply to such commonwealths and territories, and old title XIX shall apply to a Medicaid program operated by such commonwealths or territories on and after that date.

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

"SEC. 1901. PURPOSE; APPROPRIATION.

''(a) PURPOSE.—It is the purpose of this part to enable each State, as far as practicable under the conditions in the State, to provide acute care medical assistance to eligible individuals described in section 1903 whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.

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

"SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

"(a) IN GENERAL.—From the amounts appropriated under section 1901 for a fiscal year, the Secretary shall pay to each State which has a plan approved under this part, for each quarter, beginning with the quarter commencing January 1, 2011, an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as acute care medical assistance under the State plan under this part.

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

"SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

"(a) ELIGIBLE INDIVIDUALS.—

"(1) IN GENERAL.—In this part, the term 'eligible individual' means an individual—

"(A) who is—

"(i) a blind or disabled individual; or

"(ii) an individual described in paragraph (2); and

''(B) who the State determines satisfies—

''(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

''(ii) such other requirements for assistance as are imposed under this title, including documentation of citizenship or status as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

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

''(A) A child in foster care under the responsibility of the State.

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

''(C) Certain TB-infected individuals described in old section 1902(z)(1).

''(3) GRANDFATHERED INDIVIDUALS.—An individual shall be an eligible individual under the State plan under this part if—

''(A) the individual is described in paragraph (1)(A);

''(B) the individual satisfies the documentation requirements referred to in paragraph (1)(B)(ii); and

''(C) the State would have provided medical assistance under the State plan under old title XIX to the individual, but only so long as the individual continues to satisfy such old eligibility requirements.

''(4) CONCURRENT ELIGIBILITY FOR PART B.—An eligible individual under this part may be eligible under part B, but only if the individual satisfies the eligibility requirements of part B in addition to satisfying the requirements for eligibility under this part.

''(5) PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS.—Old section 1920B (relating to presumptive eligibility for certain breast or cervical cancer patients) shall apply under this part.

''(b) BENEFITS.—Subject to paragraph (3), in this part, the term 'acute care medical assistance' means the following:

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

paragraph (4)(A) of such section, without regard to any limitation based on age or services in an institution for mental diseases).

''(2) OPTIONAL BENEFITS.—Any care or services listed in a paragraph of old section 1905(a) (other than paragraph (16)).

''(3) EXCEPTIONS.—

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

''(B) LIMIT ON PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—A care or service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(a)(4)(A)) shall not be provided to an individual under the State plan under this part for more than 30 days within any 12-month period.

''(C) EXCLUSIONS.—Such term shall not include any payments with respect to care or services for any individual who is an inmate of a public institution or a patient in an institution for mental diseases (regardless of age).

"SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

''(a) IN GENERAL.—In order to receive payments under this part, a State shall have an approved State plan for acute care medical assistance. For purposes of this part, such assistance includes payments for preventive care, primary care, diagnosis and treatment of acute and chronic health conditions, emergency care, diagnosis and treatment of mental illnesses and related conditions, and rehabilitation and other services to help eligible individuals attain or retain capability for independence or self-care. A State medical assistance plan shall include a description, consistent with the requirements of this part of—

''(1) eligibility standards, including income and asset standards;

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

''(3) strategies for improving access and quality of care; and

''(4) methods of service delivery.

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

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

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

''(d) APPLICATION OF CERTAIN PRE-MODERNIZED MEDICAID REQUIREMENTS.—

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

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

''(B) Old section 1902(a)(10)(D) (relating to home health services).

''(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

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

''(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

''(F) Old section 1902(a)(19) (relating to eligibility safeguards).

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

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

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

''(J) The fourth and sixth sentences of old section 1902(a) (relating to eligibility for certain individuals).

''(2) OTHER OLD TITLE XIX REQUIREMENTS.—

''(A) Old section 1902(e)(3) (relating to optional eligibility for certain disabled individuals).

''(B) Old section 1902(e)(9) (relating to optional respiratory care services).

''(C) Old section 1902(f) (relating to eligibility of certain aged, blind, or disabled individuals).

''(D) Old section 1902(m) (relating to eligibility of certain aged or disabled individuals), other than paragraph (4).

''(E) Old section 1902(o) (relating to disregard of certain supplemental security income benefits).

''(F) Old section 1902(v) (relating to eligibility determinations of blind or disabled individuals).

''(e) OTHER REQUIREMENTS.—The State plan under this part shall—

''(1) comply with the requirements of the other parts of this title; and

''(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act .

''SEC. 1905. DEFINITIONS.

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

''(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' for any State shall be 100 percent less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States

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

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

''(1) OLD SECTION 1905 PROVISIONS.—The following provisions of old section 1905:

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

''(B) Old section 1905(e) (relating to the definition of physicians services).

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

''(D) Old section 1905(g) (relating to the provision of chiropractors' services).

''(E) Old section 1905(j) (relating to State supplementary payments).

''(F) Old section 1905(k) (relating to supplemental security income benefits payable pursuant to section 211 of Public Law 93–66).

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

"(H) Old section 1905(o) (relating to hospice care).

"(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

"(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

"(K) Old section 1905(s) (relating to the definition of a qualified disabled and working individual).

"(L) Old section 1905(t) (relating to the definition of primary care case management services).

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

"(N) Paragraphs (1) and (3) of old section 1905(w) (relating to the definition of an independent foster care adolescent).

"(O) Old section 1905(x) (relating to strategies, treatment, and services for individuals with Sickle Cell Disease).

''(2) OTHER OLD PROVISIONS.—

''(A) Old section 1903(m) (relating to the definition of a medicaid managed care organization).

"SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS AND OTHER ARRANGEMENTS.

''The following old provisions shall apply under this part:

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

''(2) Old section 1902(a)(70) (relating to State option to establish a non-emergency medical transportation brokerage program).

''(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

"SEC. 1907. DRUG REBATES.

''Old sections 1902(a)(54) and 1927 (relating to payment for covered outpatient drugs and rebates) shall apply under this part.

"SEC. 1908. MANAGED CARE.

''The following old provisions shall apply under this part:

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

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

''SEC. 1909. ANNUAL REPORTS.

''(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

''(b) APPLICATION OF OLD EPSDT REPORTING REQUIREMENTS.—Each annual report shall include the information required to be reported under old section 1902(a)(43)(D)(iv).

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

''SEC. 1911. PURPOSE.

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

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

''(2) emphasize the independence and dignity of the person served by public programs;

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

''(4) provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

''(5) provide flexibility to States to adopt new and innovative service delivery methods; and

''(6) promote independence and support activities that will enable individuals to return or maintain ties to the community, including through employment.

''(b) NO INDIVIDUAL ENTITLEMENT.—No individual determined eligible for long-term care services and supports under this part shall be entitled to a specific service or type of delivery of service.

''SEC. 1912. STATE PLAN.

''(a) IN GENERAL.—In order to receive payments under this part, a State must have an approved State plan for long-term care services and supports. A State long term care services and supports plan shall include a description, consistent with the requirements of this part, of—

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

''(2) the standardized assessments tools used to determine eligibility for specific long-term care services and supports;

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

''(4) the proposed uses of funding, if applicable, to provide targeted methods to meet individual level of support needs including tiering (preventive, emergency, low, medium, high); and

''(5) the long-term care services and supports to be available under the plan based on individual assessment of need in accordance with sections 1916 and 1917.

''(b) MINIMUM ELIGIBILITY STANDARDS.—

''(1) POPULATIONS COVERED.—The State plan shall specify the disabled and elderly populations who are eligible for long-term care services and supports.

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

cific services and supports available under the State plan.

''(3) OTHER ELIGIBILITY REQUIREMENTS.—

''(A) INCOME AND ASSETS.—A State may use different income and asset standards and methodologies for determining eligibility than those used for determining eligibility for acute care medical assistance under part A. A State may not make eligibility standards related to income, asset, and spousal impoverishment protection more restrictive than the Federal minimum requirements of December 31, 2008.

''(B) APPLICATION OF SPOUSAL IMPOVERISHMENT PROTECTIONS.—The State plan shall provide that the State shall comply with the requirements of section 1918 (relating to spousal impoverishment protections).

''(C) STATEWIDENESS.—The State plan shall provide that, except with respect to methods used for determining homestead exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.

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

sistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX (or under a waiver of that plan) and receiving long-term care services or supports on that date. The State shall provide such assistance to individuals who are and are not likely to be determined eligible for long-term care services and supports under the State plan under this part, as in effect on January 1, 2011 (or the first day on which the State plan is in effect under this part).

''(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

''(1) IN GENERAL.—The State plan shall describe the methodologies used to determine payments to providers. Such methodologies—

''(A) may be varied to assist in transitioning from facilities-based to community-based care; and

''(B) shall not be subject to Secretarial approval.

''(2) TRANSPARENCY.—The State plan shall provide that the State shall make publicly available—

''(A) the payment methodologies applicable under the plan; and

''(B) the name of any provider that receives $1,000,000 or more in any 12-month period and the actual amount paid to the provider during that period.

''(d) COORDINATION OF EFFORT WITH OTHER RELATED PUBLIC AND PRIVATE PROGRAMS.—The plan shall include a description of the State's efforts to coordinate the delivery of services and supports under the plan with other related public and private programs that serve individuals with disabilities or aged populations that need or may be at risk of needing long term care.

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

''(f) APPLICATION OF OLD TITLE XIX REQUIREMENTS.—The following old title XIX provisions shall apply to a State plan under this part:

''(1) Subsections (a)(50) and (q) of old section 1902 (relating to a monthly personal needs allowance for certain institutionalized individuals and couples).

''(2) Old section 1902(a)(67) (relating to payment for certain services furnished to a PACE program eligible individual).

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

''(4) Old section 1905(i) (relating to the definition of an institution for mental diseases).

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

''(1) comply with the requirements of the other parts of this title; and

''(2) provide that the State will make the contributions specified under section 340A–1(e) of the Public Health Service Act.

''SEC. 1913. STATE ALLOTMENTS.

''(a) APPROPRIATION.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—

''(1) for fiscal year 2011, $65,274,560,000;

''(2) for fiscal year 2012, $67,885,540,000;

''(3) for fiscal year 2013, $70,600,964,100;

''(4) for fiscal year 2014, $73,425,000,000;

''(5) for fiscal year 2015, $76,362,000,000;

''(6) for fiscal year 2016, $79,416,480,000;

''(7) for fiscal year 2017, $82,593,140,000;

''(8) for fiscal year 2018, $85,896,870,000; and

''(9) for fiscal year 2019, $89,332,743,000.

''(b) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

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

''(2) SUBSEQUENT FISCAL YEAR ALLOTMENTS.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

''(c) LIMITATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no other Federal funds are available under this title for expenditures incurred for long-term care services and supports after December 31,

2010, except as provided under a State plan approved under this part.

''(2) EXCEPTION.—

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

''(B) FULL FUNDING.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

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

''(e) GRANTS REDUCED IF INSUFFICIENT APPROPRIATIONS.—

''(1) IN GENERAL.—If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State's allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2).

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

''If the ratio of the State's non-institutional spending to total long-term care spending for fiscal year 2009 is:	**The applicable percentage is:**
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.

''(f) ADMINISTRATIVE EXPENSES.—

''(1) IN GENERAL.—Each State with a plan approved under this part shall receive a payment determined in accordance with amounts appropriated for part E for administrative expenses incurred in carrying out the plan under this part and part A.

''(2) ASSESSMENT-RELATED COSTS.—Costs attributable to providing an individualized needs-based assessment for purposes of identifying the long-term care services and supports to be provided under the State plan to an individual shall be considered a

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

"SEC. 1914. USE OF GRANTS.

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

"(b) SELF-DIRECTION.—A State shall offer individuals the opportunity to self-direct their long-term care services and supports.

"SEC. 1915. ADMINISTRATIVE PROVISIONS.

"(a) FUNDING ON A QUARTERLY BASIS.—The Secretary shall make payments to States in equal amounts of a State's annual allotment on a quarterly basis. Each quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.

"(b) PUBLICATION.—The Secretary shall publish each State's allotment—

"(1) for fiscal year 2011 not later than December 15, 2009; and

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

"SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES AND SUPPORTS.

"(a) DEFINITION.—

"(1) IN GENERAL.—Subject to subsection (e), in this part, the term 'long-term care services and supports' means any of the services or supports specified in paragraphs (2) or (3) that may be provided in a nursing facility, an institution, a home, or other setting.

"(2) SERVICES AND SUPPORTS DESCRIBED.—For purposes of paragraph (1), the services and supports described in this paragraph include assistive technology, adaptive equipment, remote monitoring equipment, case management for the aged, case management for individuals with disabilities, nursing home services, long-term rehabilitative services necessary to restore functional abilities, services provided in intermediate care facilities for people with disabilities, habilitation services (including adult day care programs), community treatment teams for individuals with mental illness, home health services, services provided in an institution for mental disease, a Program of All-Inclusive Care for the Elderly (PACE), personal care (including personal assistance services), recovery support including peer counseling, supportive employment, training skills necessary to assist the individual in achieving or maintaining independence, training of family members in-

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

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

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

''(B) Services described in subsections (a)(16) and (h) of old section 1905, but without regard to any restriction on such services on the basis of age (relating to inpatient psychiatric hospital services).

''(C) Old section 1905(a)(22) (relating to home and community care (to the extent allowed and as defined in old section 1929) for functionally disabled elderly individuals).

''(D) Old section 1905(a)(23) (relating to community supported living arrangements services (to the extent allowed and as defined in old section 1930)).

"(E) Subject to subsection (e), old section 1905(a)(24) but without regard to any restriction on furnishing services to patients or residents of facilities or institutions (relating to personal care services).

"(F) Old sections 1905(a)(26) and 1934 (relating to services furnished under a PACE program under old section 1934 to PACE program eligible individuals enrolled under the program under such old section).

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

"(4) LIMITATION.—Long-term care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster care parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.

"(b) REHABILITATIVE CARE.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, nursing home, or as part of home health expenditures as acute care benefits under the State plan under part A rather than under the State plan under this part for a cumulative period of 30 days within a 12-month pe-

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

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

''(d) APPLICATION OF PART A DEFINITIONS.—A definition specified in section 1905 shall apply to the same term used in this part, unless the Secretary determines that the application of such definition would be inconsistent with the purpose of this part.

''(e) EXCLUSION.—No payments shall be made under the State plan under this part with respect to long-term care supports and services provided for any individual who is an inmate of a public institution. Nothing in the preceding sentence shall be construed as precluding the provision of long-term care services and supports under the State plan under this part to an individual who is a patient in an institution for mental diseases.

"SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM CARE SERVICES AND SUPPORT, INCLUDING OPTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.

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

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of long-term care services and supports for individuals eligible under the State plan under this part, subject to the following requirements:

''(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, LONG-TERM CARE SERVICES AND SUPPORTS.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such long-term care services and supports, and if the individual is eligible for such services and supports, the specific services and supports that will be available under the State plan to the individual.

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

for, and receipt of, services and supports provided in a facility or institution that are more stringent that the criteria established for eligibility and receipt of services and supports in a non-facility or non-institutionalized setting.

''(C) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

''(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

''(i) IN GENERAL.—The criteria established by the State shall require an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

''(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for services exceeds the projected enrollment, but only if—

''(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

''(II) the State deems an individual receiving long-term care services and supports on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services and supports for a period of at least 12 months beginning on the date the individual first received medical assistance for such services and supports; and

''(III) after the effective date of such modification, the State, at a

minimum, applies the criteria for determining whether an individual requires the level of care provided in a facility or institutionalized setting which applied under the State plan immediately prior to the application of the modified criteria.

''(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

''(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraph (A).

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

''(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

''(II) prevent the provision of unnecessary or inappropriate care; and

"(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

"(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

"(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

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

"(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

"(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

''(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

''(vi) An evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services and supports if the individual so elects.

''(G) INDIVIDUALIZED CARE PLAN.—

''(i) IN GENERAL.—In the case of an individual who is determined to be eligible for long-term care services and supports, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

''(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

''(I) is developed—

''(aa) in consultation with the individual, the individual's

treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

''(bb) taking into account the extent of, and need for, any family or other supports for the individual;

''(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services and supports, funded for the individual); and

''(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

''(iii) STATE REQUIREMENT TO OFFER ELECTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.—

"(I) INDIVIDUAL CHOICE.—The State shall allow an individual or the individual's representative the opportunity to elect to receive self-directed long-term care services and supports in a manner which gives them the most control over such services and supports consistent with the individual's abilities and the requirements of subclauses (II) and (III).

"(II) SELF-DIRECTED.—The term 'self-directed' means, with respect to the long-term care services and supports offered under the State plan amendment, such services and supports for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services and supports, under the State plan consistent with the following requirements:

"(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports.

"(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services and supports for such individual that is approved by the State and that satisfies the requirements of subclause (III).

"(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

"(aa) specifies those services and supports which the individual or the individual's authorized representative would be responsible for directing;

"(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services and supports;

"(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services and supports;

"(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the

individual's authorized representative;

"(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services and supports in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

"(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

"(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

"(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

"(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(cc) provides a procedure to evaluate expenditures under such budgets.

"(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

"(i) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

"(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

"(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

"(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services and supports. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific long-term care services and supports that the individual will receive.

"(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any

other individual who is authorized to represent the individual.

''(b) SELF-DIRECTED PERSONAL ASSISTANCE SERVICES.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(j) in the case of an individual who elects to self-direct the receipt of such care or services.

''SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

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

''SEC. 1919. ANNUAL REPORTS.

''(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

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

''(1) The number of individuals served under the plan.

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

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

''(4) Expenditures by service category.

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

"SEC. 1931. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying our Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

''(1) for fiscal year 2011, $300,000,000; and

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

"SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

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

''(2) Old section 1902(a)(28) (relating to nursing facilities and nursing facility services).

''(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

''(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

''(5) Old section 1902(d) (relating to medical or utilization review functions).

''(6) Old section 1902(i) (relating to intermediate care facilities for the mentally retarded).

''(7) Old section 1902(y) (relating to psychiatric hospitals).

''(8) Paragraphs (2) and (6) of old section 1903(g) (relating to the Secretarial requirement to conduct sample onsite surveys of private and public institutions and recertifications for the need for certain services).

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

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

''(11) Old section 1911 (relating to Indian Health Service facilities).

''(12) Old section 1913 (relating to hospital providers of nursing facility services).

''(13) Old section 1919 (relating to requirements for nursing facilities).

''PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

''SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

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

''(1) for fiscal year 2011, $100,000,000; and

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

''(b) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.—

''(1) AVAILABILITY.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

''(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL EXPENSES FOR ATTENDEES AT EDUCATION, TRAINING, OR CONSULTATIVE ACTIVITIES.—

''(A) IN GENERAL.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business, of individuals described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

''(B) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

''(i) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

''(ii) the amount of funds expended for each such conference that were for transportation and for travel expenses.

''(c) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year, the Secretary shall submit a report to Congress which identifies—

''(1) the use of funds appropriated pursuant to subsection (a); and

''(2) the effectiveness of the use of such funds.

''SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) Old subsections (a)(25) (other than subparagraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

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

''(3) Old section 1902(a)(32) (relating to certain payment requirements).

''(4) Old section 1902(a)(35) (relating to disclosing entities under section 1124).

''(5) Old section 1902(a)(37) and the fifth sentence (relating to claims payment procedures).

''(6) Old section 1902(a)(44) (relating to payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services).

''(7) Old sections 1902(a)(45) and 1912 (relating to assignment of rights of payment).

''(8) Old sections 1902(a)(49) and 1921 (relating to information and access to information concerning sanctions taken by State licensing authorities against health care practitioners and providers).

''(9) Old sections 1902(a)(61) and 1903(q) (relating to requirements for a medicaid fraud and abuse control unit).

''(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

''(11) Old section 1902(a)(65) (relating to provider number and surety bond requirement for suppliers of durable medical equipment).

''(12) Old section 1902(a)(68) (relating to requirements for certain entities).

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

''(14) Old section 1902(a)(70)(B)(iv) (relating to prohibitions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

''(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

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

''(17) Old section 1902(x) (relating to unique identifiers for physicians).

''(18) Old section 1903(p) (relating to interstate collection of rights of support).

''(19) Old section 1903(r)(2) (relating to requirements for mechanized claims processing and information retrieval systems).

''(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (v) of paragraph (1)(D).

''(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations

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

''(22) Old section 1903(x) (relating to citizenship documentation).

''(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

''(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

''(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

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

''PART E—GRANTS TO STATES FOR ADMINISTRATION

''SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

''(a) IN GENERAL.—For the purpose of providing grants to States for administrative expenses necessary to carry out parts A and B, there is authorized to be appropriated—

''(1) for fiscal year 2011, $7,000,000,000; and

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

''(b) PAYMENTS TO STATES.—

''(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2008 (as such section was in effect for that fiscal year) to the total amount of such payments made to all States for such fiscal year.

''(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year as necessary so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

''SEC. 1952. COST-SHARING PROTECTIONS.

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

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

''(1) The State may (in a uniform manner) require payment of monthly premiums or other cost-sharing set on a sliding scale based on family income.

''(2) A premium or other cost-sharing requirement imposed under paragraph (1) may only apply to the extent that, in the case of an individual whose family income—

''(A) exceeds 150 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges imposed under the plan does not exceed 5 percent of the individual's annual income; and

''(B) exceeds 250 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges do not exceed 7.5 percent of the individual's annual income.

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

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

''(b) APPLICATION TO INSTITUTIONALIZED INDIVIDUALS.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that rules relating to the post-eligibility treatment of income (including a minium monthly personal needs allowance) applicable to institutionalized individuals under old title XIX shall apply in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

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

"SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply to the State plans under this title:

"(1) OLD STATE PLAN REQUIREMENTS.—

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

"(B) Old section 1902(a)(2) (relating to State financial participation).

"(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

"(D) Old section 1902(a)(4) (relating to administration).

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

"(F) Old section 1902(a)(6) (relating to reporting requirements).

"(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

"(H) Old section 1902(a)(8) (relating to applications for assistance).

"(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).

"(J) Old section 1902(a)(12) (relating to determinations of blindness).

''(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services), other than clause (iv) of subparagraph (A).

''(L) Subsections (a)(15) and (bb) of old section 1902(a) (relating to payment for services provided by rural health clinics and federally qualified health centers).

''(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

''(N) Old section 1902(a)(22) (relating to certain administrative provisions).

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

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

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

''(R) Old section 1902(a)(27) (relating to provider record keeping requirements).

''(S) Old section 1902(a)(30)(A) (relating to utilization review).

''(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

''(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

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

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

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

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

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

''(AA) Old section 1902(a)(42) (relating to certain audit requirements).

''(BB) Old section 1902(a)(48) (relating to eligibility cards).

''(CC) Old section 1902(a)(55) (relating to the receipt and initial processing of applications, but only to the extent such section is con-

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

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

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

''(FF) The second sentence of old section 1902 (relating to designation of certain State agencies).

''(GG) Old section 1902(b) (relating to limitations on approval of plans).

''(HH) Old section 1902(j) (relating to application of requirements to American Samoa and the Northern Mariana Islands).

''(2) OTHER OLD TITLE XIX REQUIREMENTS.—

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

''(B) Old section 1903(c) (relating to furnishing of services included in a program or plan under part B or C of the Individuals with Disabilities Education Act).

''(C) Old section 1903(d) (relating to payments).

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

''(E) Old section 1903(i) (relating to limitations on payments).

''(F) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

''(G) Subsections (b)(5) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

''(H) Old section 1904 (relating to operation of State plans).

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

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

''PART F—OTHER PROVISIONS

''SEC. 1961. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

''The following old provisions shall apply under this part:

''(1) The third sentence of old section 1902 (relating to nonapplication of certain old provisions to a religious nonmedical health care institution).

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

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

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

SEC. 402. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2009, $100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

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

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

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.

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

SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) IN GENERAL.—

(1) Not later than June 30, 2010, a State that is one of the 50 States or the District of Columbia shall inform all individuals enrolled in a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) No State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI (as in effect for fiscal year 2010) after December 31, 2010.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.—Not later

than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

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

SEC. 411. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Health Care Assistance to Low-Income Families

"SEC. 340A–1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

''(a) IN GENERAL.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in accessing health care.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

''(A) a family shall—

''(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

''(ii) have a gross income that does not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

''(iii) include at least 1 individual who is a dependent under the age of 19; and

''(B) no member of the family shall be covered by private health insurance.

''(2) DETERMINATION OF GROSS INCOME.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not older than age 65, except that the income of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

''(3) LIMITATION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

''(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph

(1) is eligible to qualify separately for financial assistance under this section.

''(B) ALIENS.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

''(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH CARE EXPENDITURES.—

''(1) IN GENERAL.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card with a dollar-amount value, in accordance with subsection (d), that may be used to pay for qualifying health care expenses.

''(2) USE OF THE DEBIT CARD.—

''(A) QUALIFYING HEALTH CARE EXPENSES.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

''(i) the purchase of health care insurance for any member of the family;

''(ii) cost sharing expenses related to health care, including deductibles, copay-

ments, and coinsurance, for any member of the family; and

"(iii) the direct purchase of health care services and supplies for any member of the family.

"(B) GEOGRAPHIC RANGE.—Each supplemental debit card may be used to pay for qualifying health care expenses incurred anywhere in the 50 States or the District of Columbia.

"(C) LIMITATIONS.—No supplemental debit card shall be used to make a payment for any cost—

"(i) incurred prior to the determination of the family's eligibility for assistance under this section; or

"(ii) that is not a health-related expense.

"(3) ROLLOVER OF UNUSED AMOUNTS.—Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover—

"(A) to the family's supplemental debit card for expenditure during the subsequent 12-month period, provided that the family to which the supplemental debit card was issued in the

previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

"(B) to the family's health savings account (as defined in section 223(g)(2) of the Internal Revenue Code of 1986).

"(4) MONTHLY STATEMENTS.—The Secretary shall issue a monthly statement to each family to which a supplemental debit card has been issued under this section, which shall state each payment made with the family's supplemental debit card during the month covered by the statement, the dollar amount of each such payment, and the provider to which each such payment was made.

"(d) AMOUNT OF FINANCIAL ASSISTANCE.—

"(1) AMOUNTS FOR CALENDAR YEAR 2011.—Subject to paragraph (5), the amount of financial assistance available to each eligible family during the calendar year 2011 shall be determined as follows:

"(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive $5,000.

"(B) Each family whose annual income exceeds 100 percent, but does not exceed 200 per-

cent, of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

"(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent, of the poverty level, $4,000.

"(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent, of the poverty level, $3,500.

"(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent, of the poverty level, $3,000.

"(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent, of the poverty level, $2,500.

"(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent, of the poverty level, $2,000.

"(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to para-

graph (5), the following amounts shall be added to the supplemental debit cards of qualifying families:

"(A) For each pregnancy during which a pregnant woman's family is eligible for assistance under this section, an additional amount of $1,000 shall be added to the family's supplemental debit card, except that no family shall receive such additional $1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

"(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of $500 shall be added to the family's supplemental debit card.

"(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of sec-

tion 25E of the Internal Revenue Code for the taxable year involved.

''(4) STATE OPTION TO INCREASE AMOUNTS.—At the option of each State, amounts in excess of the annual dollar amounts under paragraphs (1) and (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

''(5) RISK ADJUSTMENT.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

''(e) CONTRIBUTIONS OF STATES.—

''(1) IN GENERAL.—As a condition for receiving Federal funds under Part A or Part B of Medicaid, each State shall contribute 50 percent of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.

''(2) PAYMENTS FROM STATES.—

''(A) BILLING NOTIFICATION.—

''(i) TIMING.—On June 30th and December 31st of each year, the Secretary shall send written notification to each State of that State's 50 percent share of expenses, as described in paragraph (1), for the 6-month period ending on the last day of the month previous to such notification.

''(ii) CONTENTS.—Each such notification to a State shall clearly state—

''(I) the payment amount due from the State;

''(II) the name of each individual for whom payment was made through the supplemental debit card program;

''(III) the health care provider to whom each payment was made;

''(IV) the amount of each payment; and

''(V) any other information, as the Secretary requires.

''(B) PAYMENTS.—Each State shall make a payment to the Secretary, in the amount

billed, not later than 30 days after the billing notification date, in accordance with subparagraph (A)(i).

''(C) PENALTIES.—If a State fails to pay to the Secretary an amount required under subparagraph (B), interest shall accrue on such amount at the rate provided under old section 1903(d)(5) of the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

''(f) ENROLLMENT.—

''(1) IN GENERAL.—The Secretary shall establish procedures and times for enrollment in the supplemental debit card program. Open enrollment shall be available not less than 4 times per calendar year.

''(2) TRANSITION OF INDIVIDUALS ENROLLED IN MEDICAID OR THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—

''(A) INFORMATION FROM THE STATES.—Each State shall—

''(i) not later than June 30, 2010, inform all individuals then enrolled in Med-

icaid or the State Children's Health Insurance Program (SCHIP), of the changes in effect beginning on January 1, 2011; and

"(ii) not later than October 31, 2010, redetermine the eligibility of each individual enrolled in Medicaid or SCHIP, other than those individuals who qualify for Medicaid or SCHIP as disabled, elderly, or a special population, for the supplemental debit card program, according to the eligibility criteria under subsection (b).

"(B) AUTOMATIC ENROLLMENT.—The Secretary shall provide for the automatic enrollment in the supplemental debit card program of all individuals who are enrolled in Medicaid or SCHIP and who have been redetermined by a State under subparagraph (A) to be eligible for Medicaid or SCHIP. Any individual who is determined by a State not to qualify for the supplemental debit card program may retain coverage under Medicaid or SCHIP until June 30, 2011.

"(3) ASSISTANCE WITH QUALIFIED HEALTH INSURANCE CREDIT.—Each State shall, to the extent practicable, provide individuals residing within the

State with information regarding the qualified health insurance credit described in section 25E of the Internal Revenue Code of 1986, including information regarding eligibility for, and how to claim, such credit.

''(g) ADMINISTRATION.—

''(1) NATIONAL SYSTEM.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a unified national system to support the processes and transactions necessary to administer this section.

''(2) AUTOMATED SYSTEM.—The Secretary shall establish an automated means, such as an electronic benefit transfer system, by which the benefits under this section shall be transferred to eligible families.

''(3) VERIFICATION OF APPLICANT INFORMATION.—The Secretary may verify information provided by applicants with the appropriate Federal, State, and local agencies, including the Internal Revenue Service, the Social Security Administration, the Department of Labor, and child support enforcement agencies.

''(4) CHOICE COUNSELING.—The Secretary may enter into contracts or agreements with a State, a consortium of a State, or a private entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

''(5) APPEALS.—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

''(6) RESOLUTION OF ERRORS.—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information in a family's application or in the billing process described in subsection (e).

''(7) PENALTIES FOR FALSE INFORMATION.—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance paid on behalf of such person and all members of such person's family.

''(h) IMPLEMENTATION PLAN.—Not later than 6 months after the date of enactment of this section, the Secretary shall submit to Congress a plan for implementing this program during fiscal years 2009–2012.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) ADMINISTRATION OF THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To administer the program under this section, there are authorized to be appropriated—

''(A) for fiscal year 2009, $300,000,000, for the design of a unified, national system of conducting the supplemental debit card program;

''(B) for fiscal year 2010, $1,000,000,000 for start-up costs, including, contracting, hiring and training employees, and testing the program; and

''(C) for fiscal year 2011 and each subsequent fiscal year, $3,000,000,000.

''(2) AUTHORIZATION OF BENEFITS UNDER THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To provide the supplemental debit card benefits described in this section, there are authorized to be appropriated—

"(A) for fiscal year 2011, $24,020,000,000;

"(B) for fiscal year 2012, $25,220,000,000;

"(C) for fiscal year 2013, $26,480,000,000;

"(D) for fiscal year 2014, $27,810,000,000; and

"(E) for fiscal year 2015, $29,200,000,000.".

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.

Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"MEDICARE ADVANTAGE COMPETITIVE BIDDING

"SEC. 1860C–2. (a) COMPETITIVE BIDDING.—

"(1) IN GENERAL.—In order to promote competition among Medicare Advantage plans and to increase the quality of care furnished under such plans, the Secretary shall establish and implement a competitive bidding mechanism under this part.

''(2) MECHANISM TO BEGIN IN 2011.—The mechanism established under paragraph (1) shall apply to all MA organizations and plans beginning in 2011.

''(3) NO EFFECT ON PART D BENEFITS.—The mechanism established under paragraph (1) shall not affect the provisions of this part relating to benefits under part D, including the bidding mechanism used for benefits under such part.

''(b) RULES FOR COMPETITIVE BIDDING MECHANISM.—Notwithstanding any other provision of this part, the following rules shall apply under the competitive bidding mechanism established under subsection (a).

''(1) BENCHMARK.—Benchmark amounts for an area for a year shall be established solely through the competitive bids of MA plans. The benchmark amount for each area for a year shall be the average bid of the plans in that area for that year. In establishing the benchmark for an area for a year under the preceding sentence, the Secretary shall exclude the highest and lowest bid for that area and year. The benchmark amount for an area for a year may not exceed the benchmark amount for that area and year that would have applied if this section had not been enacted.

''(2) BIDS.—The MA plan bid shall reflect the per capita payments that the MA plan will accept for providing a benefit package that is actuarially equivalent to 106 percent of the value of the original Medicare fee-for-service program option. MA plan bid submissions shall include data on plan average provider network contract rates compared to the rates under the original Medicare fee-for-service program option for the top 5 most common claim submissions per provider type.

''(3) RISK ADJUSTMENT.—The benchmark under paragraph (1) and the MA plan bid shall be risk adjusted using the risk adjustment requirements under this part.

''(4) BENEFICIARY PREMIUMS.—The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is at or below the benchmark shall be zero and the beneficiary shall receive the full difference (if any) between the bid and the benchmark in the form of additional benefits or as a rebate on their premiums under this title. The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is above the benchmark shall be

equal to the amount by which the bid exceeds the benchmark.

''(5) BENCHMARK AMOUNTS FOR RURAL COUNTIES.—The Secretary may adjust the benchmark amount established under paragraph (1) for any rural county (as identified by the Secretary after consultation with the Secretary of Commerce) to encourage plan participation in such county.

''(6) EXISTING REQUIREMENTS.—Requirements relating to licensure, quality, and beneficiary protections that would otherwise apply under this part shall apply under the competitive bidding mechanism established under subsection (a).

''(c) WAIVER.—In order to implement the competitive bidding mechanism under established subsection (a), the Secretary may waive or modify requirements under this part.''.

SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to promote innovative care coordination and delivery that is cost-effective, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall

conduct a demonstration program under the Medicare program under which—

(A) groups of providers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (in this section referred to as an ''ACO''); and

(B) providers in participating ACOs are eligible for bonuses based on performance.

(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—In this section, the term ''Medicare fee-for-service beneficiary'' means an individual who is enrolled in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act and not enrolled in an MA plan under part C of such title.

(b) ELIGIBLE ACOS.—

(1) IN GENERAL.—Subject to paragraph (2), the following provider groups are eligible to participate as ACOs under the demonstration program under this section:

(A) Physicians in group practice arrangements.

(B) Networks of individual physician practices.

(C) Partnerships or joint venture arrangements between hospitals and physicians.

(D) Partnerships or joint ventures, which may include pharmacists providing medication therapy management.

(E) Hospitals employing physicians.

(F) Integrated delivery systems.

(G) Community-based coalitions of providers.

(2) REQUIREMENTS.—An ACO shall meet the following requirements:

(A) The ACO shall have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.

(B) The ACO shall include the primary care providers of at least 5,000 Medicare fee-for-service beneficiaries.

(C) The ACO shall be willing to become accountable for the overall care of the Medicare fee-for-service beneficiaries.

(D) The ACO shall provide the Secretary with a list of primary care and specialist physi-

cians participating in the ACO to support the beneficiary assignment, implementation of performance measures, and the determination of bonus payments under the demonstration program.

(E) The ACO shall have in place contracts with a core group of key specialist physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES.—

(1) IN GENERAL.—Under the demonstration program under this section, each Medicare fee-for-service Medicare beneficiary shall be automatically assigned to a primary care provider. Such assignment shall be based on the physician from whom the beneficiary received the most primary care in the preceding year.

(2) BENEFICIARIES MAY CONTINUE TO SEE PROVIDERS OUTSIDE OF THE ACO.—Under the demonstration program under this section, a Medicare fee-for-service Medicare beneficiary may continue to see providers in and outside of the ACO to which they have been assigned.

(d) BONUS PAYMENTS.—

(1) IN GENERAL.—Under the demonstration program, Medicare payments shall continue to be made to providers under the original Medicare fee-for-service program in the same manner as they would otherwise be made except that a participating ACO is eligible for bonuses if—

(A) it meets certain quality performance measures; and

(B) spending for their Medicare fee-for-service beneficiaries meets the requirement under paragraph (3).

(2) QUALITY.—Under the demonstration program under this section, providers meet the requirement under paragraph (1)(A) if they generally follow consensus-based guidelines established by non-government professional medical societies. Patient satisfaction and risk-adjusted outcomes shall be determined through an independent entity with medical expertise.

(3) REQUIREMENT RELATING TO SPENDING.—

(A) IN GENERAL.—An ACO shall only be eligible to receive a bonus payment if the average Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries over a

two-year period is at least 2 percent below the average benchmark for the corresponding two-year period. The benchmark for each ACO shall be set using the most recent three years of total per-beneficiary spending for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be updated by the projected rate of growth in national per capita spending for the original medicare fee-for-service program, as projected (using the most recent three years of data) by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(4) AMOUNT OF BONUS PAYMENTS.—The amount of the bonus payment to a participating ACO shall be one-half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark. The bonus amount, in dollars, shall be equal to the bonus share multiplied by the benchmark for the most recent year.

(5) LIMITATION.—Bonus payments may only be made to an ACO if the primary care provider to which the Medicare fee-for-service beneficiary has been assigned under subsection (c) elects to participate in such ACO.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be appropriate for the purpose of carrying out the demonstration program under this section.

(f) REPORT.—Upon completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program together with such recommendations as the Secretary determines appropriate.

SEC. 503. REDUCING GOVERNMENT HANDOUTS TO WEALTHIER SENIORS.

(a) ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.—

(1) IN GENERAL.—Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is repealed.

(2) EFFECTIVE DATE.—The repeal made by paragraph (1) shall apply to premiums for months beginning after December 2010.

(b) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(1) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(A) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

''(7) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

''(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2010 shall be reduced (and the monthly beneficiary premium shall be increased) by the monthly adjustment amount specified in subparagraph (B).

''(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

''(i) the quotient obtained by dividing—

"(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

"(II) 25.5 percent; and

"(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

"(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

''(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

''(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

''(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

"(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

"(III) The monthly adjustment amount specified in subparagraph (B).

"(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related reduction in premium subsidy under this paragraph.

"(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.".

(B) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(i) in paragraph (1), by striking "(2) and (3)" and inserting "(2), (3), and (4)"; and

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

''(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

''(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

''(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.''.

(2) CONFORMING AMENDMENTS.—

(A) MEDICARE.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.) is amended—

(i) in section 1860D–13(a)(1)—

(I) by redesignating subparagraph (F) as subparagraph (G);

(II) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(III) by inserting after subparagraph (E) the following new subparagraph:

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''; and

(ii) in section 1860D–15(a)(1)(B), by striking ''paragraph (1)(B)'' and inserting ''paragraphs (1)(B) and (1)(F)''.

(B) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(i) in the heading, by striking ''PART B PREMIUM SUBSIDY ADJUSTMENT'' and inserting ''PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS'';

(ii) in subparagraph (A)—

(I) in the matter preceding clause (i), by inserting ''or 1860D–13(a)(7)'' after ''1839(i)''; and

(II) in clause (vii), by inserting after ''subsection (i) of such section'' the following: ''or under section 1860D–13(a)(7) of such Act'';

(iii) in subparagraph (B)—

(I) by inserting ''or such section 1860D–13(a)(7)'' before the period at the end;

(II) as amended by clause (i), by inserting ''or for the purpose of resolving tax payer appeals with respect to any such premium adjustment'' before the period at the end; and

(III) by adding at the end the following new sentence: ''Officers, employees, and contractors of the Social Security Administration may disclose

such return information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.''; and

(iv) by adding at the end the following new subparagraph:

''(C) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.''.

SEC. 504. REWARDING PREVENTION.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j)(1) With respect to the monthly premium amount for months after December 2010, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

''(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premiums to be paid under this part for the month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.''.

SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANSPARENCY.

(a) TRANSPARENCY.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''PRICE TRANSPARENCY REQUIREMENTS

''SEC. 1899. (a) PRE-TREATMENT DISCLOSURE.—A provider of services (as defined in section 1861(u)) and a supplier (as defined in section 1861(d)) shall provide to each individual (regardless of whether or not the individual is a beneficiary under this title) who is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider of services or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of scheduling.

''(b) POST-TREATMENT DISCLOSURE.—A provider of services (as so defined) and a supplier (as so defined) shall include with any bill that includes the charges for a treatment with respect to an individual (regardless of whether or not the individual is a beneficiary under this title), an itemized list of component charges for such treatment, including charges for drugs and medical equipment involved, as determined at the time of billing. With respect to each item included on such list, the provider of services or supplier shall include the price charged for the item.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to providers of services and suppliers on and after January 1, 2011.

SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID CLAIMS AND PATIENT ENCOUNTER DATA.

(a) PUBLIC AVAILABILITY.—Not later than 1 year after the date of enactment of this Act (and annually thereafter), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall make available to the public (including through an Internet website) data on claims and patient encounters under titles XVIII and XIX of the Social Security Act during the preceding calendar year. Such data shall be appropriately disaggregated and patient deidentified, as determined necessary by the Secretary in order to comply with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(b) PROVISION OF DATA TO STATE EXCHANGES AND HEALTH INSURANCE ISSUERS UNDER THE STATE EXCHANGE.—The Secretary shall submit such data directly to a State Exchange under title II and health insurance issuers under such Exchange (in a form and manner determined appropriate by the Secretary).

(c) MATCHING OF DATA.—The Secretary shall ensure that the total amount of claims under such titles during the preceding year for which data is made available under subsection (a) is equal to the reported outlays from

the Federal government and the States under such titles during the preceding years.

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.

(a) PROCEDURES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used. Such procedures shall provide that the new Medicare beneficiary identifier includes biometric identification protections.

(2) MAINTAINING EXISTING HICN STRUCTURE.—In order to minimize the impact of the

change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD.—The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) PHASE-IN AUTHORITY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the So-

cial Security Act or enrolled under part B of such title on or after such date.

(b) EDUCATION AND OUTREACH.—The Secretary shall establish a program of education and outreach for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and suppliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) DATA MATCHING.—

(1) ACCESS TO CERTAIN INFORMATION.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary—

''(i) enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met, in order to determine—

''(I) whether a beneficiary under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible for benefits under such program; and

''(II) whether a provider of services or a supplier under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such program; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed and procedures to permit the Secretary to use such information for the purpose described in clause (i).

''(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

''(C) Information provided pursuant to an agreement under this paragraph shall include information regarding whether—

''(i) the name (including the first name and any family name or surname), the date of birth (including the month, day, and year), and

social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

"(ii) such individual is shown on the records of the Commissioner as being deceased.".

(2) INVESTIGATION BASED ON CERTAIN INFORMATION.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGATION OF CLAIMS INVOLVING INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

"(a) DATA AGREEMENT.—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

"(b) INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.—

"(1) IN GENERAL.—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI sub-

mits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information provided pursuant to such agreement, is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, conduct an investigation with respect to the provider of services or supplier. If the Secretary determines further action is appropriate, the Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services as soon as practicable.

''(2) ASSESSMENT OF IMPLEMENTATION AND EFFECTIVENESS BY THE OIG.—The Inspector General of the Department of Health and Human Services shall test the implementation of the provisions of this section (including the implementation of the agreement under section 205(r)(9)) and conduct such period assessments of such implementation as the Inspector General determines necessary to determine the effectiveness of such implementation.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

Title XVIII of the Social Security Act, as amended by this Act, is amended by adding at the end the following new section:

''USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

''SEC. 1899A. (a) IN GENERAL.—The Secretary shall establish procedures for the use of technology (including front-end, pre-payment technology similar to that used by hedge funds, investment funds, and banks) to provide real-time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.

''(b) COMPETITIVE BIDDING.—The procedures established under subsection (a) shall ensure that the implementation of such technology is conducted through a competitive bidding process.''.

SEC. 513. DETECTION OF MEDICARE FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(7) Implementation of fraud and abuse detection methods under subsection (i).'';

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence ''In the case of an activity described in subsection (b)(8), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is selected through a competitive bidding process in accordance with subsection (i)(3).''; and

(3) by adding at the end the following new subsection:

''(i) DETECTION OF MEDICARE FRAUD AND ABUSE.—

''(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary

shall designate the counties identified under the preceding sentence as 'high risk areas'.

''(2) FRAUD AND ABUSE DETECTION.—

''(A) INITIAL IMPLEMENTATION.—The Secretary shall establish procedures for the implementation of fraud and abuse detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1) (and, beginning not later than 18 months after the date of enactment of this subsection, with respect to items and services furnished by such providers of services and suppliers in areas not so designated) including the following:

''(i) Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent.

''(ii) Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

"(B) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under subparagraph (A) participate in the program under this title.

"(C) EXPANDED IMPLEMENTATION.—Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services and suppliers, including those not in high risk areas designated under paragraph (1).

"(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

"(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent

fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION AND EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.

(a) EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraphs:

''(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

''(i) that the National Provider Identifier of the physician or practitioner prescribing or ordering the item or service is valid and active;

''(ii) that the Medicare identification number of the supplier is valid and active; and

''(iii) that the item or service for which the claim for payment is submitted was properly identified on the CMS–855S Medicare enrollment application.

''(B) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, accreditors, car-

riers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS–855S Medicare enrollment application submitted by the supplier.

''(C) NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

''(i) the National Supplier Clearinghouse shall—

''(I) provide the supplier written notification of the reason for such denial; and

''(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

''(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment

under this title in order to permit the resubmission of such claim if payment of such claim would otherwise be allowed under this title.

''(D) IMPROVEMENTS TO MEDICARE ENROLLMENT APPLICATION.—The Secretary shall establish procedures under which a prospective supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title shall certify, as part of the CMS–855S Medicare enrollment application submitted by such supplier, under penalty of perjury, that the information provided by the supplier on such application is accurate to the best of the supplier's knowledge.

''(23) TERMINATION OF PARTICIPATION FOR SUBMISSION OF FRAUDULENT CLAIMS.—If the Secretary finds that a supplier of durable medical equipment, prosthetics, orthotics, and supplies under this title has submitted fraudulent claims for payment under this title, the Secretary shall terminate the suppliers participation under this title. Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish a process under which a supplier whose participation has been termi-

nated under the preceding sentence may appeal such termination and such appeal shall be resolved not later than 60 days after the date on which the appeal was made.''.

(b) EXEMPTION OF PHARMACISTS FROM SURETY BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the second sentence, by inserting ''and shall waive such requirement in the case of a pharmacist'' before the period at the end.

SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS OF SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN COMBATING FRAUD.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

TITLE VI—ENDING LAWSUIT ABUSE

SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

''(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

''(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

''(1) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. A grant shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

''(2) STATE REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall—

"(A) develop and implement an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (d); and

"(B) implement policies that provide for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives under subparagraph (A).

"(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented under paragraph (2)(A) will—

"(A) make the medical liability system of the State more reliable through the prompt and fair resolution of disputes;

"(B) encourage the early disclosure of health care errors;

"(C) enhance patient safety; and

"(D) maintain access to medical liability insurance.

"(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from, and methods by which, compensation would be paid for medical liability claims resolved under the proposed alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

"(5) SCOPE.—

"(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall utilize the proposed alternative identified under paragraph (2)(A) for the resolution of all types of disputes concerning injuries allegedly caused by health care providers or health care organizations.

"(B) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—

"(i) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the

date of enactment of this section to establish any alternative to tort litigation.

''(ii) ALTERNATIVE FOR PRACTICE AREAS OR INJURIES.—In the case of a State that has established an alternative to tort litigation for a certain area of health care practice or a category of injuries, the alternative selected as provided for in this section shall supplement not replace or invalidate such established alternative unless the State intends otherwise.

''(6) NOTIFICATION OF PATIENTS.—To be eligible to receive a grant under subsection (a), the State shall demonstrate how patients will be notified when they are receiving health care services that fall within the scope of the alternative selected under this section by the State to current tort litigation.

''(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section may not preclude any party to a dispute that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation at any point during the consideration of the claim under such alternative.

''(d) MODELS.—

''(1) IN GENERAL.—The models in this section are the following:

''(2) EXPERT PANEL REVIEW AND EARLY OFFER GUIDELINES.—

''(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

''(B) ESTABLISHMENT OF PANEL.—Under the system under this paragraph, the State shall establish an expert panel to review any disputes concerning injuries allegedly caused by health care providers or health care organizations according to the guidelines described in this paragraph.

''(C) COMPOSITION.—

''(i) IN GENERAL.—An expert panel under this paragraph shall be composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

''(ii) LICENSURE AND EXPERTISE.—Each physician or health care professional

appointed to an expert panel under clause (i) shall—

"(I) be appropriately credentialed or licensed in the State in which the dispute takes place to deliver health care services; and

"(II) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

"(iii) INDEPENDENCE.—

"(I) IN GENERAL.—Subject to subclause (II), each individual appointed to an expert panel under this paragraph shall—

"(aa) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

"(bb) not otherwise have a conflict of interest with such a party.

"(II) EXCEPTION.—Nothing in subclause (I) shall be construed to

prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and neither party objects.

''(iv) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(I) IN GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

''(aa) by a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

''(bb) by a health care professional other than a physician,

at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such a physician) of such a same or similar specialty.

''(II) PRACTICING DEFINED.—In this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

''(v) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least

1 medical expert on the expert panel shall have expertise described in clause (iv)(I) in pediatrics.

''(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and compensation based on a schedule of compensation that is developed by the panel. Such a schedule shall at least include—

''(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

''(I) any health or accident insurance;

''(II) any wage or salary continuation plan; or

''(III) any disability income insurance;

''(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State, in consultation with relevant experts and with the Secretary;

"(iii) reasonable attorney's fees; and

"(iv) regular updates of the schedule under clause (ii) as necessary.

"(E) ACCEPTANCE.—If the parties to a dispute who come before an expert panel under this paragraph accept the determination of the expert panel concerning liability and compensation, such compensation shall be paid to the claimant and the claimant shall agree to forgo any further action against the health care providers or health care organizations involved.

"(F) FAILURE TO ACCEPT.—If any party decides not to accept the expert panel's determination under this paragraph, the State may choose whether to allow the panel to review the determination de novo, with deference, or to provide an opportunity for parties to reject the determination of the panel.

"(G) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

"(i) RIGHT TO FILE.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not sat-

isfied with the final decision of the panel after such a review, the party shall have the right to file a claim relating to the injury involved in a State court of competent jurisdiction.

''(ii) FORFEIT OF AWARDS.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

''(iii) ADMISSIBILITY.—The determinations of the expert panel pursuant to a review under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

''(3) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an administrative health care tribunal system under which the parties involved shall have the right to request a hearing to review any dispute concerning injuries allegedly caused by health care providers or health care organizations before an

administrative health care tribunal established by the State involved.

''(B) REQUIREMENTS.—In establishing an administrative health care tribunal under this paragraph, a State shall—

''(i) ensure that such tribunals are presided over by special judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily;

''(ii) provide authority to such judges to make binding rulings, rendered in written decisions, on standards of care, causation, compensation, and related issues with reliance on independent expert witnesses commissioned by the tribunal;

''(iii) establish a legal standard for the tribunal that shall be the same as the standard that would apply in the State court of competent jurisdiction which would otherwise handle the claim; and

''(iv) provide for an appeals process to allow for review of decisions by State courts.

''(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall at a minimum include—

''(i) payment for the net economic loss incurred by the patient, on a periodic basis, reduced by any payments received by the patient under—

''(I) any health or accident insurance;

''(II) any wage or salary continuation plan; or

''(III) any disability income insurance;

''(ii) payment for the non-economic damages incurred by the patient, if appropriate for the injury, based on a defined payment schedule developed by the State in consultation with relevant experts and with the Secretary;

''(iii) reasonable attorney's fees; and

"(iv) regular updates of the schedule under clause (ii) as necessary.

"(D) REVIEW BY STATE COURT AFTER EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

"(i) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determinations of a tribunal under this paragraph, from filing a claim for the injury involved in a State court of competent jurisdiction.

"(ii) FORFEIT OF AWARD.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

"(iii) ADMISSIBILITY.—The determinations of the tribunal under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

"(4) EXPERT PANEL REVIEW AND ADMINISTRATIVE HEALTH CARE TRIBUNAL COMBINATION MODEL.—

"(A) IN GENERAL.—A State may use amounts received under a grant under this sec-

tion to develop and implement an expert panel review and administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in this subparagraph prior to the submission of such dispute to a State court.

''(B) GENERAL PROCEDURE.—

''(i) ESTABLISHMENT OF EXPERT PANEL.—Prior to submitting any dispute described in subparagraph (A) to an administrative health care tribunal under the system established under this paragraph, the State shall establish an expert panel (in accordance with subparagraph (C)) to review the allegations involved in such dispute.

''(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be re-

ferred to an administrative health care tribunal (in accordance with subparagraph (D).

''(C) EXPERT REVIEW PANEL.—

''(i) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

''(ii) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party to a dispute before an expert panel under this subparagraph refuses to accept the panel's determination, the dispute shall be referred to an administrative health care tribunal under subparagraph (D).

''(D) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

''(i) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subparagraph (C), the parties shall request a hearing concerning the liability or compensation involved by an administrative health care tri-

bunal established by the State involved under this subparagraph.

''(ii) REQUIREMENTS.—The provisions of paragraph (3) shall apply with respect to the establishment and operation of an administrative health care tribunal under this subparagraph.

''(iii) FORFEIT OF AWARDS.—Any party proceeding to the second step-administrative health care tribunal-under this model shall forfeit any compensation awarded by the expert panel.

''(iv) ADMISSIBILITY.—The determinations of the expert panel under subparagraph (C) shall be admissible into evidence in any administrative health care tribunal proceeding under this subparagraph.

''(E) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determination of the tribunal (after having proceeded through both the expert panel under subparagraph (C) and the tribunal under subparagraph (D)) from filing a claim for the injury involved in a State court of competent jurisdiction.

''(F) ADMISSIBILITY.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible into evidence in any State court proceeding under this paragraph.

''(G) FORFEIT OF AWARDS.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

''(e) DEFINITIONS.—In this section:

''(1) CURRENT TORT LITIGATION.—The term 'current tort litigation' means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

''(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

''(3) NET ECONOMIC LOSS.—The term 'net economic loss' means—

"(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

"(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

"(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

"(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

"(4) NON-ECONOMIC DAMAGES.—The term 'non-economic damages' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pe-

cuniary losses of any kind or nature, to the extent permitted under State law.

''(f) FUNDING.—

''(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State under section 1913 of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to the any increase applicable for that fiscal year under section 203(b) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).''.

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and authorized exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Current Federal security and confidentiality standards and State security and confiden-

tiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) DEFINITIONS.—In this section:

(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term ''current Federal security and confidentiality standards'' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 1173(d) of the Social Security Act (42 U.S.C. 1320d–2(d)).

(2) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term ''State security and confidentiality laws'' means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(3) STATE.—The term ''State'' has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

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.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.''; and

(2) in subsection (i), by adding at the end the following new paragraph:

''(8) The term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of

health information to better coordinate care or improve health care quality, efficiency, or research.''.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting ''; and''; and

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

''(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provi-

sion of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.''; and

(2) by adding at the end the following new subsection:

''(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the

date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

''(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in

conjunction with other health information technology; or

"(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

"(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

"(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.

"(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term 'health information technology' means hardware, software, license, right, intellectual

property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

''(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term 'specified entity' means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.''.

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of

such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than 3 years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 711(b)(1), the following: ''For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 712(a), is amended by adding at the end the following new subparagraph:

''(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

''(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

''(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

SEC. 801. ESTABLISHMENT.

(a) IN GENERAL.—There is hereby established a Health Care Services Commission (in this title, referred to as the ''Commission'') to be composed of 5 commissioners (in this title referred to as the ''Commissioners'') to be appointed by the President by and with the advice and consent of the Senate. Not more than 3 of such Commissioners shall be members of the same political party, and in making appointments members of different political parties shall be appointed alternately as nearly as may be practicable. No Commissioner shall engage in any other business, vocation, or employment than that of serving as Commissioner. Each Commissioner shall hold office for a term of 5 years and until a successor is appointed and has qualified, except that—

(1) such Commissioner shall not so continue to serve beyond the expiration of the next session of Congress subsequent to the expiration of said fixed term of office;

(2) any Commissioner appointed to fill a vacancy occurring prior to the expiration of the term

for which a predecessor was appointed shall be appointed for the remainder of such term; and

(3) the terms of office of the Commissioners first taking office after the date of the enactment of this Act shall expire as designated by the President at the time of nomination, 1 at the end of 1 year, 1 at the end of 2 years, 1 at the end of 3 years, 1 at the end of 4 years, and 1 at the end of 5 years, after the date of the enactment of this Act.

(b) PURPOSE.—The purpose of the Commission is to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice and in the organization, financing, and delivery of health care services.

(c) APPOINTMENT OF CHAIRMAN.—The President shall, from among the Commissioners appointed under subsection (a), designate an individual to serve as the Chairman of the Commission.

SEC. 802. GENERAL AUTHORITIES AND DUTIES.

(a) IN GENERAL.—In carrying out section 801(b), the Commissioners shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on

health care services and on systems for the delivery of such services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND UNDERSERVED POPULATIONS.—In carrying out subsection (a), the Commissioners shall undertake and support research, demonstration projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) the health of low-income groups, minority groups, and the elderly.

SEC. 803. DISSEMINATION.

(a) IN GENERAL.—The Commissioners shall—

(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations; and

(3) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other

than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) CERTAIN INTERAGENCY AGREEMENT.—The Commissioners and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(1).

Subtitle B—Forum for Quality and Effectiveness in Health Care

SEC. 811. ESTABLISHMENT OF OFFICE.

There is established within the Commission an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director (referred to in this title as the ''Director'') who shall be appointed by the Commissioners.

SEC. 812. MEMBERSHIP.

(a) IN GENERAL.—The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care

organizations and appointed by the Commission and shall include representation from at least the following:

(1) Health insurance industry.

(2) Health care provider groups.

(3) Non-profit organizations.

(4) Rural health organizations.

(b) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commission shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

(c) TREATMENT OF OTHER EMPLOYMENT.—Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office independently from any other position of employment.

SEC. 813. DUTIES.

(a) ESTABLISHMENT OF FORUM PROGRAM.—The Commissioners, acting through the Director, shall establish a program to be known as the Forum for Quality and

Effectiveness in Health Care. For the purpose of promoting transparency in price, quality, appropriateness, and effectiveness of health care, the Director, using the process set forth in section 814, shall arrange for the development and periodic review and updating of standards of quality, performance measures, and medical review criteria through which health care providers and other appropriate entities may assess or review the provision of health care and assure the quality of such care.

(b) CERTAIN REQUIREMENTS.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) AUTHORITY FOR CONTRACTS.—In carrying out this subtitle, the Director may enter into contracts with public or nonprofit private entities.

(d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—For each fiscal year beginning with 2010, the Director shall make publicly available the following:

(1) Quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measures, and review criteria under subsection (a) and any updates to such guidelines, standards, performance measures, and review criteria.

(2) After consideration of such comments, a final report that contains final recommendations for such guidelines, standards, performance measures, review criteria, and updates.

(e) DATE CERTAIN FOR INITIAL GUIDELINES AND STANDARDS.—The Commissioners, by not later than January 1, 2012, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a).

SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES AND STANDARDS.

(a) ADOPTION OF RECOMMENDATIONS OF FORUM FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—For each fiscal year, the Commissioners shall adopt the recommendations made for such year in the final report under subsection (d)(2) of section 813 for guidelines,

standards, performance measures, and review criteria described in subsection (a) of such section.

(b) ENFORCEMENT AUTHORITY.—The Commissioners, in consultation with the Secretary of Health and Human Services, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measures, and review criteria adopted under subsection (a). Such recommendations may include the following, with respect to a health care provider who is not in compliance with such guidelines, standards, measures, and criteria:

(1) Exclusion from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))).

(2) Imposition of a civil money penalty on such provider.

SEC. 815. ADDITIONAL REQUIREMENTS.

(a) PROGRAM AGENDA.—The Commissioners shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 813(a), including with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which

the standards, performance measures, and review criteria are to be developed and those that are to be given priority in the development of the standards, performance measures, and review criteria.

Subtitle C—General Provisions

SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.

The Commissioners, in carrying out this title, may accept voluntary and uncompensated services.

SEC. 822. FUNDING.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 823. DEFINITIONS.

For purposes of this title:

(1) The term ''Commissioners'' means the Commissioners of the Health Care Services Commission.

(2) The term ''Commission'' means the Health Care Services Commission.

(3) The term ''Director'' means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle D—Terminations and Transition

SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 832. TRANSITION.

All orders, grants, contracts, privileges, and other determinations or actions of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless changed pursuant to law.

Subtitle E—Independent Health Record Trust

SEC. 841. SHORT TITLE.

This subtitle may be cited as the ''Independent Health Record Trust Act of 2009''.

SEC. 842. PURPOSE.

It is the purpose of this subtitle to provide for the establishment of a nationwide health information technology network that—

(1) improves health care quality, reduces medical errors, increases the efficiency of care, and ad-

vances the delivery of appropriate, evidence-based health care services;

(2) promotes wellness, disease prevention, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

(3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services;

(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and

(7) ensures that the health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 843. DEFINITIONS.

In this subtitle:

(1) ACCESS.—The term ''access'' means, with respect to an electronic health record, entering information into such account as well as retrieving information from such account.

(2) ACCOUNT.—The term ''account'' means an electronic health record of an individual contained in an independent health record trust.

(3) AFFIRMATIVE CONSENT.—The term ''affirmative consent'' means, with respect to an electronic health record of an individual contained in an IHRT, express consent given by the individual for the use of such record in response to a clear and conspicuous request for such consent or at the individual's own initiative.

(4) AUTHORIZED EHR DATA USER.—The term ''authorized EHR data user'' means, with respect to an electronic health record of an IHRT participant contained as part of an IHRT, any entity (other than the participant) authorized (in the form of affirmative consent) by the participant to access the electronic health record.

(5) CONFIDENTIALITY.—The term ''confidentiality'' means, with respect to individually identifiable health information of an individual, the obliga-

tion of those who receive such information to respect the health information privacy of the individual.

(6) ELECTRONIC HEALTH RECORD.—The term ''electronic health record'' means a longitudinal collection of information concerning a single individual, including medical records and personal health information, that is stored electronically.

(7) HEALTH INFORMATION PRIVACY.—The term ''health information privacy'' means, with respect to individually identifiable health information of an individual, the right of such individual to control the acquisition, uses, or disclosures of such information.

(8) HEALTH PLAN.—The term ''health plan'' means a group health plan (as defined in section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1))) as well as a plan that offers health insurance coverage in the individual market.

(9) HIPAA PRIVACY REGULATIONS.—The term ''HIPAA privacy regulations'' means the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(10) INDEPENDENT HEALTH RECORD TRUST; IHRT.—The terms ''independent health record trust''

and ''IHRT'' mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this subtitle with respect to electronic health records of individuals participating in the trust or IHRT.

(11) IHRT OPERATOR.—The term ''IHRT operator'' means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT in accordance with this subtitle.

(12) IHRT PARTICIPANT.—The term ''IHRT participant'' means, with respect to an IHRT, an individual who has a participation agreement in effect with respect to the maintenance of the individual's electronic health record by the IHRT.

(13) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' has the meaning given such term in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)).

(14) SECURITY.—The term ''security'' means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect

such information from unwarranted access or disclosure.

SEC. 844. ESTABLISHMENT, CERTIFICATION, AND MEMBERSHIP OF INDEPENDENT HEALTH RECORD TRUSTS.

(a) ESTABLISHMENT.—Not later than one year after the date of the enactment of this Act, the Federal Trade Commission, in consultation with the National Committee on Vital and Health Statistics, shall prescribe standards for the establishment, certification, operation, and interoperability of IHRTs to carry out the purposes described in section 842 in accordance with the provisions of this subtitle.

(b) CERTIFICATION.—

(1) CERTIFICATION BY FTC.—The Federal Trade Commission shall provide for the certification of IHRTs. No IHRT may be certified unless the IHRT is determined to meet the standards for certification established under subsection (a).

(2) DECERTIFICATION.—The Federal Trade Commission shall establish a process for the revocation of certification of an IHRT under this section in the case that the IHRT violates the standards established under subsection (a).

(c) MEMBERSHIP.—

(1) IN GENERAL.—To be eligible to be a participant in an IHRT, an individual shall—

(A) submit to the IHRT information as required by the IHRT to establish an electronic health record with the IHRT; and

(B) enter into a privacy protection agreement described in section 846(b)(1) with the IHRT.

The process to determine eligibility of an individual under this subsection shall allow for the establishment by such individual of an electronic health record as expeditiously as possible if such individual is determined so eligible.

(2) NO LIMITATION ON MEMBERSHIP.—Nothing in this subsection shall be construed to permit an IHRT to restrict membership, including on the basis of health condition.

SEC. 845. DUTIES OF IHRT TO IHRT PARTICIPANTS.

(a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF FIDUCIARY DUTY.—

(1) FIDUCIARY DUTY.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, the IHRT shall have a fiduciary duty to act for the benefit and in the interests of such participant and of the IHRT as a whole.

Such duty shall include obtaining the affirmative consent of such participant prior to the release of information in such participant's electronic health record in accordance with the requirements of this subtitle.

(2) PENALTIES.—If the IHRT knowingly or recklessly breaches the fiduciary duty described in paragraph (1), the IHRT shall be subject to the following penalties:

(A) Loss of certification of the IHRT.

(B) A fine that is not in excess of $50,000.

(C) A term of imprisonment for the individuals involved of not more than 5 years.

(b) ELECTRONIC HEALTH RECORD DEEMED TO BE HELD IN TRUST BY IHRT.—With respect to an individual, an electronic health record maintained by an IHRT shall be deemed to be held in trust by the IHRT for the benefit of the individual and the IHRT shall have no legal or equitable interest in such electronic health record.

SEC. 846. AVAILABILITY AND USE OF INFORMATION FROM RECORDS IN IHRT CONSISTENT WITH PRIVACY PROTECTIONS AND AGREEMENTS.

(a) PROTECTED ELECTRONIC HEALTH RECORDS USE AND ACCESS.—

(1) GENERAL RIGHTS REGARDING USES OF INFORMATION.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant maintained by an IHRT, subject to paragraph (2)(C), primary uses and secondary uses (described in subparagraphs (B) and (C), respectively) of information within such record (other than by such participant) shall be permitted only upon the authorization of such use, prior to such use, by such participant.

(B) PRIMARY USES.—For purposes of subparagraph (A) and with respect to an electronic health record of an individual, a primary use is a use for purposes of the individual's self-care or care by health care professionals.

(C) SECONDARY USES.—For purposes of subparagraph (B) and with respect to an electronic health record of an individual, a secondary use is any use not described in subparagraph (B) and includes a use for purposes of public health research or other related activities. Additional authorization is required for a secondary use extending beyond the original purpose of the secondary use authorized by the

IHRT participant involved. Nothing in this paragraph shall be construed as requiring authorization for every secondary use that is within the authorized original purpose.

(2) RULES FOR PRIMARY USE OF RECORDS FOR HEALTH CARE PURPOSES.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(A) ACCESS BY IHRT PARTICIPANTS TO THEIR ELECTRONIC HEALTH RECORDS.—

(i) OWNERSHIP.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(ii) ADDITION OF PERSONAL INFORMATION.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that

is entered into the electronic health record by any authorized EHR data user. Such participant shall have the right to propose an amendment to information that is entered by an authorized EHR data user pursuant to standards prescribed by the Federal Trade Commission for purposes of amending such information.

(iii) IDENTIFICATION OF INFORMATION ENTERED BY PARTICIPANT.—Any additions or amendments made by the participant to the health record shall be identified and disclosed within such record as being made by such participant.

(B) ACCESS BY ENTITIES OTHER THAN IHRT PARTICIPANT.—

(i) AUTHORIZED ACCESS ONLY.—Except as provided under subparagraph (C) and paragraph (4), access to the electronic health record (or any portion of the record)—

(I) may be made only by authorized EHR data users and only to such portions of the record as specified by the participant; and

(II) may be limited by the participant for purposes of entering information into such record, retrieving information from such record, or both.

(ii) IDENTIFICATION OF ENTITY THAT ENTERS INFORMATION.—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(iii) SATISFACTION OF HIPAA PRIVACY REGULATIONS.—In the case of a record of a covered entity (as defined for purposes of HIPAA privacy regulations), with respect to an individual, if such individual is an IHRT participant with an independent health record trust and such covered entity is an authorized EHR data user, the requirement under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed met if such entity, without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately formatted electronic copy

of the record (and updates to such records) for inclusion in the electronic health record of the participant maintained by the trust;

(II) enters such record into the electronic health record of the participant so maintained; or

(III) otherwise makes such record available for electronic access by the IHRT or the individual in a manner that permits such record to be included in the account of the individual contained in the IHRT.

(iv) NOTIFICATION OF SENSITIVE INFORMATION.—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall not be forwarded or entered by an authorized EHR data user into the electronic health record of the participant maintained by the trust unless the user certifies that the participant has been notified of such information.

(C) DEEMED AUTHORIZATION FOR ACCESS FOR EMERGENCY HEALTH CARE.—

(i) FINDINGS.—Congress finds that—

(I) given the size and nature of visits to emergency departments in the United States, readily available health information could make the difference between life and death; and

(II) because of the case mix and volume of patients treated, emergency departments are well positioned to provide information for public health surveillance, community risk assessment, research, education, training, quality improvement, and other uses.

(ii) USE OF INFORMATION.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT, the participant shall be deemed as providing authorization (in the form of affirmative consent) for health care providers to access, in connection with providing emergency care services to the participant, a limited, authenticated information set concerning the participant for emergency response purposes, unless the

participant specifies that such information set (or any portion of such information set) may not be so accessed. Such limited information set may include information—

(I) patient identification data, as determined appropriate by the participant;

(II) provider identification that includes the use of unique provider identifiers;

(III) payment information;

(IV) information related to the individual's vitals, allergies, and medication history;

(V) information related to existing chronic problems and active clinical conditions of the participant; and

(VI) information concerning physical examinations, procedures, results, and diagnosis data.

(3) RULES FOR SECONDARY USES OF RECORDS FOR RESEARCH AND OTHER PURPOSES.—

(A) IN GENERAL.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health

record) maintained by an IHRT, the IHRT may sell such record (or specified parts of such record) only if—

(i) the transfer is authorized by the participant pursuant to an agreement between the participant and the IHRT and is in accordance with the privacy protection agreement described in subsection (b)(1) entered into between such participant and such IHRT;

(ii) such agreement includes parameters with respect to the disclosure of information involved and a process for the authorization of the further disclosure of information in such record;

(iii) the information involved is to be used for research or other activities only as provided for in the agreement;

(iv) the recipient of the information provides assurances that the information will not be further transferred or reused in violation of such agreement; and

(v) the transfer otherwise meets the requirements and standards prescribed by the Federal Trade Commission.

(B) TREATMENT OF PUBLIC HEALTH REPORTING.—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

(4) LAW ENFORCEMENT CLARIFICATION.—Nothing in this subtitle shall prevent an IHRT from disclosing information contained in an electronic health record maintained by the IHRT when required for purposes of a lawful investigation or official proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or any regulation, rule, or order issued pursuant to such a statute.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a health care provider that does not utilize electronic methods or appropriate levels of health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a require-

ment for participation or compliance under this subtitle.

(b) PRIVACY PROTECTION AGREEMENT; TREATMENT OF STATE PRIVACY AND SECURITY LAWS.—

(1) PRIVACY PROTECTION AGREEMENT.—A privacy protection agreement described in this subsection is an agreement, with respect to an electronic health record of an IHRT participant to be maintained by an independent health record trust, between the participant and the trust—

(A) that is consistent with the standards described in subsection (a)(2);

(B) under which the participant specifies the portions of the record that may be accessed, under what circumstances such portions may be accessed, any authorizations for indicated authorized EHR data users to access information contained in the record, and the purposes for which the information (or portions of the information) in the record may be used;

(C) which provides a process for the authorization of the transfer of information contained in the record to a third party, including for the sale of such information for purposes of research, by an authorized EHR data user and

reuse of such information by such third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant; and

(D) under which the trust provides assurances that the trust will not transfer, disclose, or provide access to the record (or any portion of the record) in violation of the parameters established in the agreement or to any person or entity who has not agreed to use and transfer such record (or portion of such record) in accordance with such agreement.

(2) TREATMENT OF STATE LAWS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the provisions of a privacy protection agreement entered into between an IHRT and an IHRT participant shall preempt any provision of State law (or any State regulation) relating to the privacy and confidentiality of individually identifiable health information or to the security of such health information.

(B) EXCEPTION FOR PRIVILEGED INFORMATION.—The provisions of a privacy protection agreement shall not preempt any provision of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

(C) STATE DEFINED.—For purposes of this section, the term ''State'' has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION AND INFORMATION SHARING.

(a) IN GENERAL.—Participation in an independent health record trust, or authorizing access to information from such a trust, is voluntary. No employer, health insurance issuer, group health plan, health care provider, or other person may require, as a condition of employment, issuance of a health insurance policy, coverage under a group health plan, the provision of health care services, payment for such services, or otherwise, that an individual participate in, or authorize access to information from, an independent health record trust.

(b) ENFORCEMENT.—The penalties provided for in subsection (a) of section 1177 of the Social Security Act (42 U.S.C. 1320d–6) shall apply to a violation of subsection (a) in the same manner as such penalties apply to a person in violation of subsection (a) of such section.

SEC. 848. FINANCING OF ACTIVITIES.

(a) IN GENERAL.—Except as provided in subsection (b), an IHRT may generate revenue to pay for the operations of the IHRT through—

(1) charging IHRT participants account fees for use of the trust;

(2) charging authorized EHR data users for accessing electronic health records maintained in the trust;

(3) the sale of information contained in the trust (as provided for in section 846(a)(3)(A)); and

(4) any other activity determined appropriate by the Federal Trade Commission.

(b) PROHIBITION AGAINST ACCESS FEES FOR HEALTH CARE PROVIDERS.—For purposes of providing incentives to health care providers to access information maintained in an IHRT, as authorized by the IHRT participants involved, the IHRT may not charge a fee for services specified by the IHRT. Such services shall include the transmittal of information from a health care provider

to be included in an independent electronic health record maintained by the IHRT (or permitting such provider to input such information into the record), including the transmission of or access to information described in section 846(a)(2)(C)(ii) by appropriate emergency responders.

(c) REQUIRED DISCLOSURES.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be fully disclosed to each IHRT participant of such IHRT and to the public.

(d) TREATMENT OF INCOME.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 849. REGULATORY OVERSIGHT.

(a) IN GENERAL.—In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) ESTABLISHMENT OF INTERAGENCY STEERING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) CHAIRPERSON.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

(3) MEMBERSHIP.—The members of the Interagency Steering Committee shall consist of the Attorney General, the Chairperson of the Federal Trade Commission, the Chairperson for the National Committee for Vital and Health Statistics, a representative of the Federal Reserve, and other Federal officials determined appropriate by the Secretary of Health and Human Services.

(4) DUTIES.—The Interagency Steering Committee shall coordinate the implementation of this title, including the implementation of policies described in subsection (d) based upon the recommendations provided under such subsection, and regulations promulgated under this subtitle.

(c) FEDERAL ADVISORY COMMITTEE.—

(1) IN GENERAL.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall con-

sist of representatives of nongovernment entities, at least one of whom shall be a representative from an organization representing health care consumers.

(2) DUTIES.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs based on each of the following factors:

(A) Privacy and security policies.

(B) Economic progress.

(C) Interoperability standards.

(d) POLICIES RECOMMENDED BY FEDERAL TRADE COMMISSION.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall recommend policies to—

(1) provide assistance to encourage the growth of independent health record trusts;

(2) track economic progress as it pertains to operators of independent health records trusts and individuals receiving nontaxable income with respect to accounts;

(3) conduct public education activities regarding the creation and usage of the independent health records trusts;

(4) establish standards for the interoperability of health information technology to ensure that in-

formation contained in such record may be shared between the trust involved, the participant, and authorized EHR data users, including for the standardized collection and transmission of individual health records (or portions of such records) to authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(5) carry out any other activities determined appropriate by the Federal Trade Commission.

(e) REGULATIONS PROMULGATED BY FEDERAL TRADE COMMISSION.—The Federal Trade Commission shall promulgate regulations based on, at a minimum, the following factors:

(1) Requiring that an IHRT participant, who has an electronic health record that is maintained by an IHRT, be notified of a security breech with respect to such record, and any corrective action taken on behalf of the participant.

(2) Requiring that information sent to, or received from, an IHRT that has been designated as high-risk should be authenticated through the use of methods such as the periodic changing of passwords, the use of biometrics, the use of tokens or other technology as determined appropriate by the council.

(3) Requiring a delay in releasing sensitive health care test results and other similar information to patients directly in order to give physicians time to contact the patient.

(4) Recommendations for entities operating IHRTs, including requiring analysis of the potential risk of health transaction security breeches based on set criteria.

(5) The conduct of audits of IHRTs to ensure that they are in compliance with the requirements and standards established under this subtitle.

(6) Disclosure to IHRT participants of the means by which such trusts are financed, including revenue from the sale of patient data.

(7) Prevention of certification of an entity seeking independent heath record trust certification based on—

(A) the potential for conflicts between the interests of such entity and the security of the health information involved; and

(B) the involvement of the entity in any activity that is contrary to the best interests of a patient.

(8) Prevention of the use of revenue sources that are contrary to a patient's interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete or accurate electronic health record of such account holder.

(f) COMPLIANCE REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report on compliance by and progress of independent health record trusts with this subtitle. Such report shall describe the following:

(1) The number of complaints submitted about independent health record trusts, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(2) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall be divided by enforcement actions related to security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(3) The economic progress of the individual owner or institution operator as achieved through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as provided for by the Interagency Steering Committee council under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(g) INTERAGENCY MEMORANDUM OF UNDERSTANDING.—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding, that—

(1) regulations, rulings, and interpretations issued by Federal officials relating to the same matter over which 2 or more such officials have respon-

sibility under this subtitle are administered so as to have the same effect at all times; and

(2) the memorandum provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE IX—MISCELLANEOUS

SEC. 901. HEALTH CARE CHOICE FOR VETERANS.

Beginning not later than 2 years after the date of the enactment of this Act, the Secretary of Veterans Affairs may—

(1) permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through such non-Department of Veterans Affairs providers and facilities as the Secretary may approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Veteran Affairs shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to veterans, and such survivors and dependents,

at such rates as the Secretary may specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 902. HEALTH CARE CHOICE FOR INDIANS.

(a) IN GENERAL.—Beginning not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to receive such care and services through such non- Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Health and Human Services shall prescribe for purposes of this section, make payments to such

providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), at such rates as the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

(b) DEFINITIONS.—In this section, the terms ''Indian'', ''Indian Health Program'', ''Indian Tribe'', ''Tribal Organization'', and ''Urban Indian Organization'' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

SEC. 903. TERMINATION OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

The Federal Coordinating Council for Comparative Effectiveness Research is hereby terminated and section 804 of the American Recovery and Reinvestment Act of 2009 establishing and funding such Council is hereby repealed.

SEC. 904. HHS AND GAO JOINT STUDY AND REPORT ON COSTS OF THE 5 MEDICAL CONDITIONS THAT HAVE THE GREATEST IMPACT.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall jointly conduct a study on the costs of the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost. Such study shall include—

(1) current estimates as well as a ''generational score'' to capture the financial cost and health toll certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall jointly submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legis-

lation and administrative action as the Secretary and the Comptroller General determine appropriate.

(c) TARGETING OF PREVENTION AND WELLNESS EFFORTS.—The Secretary shall target prevention and wellness efforts conducted under the provisions of and amendments made by this Act in order to combat medical conditions identified in the report submitted under subsection (b), including such medical conditions identified as the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost as of or after the date of enactment of this Act.

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