

109TH CONGRESS  
1ST SESSION

**S.** \_\_\_\_\_

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IN THE SENATE OF THE UNITED STATES

Mr. FRIST (for himself, Mr. McCONNELL, Mr. GREGG, Mr. ENZI, Mr. GRASS-  
LEY, Ms. MURKOWSKI, Mr. DEMINT \_\_\_\_\_

\_\_\_\_\_) introduced the following bill; which was read twice  
and referred to the Committee on \_\_\_\_\_

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**A BILL**

To reduce healthcare costs, expand access to affordable  
healthcare coverage, and improve healthcare and  
strengthen the healthcare safety net, and for other pur-  
poses.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Healthy America Act of 2005”.

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

Sec. 1. Short title; table of contents.

## 2

Sec. 2. Findings.

TITLE I—MAKING HEALTH CARE MORE AFFORDABLE

Subtitle A—Medical Liability Reform

- Sec. 101. Short title.
- Sec. 102. Findings and purpose.
- Sec. 103. Encouraging speedy resolution of claims.
- Sec. 104. Compensating patient injury.
- Sec. 105. Maximizing patient recovery.
- Sec. 106. Additional health benefits.
- Sec. 107. Punitive damages.
- Sec. 108. Authorization of payment of future damages to claimants in health care lawsuits.
- Sec. 109. Definitions.
- Sec. 110. Effect on other laws.
- Sec. 111. State flexibility and protection of States' rights.
- Sec. 112. Applicability; effective date.

Subtitle B—Health Information Technology

CHAPTER 1—GENERAL PROVISIONS

- Sec. 121. Improving health care, quality, safety, and efficiency.
- Sec. 122. HIPAA report.
- Sec. 123. Study of reimbursement incentives.
- Sec. 124. Reauthorization of incentive grants regarding telemedicine.
- Sec. 125. Sense of the Senate on physician payment.
- Sec. 126. Establishment of quality measurement systems for medicare value-based purchasing programs.
- Sec. 127. Exception to Federal anti-kickback and physician self referral laws for the provision of permitted support.

CHAPTER 2—VALUE BASED PURCHASING

- Sec. 131. Value based purchasing programs.

Subtitle C—Patient Safety and Quality Improvement

- Sec. 141. Short title.
- Sec. 142. Findings and purposes.
- Sec. 143. Amendments to Public Health Service Act.
- Sec. 144. Studies and reports.

Subtitle D—Fraud and Abuse

- Sec. 151. National expansion of the medicare-medicaid data match pilot program.

Subtitle E—Miscellaneous Provisions

- Sec. 161. Sense of the Senate on establishing a mandated benefits commission.
- Sec. 162. Enforcement of reimbursement provisions by fiduciaries.

TITLE II—EXPANDING ACCESS TO AFFORDABLE HEALTH COVERAGE THROUGH TAX INCENTIVES AND OTHER INITIATIVES

Subtitle A—Refundable Health Insurance Credit

## 3

- Sec. 201. Refundable health insurance costs credit.
- Sec. 202. Advance payment of credit to issuers of qualified health insurance.

## Subtitle B—High Deductible Health Plans and Health Savings Accounts

- Sec. 211. Deduction of premiums for high deductible health plans.
- Sec. 212. Refundable credit for contributions to health savings accounts of small business employees.

## Subtitle C—Improvement of the Health Coverage Tax Credit

- Sec. 221. Change in State-based coverage rules related to preexisting conditions.
- Sec. 222. Eligibility of spouse of certain individuals entitled to medicare.
- Sec. 223. Eligible PBGC pension recipient.
- Sec. 224. Application of option to offer State-based coverage to Puerto Rico, Northern Mariana Islands, American Samoa, Guam, and the United States Virgin Islands.
- Sec. 225. Clarification of disclosure rules.
- Sec. 226. Clarification that State-based COBRA continuation coverage is subject to same rules as Federal COBRA.
- Sec. 227. Application of rules for other specified coverage to eligible alternative taa recipients consistent with rules for other eligible individuals.

## Subtitle D—Long-Term Care Insurance

- Sec. 231. Sense of the Senate concerning long-term care.

## Subtitle E—Other Provisions

- Sec. 241. Disposition of unused health benefits in cafeteria plans and flexible spending arrangements.
- Sec. 242. Microentrepreneurs.
- Sec. 243. Study on access to affordable health insurance for full-time college and university students.
- Sec. 244. Extension of funding for operation of State high risk health insurance pools.
- Sec. 245. Sense of the senate on affordable health coverage for small employers.

## Subtitle F—Covering Kids

- Sec. 251. Short title.
- Sec. 252. Grants to promote innovative outreach and enrollment under medicaid and SCHIP.
- Sec. 253. State option to provide for simplified determinations of a child's financial eligibility for medical assistance under medicaid or child health assistance under SCHIP.

## TITLE III—IMPROVING CARE AND STRENGTHENING THE SAFETY NET

## Subtitle A—High Needs Areas

- Sec. 301. Purpose.
- Sec. 302. High need community health centers.
- Sec. 303. Grant application process.

## Subtitle B—Qualified Integrated Health Care systems

Sec. 321. Grants to qualified integrated health care systems.

## Subtitle C—Miscellaneous Provisions

Sec. 331. Community health center collaborative access expansion.

Sec. 332. Improvements to section 340B program.

Sec. 333. Forbearance for student loans for physicians providing services in free clinics.

Sec. 334. Amendments to the Public Health Service Act relating to liability.

Sec. 335. Sense of the Senate concerning health disparities.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Health care costs are growing rapidly, put-  
4 ting health insurance and needed care out of reach  
5 for too many Americans.

6 (2) Rapidly growing health care costs pose a  
7 threat to the United States economy, as they make  
8 American businesses less competitive and make it  
9 more difficult to create new jobs.

10 (3) Growing health care costs are compromising  
11 the stability of health care safety net and entitle-  
12 ment programs.

13 (4) There are a series of steps Congress can  
14 and should take to slow the growth of health care  
15 costs, expand access to health coverage, and improve  
16 access to quality health care for millions of Ameri-  
17 cans.

1 **TITLE I—MAKING HEALTH CARE**  
2 **MORE AFFORDABLE**  
3 **Subtitle A—Medical Liability**  
4 **Reform**

5 **SEC. 101. SHORT TITLE.**

6 This subtitle may be cited as the “Patients First Act  
7 of 2005”.

8 **SEC. 102. FINDINGS AND PURPOSE.**

9 (a) FINDINGS.—

10 (1) EFFECT ON HEALTH CARE ACCESS AND  
11 COSTS.—Congress finds that our current civil justice  
12 system is adversely affecting patient access to health  
13 care services, better patient care, and cost-efficient  
14 health care, in that the current health care liability  
15 system is a costly and ineffective mechanism for re-  
16 solving claims of health care liability and compen-  
17 sating injured patients, and is a deterrent to the  
18 sharing of information among health care profes-  
19 sionals which impedes efforts to improve patient  
20 safety and quality of care.

21 (2) EFFECT ON INTERSTATE COMMERCE.—  
22 Congress finds that the health care and insurance  
23 industries are industries affecting interstate com-  
24 merce and the health care liability litigation systems  
25 existing throughout the United States are activities

1       that affect interstate commerce by contributing to  
2       the high costs of health care and premiums for  
3       health care liability insurance purchased by health  
4       care system providers.

5           (3) EFFECT ON FEDERAL SPENDING.—Con-  
6       gress finds that the health care liability litigation  
7       systems existing throughout the United States have  
8       a significant effect on the amount, distribution, and  
9       use of Federal funds because of—

10           (A) the large number of individuals who  
11           receive health care benefits under programs op-  
12           erated or financed by the Federal Government;

13           (B) the large number of individuals who  
14           benefit because of the exclusion from Federal  
15           taxes of the amounts spent to provide them  
16           with health insurance benefits; and

17           (C) the large number of health care pro-  
18           viders who provide items or services for which  
19           the Federal Government makes payments.

20       (b) PURPOSE.—It is the purpose of this subtitle to  
21       implement reasonable, comprehensive, and effective health  
22       care liability reforms designed to—

23           (1) improve the availability of health care serv-  
24       ices in cases in which health care liability actions

1 have been shown to be a factor in the decreased  
2 availability of services;

3 (2) reduce the incidence of “defensive medi-  
4 cine” and lower the cost of health care liability in-  
5 surance, all of which contribute to the escalation of  
6 health care costs;

7 (3) ensure that persons with meritorious health  
8 care injury claims receive fair and adequate com-  
9 pensation, including reasonable noneconomic dam-  
10 ages;

11 (4) improve the fairness and cost-effectiveness  
12 of our current health care liability system to resolve  
13 disputes over, and provide compensation for, health  
14 care liability by reducing uncertainty in the amount  
15 of compensation provided to injured individuals;

16 (5) provide an increased sharing of information  
17 in the health care system which will reduce unin-  
18 tended injury and improve patient care.

19 **SEC. 103. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

20 The time for the commencement of a health care law-  
21 suit shall be 3 years after the date of manifestation of  
22 injury or 1 year after the claimant discovers, or through  
23 the use of reasonable diligence should have discovered, the  
24 injury, whichever occurs first. In no event shall the time  
25 for commencement of a health care lawsuit exceed 3 years

1 after the date of manifestation of injury unless tolled for  
2 any of the following:

3 (1) Upon proof of fraud;

4 (2) Intentional concealment; or

5 (3) The presence of a foreign body, which has  
6 no therapeutic or diagnostic purpose or effect, in the  
7 person of the injured person.

8 Actions by a minor shall be commenced within 3 years  
9 from the date of the alleged manifestation of injury except  
10 that actions by a minor under the full age of 6 years shall  
11 be commenced within 3 years of manifestation of injury  
12 or prior to the minor's 8th birthday, whichever provides  
13 a longer period. Such time limitation shall be tolled for  
14 minors for any period during which a parent or guardian  
15 and a health care provider or health care organization  
16 have committed fraud or collusion in the failure to bring  
17 an action on behalf of the injured minor.

18 **SEC. 104. COMPENSATING PATIENT INJURY.**

19 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL  
20 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any  
21 health care lawsuit, the full amount of a claimant's eco-  
22 nomic loss may be fully recovered without limitation.

23 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any  
24 health care lawsuit, the amount of noneconomic damages  
25 recovered may be as much as \$250,000, regardless of the



1 number of parties against whom the action is brought or  
2 the number of separate claims or actions brought with re-  
3 spect to the same occurrence.

4 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC  
5 DAMAGES.—In any health care lawsuit, an award for fu-  
6 ture noneconomic damages shall not be discounted to  
7 present value. The jury shall not be informed about the  
8 maximum award for noneconomic damages. An award for  
9 noneconomic damages in excess of \$250,000 shall be re-  
10 duced either before the entry of judgment, or by amend-  
11 ment of the judgment after entry of judgment, and such  
12 reduction shall be made before accounting for any other  
13 reduction in damages required by law. If separate awards  
14 are rendered for past and future noneconomic damages  
15 and the combined awards exceed \$250,000, the future  
16 noneconomic damages shall be reduced first.

17 (d) FAIR SHARE RULE.—In any health care lawsuit,  
18 each party shall be liable for that party's several share  
19 of any damages only and not for the share of any other  
20 person. Each party shall be liable only for the amount of  
21 damages allocated to such party in direct proportion to  
22 such party's percentage of responsibility. A separate judg-  
23 ment shall be rendered against each such party for the  
24 amount allocated to such party. For purposes of this sec-

tion, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

**SEC. 105. MAXIMIZING PATIENT RECOVERY.**

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first \$50,000 recovered by the claimant(s).

(2)  $33\frac{1}{3}$  percent of the next \$50,000 recovered by the claimant(s).

(3) 25 percent of the next \$500,000 recovered by the claimant(s).

1           (4) 15 percent of any amount by which the re-  
2       covery by the claimant(s) is in excess of \$600,000.

3       (b) APPLICABILITY.—The limitations in subsection  
4 (a) shall apply whether the recovery is by judgment, settle-  
5 ment, mediation, arbitration, or any other form of alter-  
6 native dispute resolution. In a health care lawsuit involv-  
7 ing a minor or incompetent person, a court retains the  
8 authority to authorize or approve a fee that is less than  
9 the maximum permitted under this section.

10       (c) EXPERT WITNESSES.—

11           (1) REQUIREMENT.—No individual shall be  
12       qualified to testify as an expert witness concerning  
13       issues of negligence in any health care lawsuit  
14       against a defendant unless such individual—

15               (A) except as required under paragraph  
16       (2), is a health care professional who—

17                       (i) is appropriately credentialed or li-  
18                       censed in 1 or more States to deliver  
19                       health care services; and

20                       (ii) typically treats the diagnosis or  
21                       condition or provides the type of treatment  
22                       under review; and

23               (B) can demonstrate by competent evi-  
24       dence that, as a result of training, education,  
25       knowledge, and experience in the evaluation, di-

1           agnosis, and treatment of the disease or injury  
2           which is the subject matter of the lawsuit  
3           against the defendant, the individual was sub-  
4           stantially familiar with applicable standards of  
5           care and practice as they relate to the act or  
6           omission which is the subject of the lawsuit on  
7           the date of the incident.

8           (2) PHYSICIAN REVIEW.—In a health care law-  
9           suit, if the claim of the plaintiff involved treatment  
10          that is recommended or provided by a physician  
11          (allopathic or osteopathic), an individual shall not be  
12          qualified to be an expert witness under this sub-  
13          section with respect to issues of negligence con-  
14          cerning such treatment unless such individual is a  
15          physician.

16          (3) SPECIALTIES AND SUBSPECIALTIES.—With  
17          respect to a lawsuit described in paragraph (1), a  
18          court shall not permit an expert in one medical spe-  
19          cialty or subspecialty to testify against a defendant  
20          in another medical specialty or subspecialty unless,  
21          in addition to a showing of substantial familiarity in  
22          accordance with paragraph (1)(B), there is a show-  
23          ing that the standards of care and practice in the  
24          two specialty or subspecialty fields are similar.

1           (4) LIMITATION.—The limitations in this sub-  
2           section shall not apply to expert witnesses testifying  
3           as to the degree or permanency of medical or phys-  
4           ical impairment.

5   **SEC. 106. ADDITIONAL HEALTH BENEFITS.**

6           (a) IN GENERAL.—The amount of any damages re-  
7           ceived by a claimant in any health care lawsuit shall be  
8           reduced by the court by the amount of any collateral  
9           source benefits to which the claimant is entitled, less any  
10          insurance premiums or other payments made by the claim-  
11          ant (or by the spouse, parent, child, or legal guardian of  
12          the claimant) to obtain or secure such benefits.

13          (b) PRESERVATION OF CURRENT LAW.—Where a  
14          payor of collateral source benefits has a right of recovery  
15          by reimbursement or subrogation and such right is per-  
16          mitted under Federal or State law, subsection (a) shall  
17          not apply.

18          (c) APPLICATION OF PROVISION.—This section shall  
19          apply to any health care lawsuit that is settled or resolved  
20          by a fact finder.

21   **SEC. 107. PUNITIVE DAMAGES.**

22          (a) IN GENERAL.—Punitive damages may, if other-  
23          wise permitted by applicable State or Federal law, be  
24          awarded against any person in a health care lawsuit only  
25          if it is proven by clear and convincing evidence that such

1 person acted with malicious intent to injure the claimant,  
2 or that such person deliberately failed to avoid unneces-  
3 sary injury that such person knew the claimant was sub-  
4 stantially certain to suffer. In any health care lawsuit  
5 where no judgment for compensatory damages is rendered  
6 against such person, no punitive damages may be awarded  
7 with respect to the claim in such lawsuit. No demand for  
8 punitive damages shall be included in a health care lawsuit  
9 as initially filed. A court may allow a claimant to file an  
10 amended pleading for punitive damages only upon a mo-  
11 tion by the claimant and after a finding by the court, upon  
12 review of supporting and opposing affidavits or after a  
13 hearing, after weighing the evidence, that the claimant has  
14 established by a substantial probability that the claimant  
15 will prevail on the claim for punitive damages. At the re-  
16 quest of any party in a health care lawsuit, the trier of  
17 fact shall consider in a separate proceeding—

18 (1) whether punitive damages are to be award-  
19 ed and the amount of such award; and

20 (2) the amount of punitive damages following a  
21 determination of punitive liability.

22 If a separate proceeding is requested, evidence relevant  
23 only to the claim for punitive damages, as determined by  
24 applicable State law, shall be inadmissible in any pro-

1 ceeding to determine whether compensatory damages are  
2 to be awarded.

3 (b) DETERMINING AMOUNT OF PUNITIVE DAM-  
4 AGES.—

5 (1) FACTORS CONSIDERED.—In determining  
6 the amount of punitive damages, if awarded, in a  
7 health care lawsuit, the trier of fact shall consider  
8 only the following:

9 (A) the severity of the harm caused by the  
10 conduct of such party;

11 (B) the duration of the conduct or any  
12 concealment of it by such party;

13 (C) the profitability of the conduct to such  
14 party;

15 (D) the number of products sold or med-  
16 ical procedures rendered for compensation, as  
17 the case may be, by such party, of the kind  
18 causing the harm complained of by the claim-  
19 ant;

20 (E) any criminal penalties imposed on such  
21 party, as a result of the conduct complained of  
22 by the claimant; and

23 (F) the amount of any civil fines assessed  
24 against such party as a result of the conduct  
25 complained of by the claimant.

1           (2) MAXIMUM AWARD.—The amount of punitive  
2           damages, if awarded, in a health care lawsuit may  
3           be as much as \$250,000 or as much as two times  
4           the amount of economic damages awarded, which-  
5           ever is greater. The jury shall not be informed of  
6           this limitation.

7           (c) NO PENALTIES FOR PROVIDERS IN COMPLIANCE  
8           WITH FDA STANDARDS.—A health care provider who  
9           prescribes a medical product approved or cleared by the  
10          Food and Drug Administration shall not be named as a  
11          party to a product liability lawsuit involving such product  
12          and shall not be liable to a claimant in a class action law-  
13          suit against the manufacturer, distributor, or seller of  
14          such product.

15   **SEC. 108. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**  
16                   **AGES TO CLAIMANTS IN HEALTH CARE LAW-**  
17                   **SUITS.**

18          (a) IN GENERAL.—In any health care lawsuit, if an  
19          award of future damages, without reduction to present  
20          value, equaling or exceeding \$50,000 is made against a  
21          party with sufficient insurance or other assets to fund a  
22          periodic payment of such a judgment, the court shall, at  
23          the request of any party, enter a judgment ordering that  
24          the future damages be paid by periodic payments in ac-  
25          cordance with the Uniform Periodic Payment of Judg-



1 ments Act promulgated by the National Conference of  
2 Commissioners on Uniform State Laws.

3 (b) APPLICABILITY.—This section applies to all ac-  
4 tions which have not been first set for trial or retrial be-  
5 fore the effective date of this Act.

6 **SEC. 109. DEFINITIONS.**

7 In this subtitle:

8 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
9 TEM; ADR.—The term “alternative dispute resolution  
10 system” or “ADR” means a system that provides  
11 for the resolution of health care lawsuits in a man-  
12 ner other than through a civil action brought in a  
13 State or Federal court.

14 (2) CLAIMANT.—The term “claimant” means  
15 any person who brings a health care lawsuit, includ-  
16 ing a person who asserts or claims a right to legal  
17 or equitable contribution, indemnity or subrogation,  
18 arising out of a health care liability claim or action,  
19 and any person on whose behalf such a claim is as-  
20 serted or such an action is brought, whether de-  
21 ceased, incompetent, or a minor.

22 (3) COLLATERAL SOURCE BENEFITS.—The  
23 term “collateral source benefits” means any amount  
24 paid or reasonably likely to be paid in the future to  
25 or on behalf of the claimant, or any service, product

1 or other benefit provided or reasonably likely to be  
2 provided in the future to or on behalf of the claim-  
3 ant, as a result of the injury or wrongful death, pur-  
4 suant to—

5 (A) any State or Federal health, sickness,  
6 income-disability, accident, or workers' com-  
7 pensation law;

8 (B) any health, sickness, income-disability,  
9 or accident insurance that provides health bene-  
10 fits or income-disability coverage;

11 (C) any contract or agreement of any  
12 group, organization, partnership, or corporation  
13 to provide, pay for, or reimburse the cost of  
14 medical, hospital, dental, or income disability  
15 benefits; and

16 (D) any other publicly or privately funded  
17 program.

18 (4) COMPENSATORY DAMAGES.—The term  
19 “compensatory damages” means objectively  
20 verifiable monetary losses incurred as a result of the  
21 provision of, use of, or payment for (or failure to  
22 provide, use, or pay for) health care services or med-  
23 ical products, such as past and future medical ex-  
24 penses, loss of past and future earnings, cost of ob-  
25 taining domestic services, loss of employment, and

1       loss of business or employment opportunities, dam-  
2       ages for physical and emotional pain, suffering, in-  
3       convenience, physical impairment, mental anguish,  
4       disfigurement, loss of enjoyment of life, loss of soci-  
5       ety and companionship, loss of consortium (other  
6       than loss of domestic service), hedonic damages, in-  
7       jury to reputation, and all other nonpecuniary losses  
8       of any kind or nature. The term “compensatory  
9       damages” includes economic damages and non-  
10      economic damages, as such terms are defined in this  
11      section.

12           (5) CONTINGENT FEE.—The term “contingent  
13      fee” includes all compensation to any person or per-  
14      sons which is payable only if a recovery is effected  
15      on behalf of one or more claimants.

16           (6) ECONOMIC DAMAGES.—The term “economic  
17      damages” means objectively verifiable monetary  
18      losses incurred as a result of the provision of, use  
19      of, or payment for (or failure to provide, use, or pay  
20      for) health care services or medical products, such as  
21      past and future medical expenses, loss of past and  
22      future earnings, cost of obtaining domestic services,  
23      loss of employment, and loss of business or employ-  
24      ment opportunities.

1           (7) HEALTH CARE LAWSUIT.—The term  
2           “health care lawsuit” means any health care liability  
3           claim concerning the provision of health care goods  
4           or services affecting interstate commerce, or any  
5           health care liability action concerning the provision  
6           of health care goods or services affecting interstate  
7           commerce, brought in a State or Federal court or  
8           pursuant to an alternative dispute resolution system,  
9           against a health care provider, a health care organi-  
10          zation, or the manufacturer, distributor, supplier,  
11          marketer, promoter, or seller of a medical product,  
12          regardless of the theory of liability on which the  
13          claim is based, or the number of claimants, plain-  
14          tiffs, defendants, or other parties, or the number of  
15          claims or causes of action, in which the claimant al-  
16          leges a health care liability claim.

17          (8) HEALTH CARE LIABILITY ACTION.—The  
18          term “health care liability action” means a civil ac-  
19          tion brought in a State or Federal Court or pursu-  
20          ant to an alternative dispute resolution system,  
21          against a health care provider, a health care organi-  
22          zation, or the manufacturer, distributor, supplier,  
23          marketer, promoter, or seller of a medical product,  
24          regardless of the theory of liability on which the  
25          claim is based, or the number of plaintiffs, defend-

1       ants, or other parties, or the number of causes of ac-  
2       tion, in which the claimant alleges a health care li-  
3       ability claim.

4           (9) HEALTH CARE LIABILITY CLAIM.—The  
5       term “health care liability claim” means a demand  
6       by any person, whether or not pursuant to ADR,  
7       against a health care provider, health care organiza-  
8       tion, or the manufacturer, distributor, supplier, mar-  
9       keter, promoter, or seller of a medical product, in-  
10      cluding, but not limited to, third-party claims, cross-  
11      claims, counter-claims, or contribution claims, which  
12      are based upon the provision of, use of, or payment  
13      for (or the failure to provide, use, or pay for) health  
14      care services or medical products, regardless of the  
15      theory of liability on which the claim is based, or the  
16      number of plaintiffs, defendants, or other parties, or  
17      the number of causes of action.

18          (10) HEALTH CARE ORGANIZATION.—The term  
19      “health care organization” means any person or en-  
20      tity which is obligated to provide or pay for health  
21      benefits under any health plan, including any person  
22      or entity acting under a contract or arrangement  
23      with a health care organization to provide or admin-  
24      ister any health benefit.

1           (11) HEALTH CARE PROVIDER.—The term  
2           “health care provider” means any person or entity  
3           required by State or Federal laws or regulations to  
4           be licensed, registered, or certified to provide health  
5           care services, and being either so licensed, reg-  
6           istered, or certified, or exempted from such require-  
7           ment by other statute or regulation.

8           (12) HEALTH CARE GOODS OR SERVICES.—The  
9           term “health care goods or services” means any  
10          goods or services provided by a health care organiza-  
11          tion, provider, or by any individual working under  
12          the supervision of a health care provider, that relates  
13          to the diagnosis, prevention, or treatment of any  
14          human disease or impairment, or the assessment of  
15          the health of human beings.

16          (13) MALICIOUS INTENT TO INJURE.—The  
17          term “malicious intent to injure” means inten-  
18          tionally causing or attempting to cause physical in-  
19          jury other than providing health care goods or serv-  
20          ices.

21          (14) MEDICAL PRODUCT.—The term “medical  
22          product” means a drug or device intended for hu-  
23          mans, and the terms “drug” and “device” have the  
24          meanings given such terms in sections 201(g)(1) and  
25          201(h) of the Federal Food, Drug and Cosmetic Act

1 (21 U.S.C. 321), respectively, including any compo-  
2 nent or raw material used therein, but excluding  
3 health care services.

4 (15) NONECONOMIC DAMAGES.—The term  
5 “noneconomic damages” means damages for phys-  
6 ical and emotional pain, suffering, inconvenience,  
7 physical impairment, mental anguish, disfigurement,  
8 loss of enjoyment of life, loss of society and compan-  
9 ionship, loss of consortium (other than loss of do-  
10 mestic service), hedonic damages, injury to reputa-  
11 tion, and all other nonpecuniary losses of any kind  
12 or nature.

13 (16) PUNITIVE DAMAGES.—The term “punitive  
14 damages” means damages awarded, for the purpose  
15 of punishment or deterrence, and not solely for com-  
16 pensatory purposes, against a health care provider,  
17 health care organization, or a manufacturer, dis-  
18 tributor, or supplier of a medical product. Punitive  
19 damages are neither economic nor noneconomic  
20 damages.

21 (17) RECOVERY.—The term “recovery” means  
22 the net sum recovered after deducting any disburse-  
23 ments or costs incurred in connection with prosecu-  
24 tion or settlement of the claim, including all costs  
25 paid or advanced by any person. Costs of health care

1 incurred by the plaintiff and the attorneys' office  
2 overhead costs or charges for legal services are not  
3 deductible disbursements or costs for such purpose.

4 (18) STATE.—The term “State” means each of  
5 the several States, the District of Columbia, the  
6 Commonwealth of Puerto Rico, the Virgin Islands,  
7 Guam, American Samoa, the Northern Mariana Is-  
8 lands, the Trust Territory of the Pacific Islands, and  
9 any other territory or possession of the United  
10 States, or any political subdivision thereof.

11 **SEC. 110. EFFECT ON OTHER LAWS.**

12 (a) VACCINE INJURY.—

13 (1) To the extent that title XXI of the Public  
14 Health Service Act establishes a Federal rule of law  
15 applicable to a civil action brought for a vaccine-re-  
16 lated injury or death—

17 (A) this subtitle does not affect the appli-  
18 cation of the rule of law to such an action; and

19 (B) any rule of law prescribed by this sub-  
20 title in conflict with a rule of law of such title  
21 XXI shall not apply to such action.

22 (2) If there is an aspect of a civil action  
23 brought for a vaccine-related injury or death to  
24 which a Federal rule of law under title XXI of the  
25 Public Health Service Act does not apply, then this



1 subtitle or otherwise applicable law (as determined  
2 under this subtitle) will apply to such aspect of such  
3 action.

4 (b) OTHER FEDERAL LAW.—Except as provided in  
5 this section, nothing in this subtitle shall be deemed to  
6 affect any defense available to a defendant in a health care  
7 lawsuit or action under any other provision of Federal law.

8 **SEC. 111. STATE FLEXIBILITY AND PROTECTION OF**  
9 **STATES' RIGHTS.**

10 (a) HEALTH CARE LAWSUITS.—The provisions gov-  
11 erning health care lawsuits set forth in this subtitle pre-  
12 empt, subject to subsections (b) and (c), State law to the  
13 extent that State law prevents the application of any pro-  
14 visions of law established by or under this subtitle. The  
15 provisions governing health care lawsuits set forth in this  
16 subtitle supersede chapter 171 of title 28, United States  
17 Code, to the extent that such chapter—

18 (1) provides for a greater amount of damages  
19 or contingent fees, a longer period in which a health  
20 care lawsuit may be commenced, or a reduced appli-  
21 cability or scope of periodic payment of future dam-  
22 ages, than provided in this subtitle; or

23 (2) prohibits the introduction of evidence re-  
24 garding collateral source benefits, or mandates or

1       permits subrogation or a lien on collateral source  
2       benefits.

3       (b) PROTECTION OF STATES' RIGHTS.—Any issue  
4 that is not governed by any provision of law established  
5 by or under this subtitle (including State standards of  
6 negligence) shall be governed by otherwise applicable State  
7 or Federal law. This subtitle does not preempt or super-  
8 sede any law that imposes greater protections (such as a  
9 shorter statute of limitations) for health care providers  
10 and health care organizations from liability, loss, or dam-  
11 ages than those provided by this subtitle.

12       (c) STATE FLEXIBILITY.—No provision of this sub-  
13 title shall be construed to preempt—

14           (1) any State law (whether effective before, on,  
15       or after the date of the enactment of this subtitle)  
16       that specifies a particular monetary amount of com-  
17       pensatory or punitive damages (or the total amount  
18       of damages) that may be awarded in a health care  
19       lawsuit, regardless of whether such monetary  
20       amount is greater or lesser than is provided for  
21       under this subtitle, notwithstanding section 104(a);  
22       or

23           (2) any defense available to a party in a health  
24       care lawsuit under any other provision of State or  
25       Federal law.

1 **SEC. 112. APPLICABILITY; EFFECTIVE DATE.**

2 This subtitle shall apply to any health care lawsuit  
3 brought in a Federal or State court, or subject to an alter-  
4 native dispute resolution system, that is initiated on or  
5 after the date of the enactment of this Act, except that  
6 any health care lawsuit arising from an injury occurring  
7 prior to the date of the enactment of this Act shall be  
8 governed by the applicable statute of limitations provisions  
9 in effect at the time the injury occurred.

10 **Subtitle B—Health Information**  
11 **Technology**

12 **CHAPTER 1—GENERAL PROVISIONS**

13 **SEC. 121. IMPROVING HEALTH CARE, QUALITY, SAFETY,**  
14 **AND EFFICIENCY.**

15 The Public Health Service Act (42 U.S.C. 201 et  
16 seq.) is amended by adding at the end the following:

17 **“TITLE XXIX—HEALTH**  
18 **INFORMATION TECHNOLOGY**

19 **“SEC. 2901. DEFINITIONS.**

20 “In this title:

21 “(1) **HEALTH CARE PROVIDER.**—The term  
22 ‘health care provider’ means a hospital, skilled nurs-  
23 ing facility, home health entity, health care clinic,  
24 federally qualified health center, group practice (as  
25 defined in section 1877(h)(4) of the Social Security  
26 Act), a pharmacist, a pharmacy, a laboratory, a phy-

1       sician (as defined in section 1861(r) of the Social  
2       Security Act), a health facility operated by or pursu-  
3       ant to a contract with the Indian Health Service, a  
4       rural health clinic, and any other category of facility  
5       or clinician determined appropriate by the Secretary.

6               “(2) HEALTH INFORMATION.—The term ‘health  
7       information’ has the meaning given such term in  
8       section 1171(4) of the Social Security Act.

9               “(3) HEALTH INSURANCE PLAN.—The term  
10      ‘health insurance plan’ means—

11              “(A) a health insurance issuer (as defined  
12              in section 2791(b)(2));

13              “(B) a group health plan (as defined in  
14              section 2791(a)(1)); and

15              “(C) a health maintenance organization  
16              (as defined in section 2791(b)(3)).

17               “(4) LABORATORY.—The term ‘laboratory’ has  
18      the meaning given that term in section 353.

19               “(5) PHARMACIST.—The term ‘pharmacist’ has  
20      the meaning given that term in section 804 of the  
21      Federal Food, Drug, and Cosmetic Act.

22               “(6) STATE.—The term ‘State’ means each of  
23      the several States, the District of Columbia, Puerto  
24      Rico, the Virgin Islands, Guam, American Samoa,  
25      and the Northern Mariana Islands.

1   **“SEC. 2902. OFFICE OF THE NATIONAL COORDINATOR OF**  
2                   **HEALTH INFORMATION TECHNOLOGY.**

3           “(a) OFFICE OF NATIONAL HEALTH INFORMATION  
4   TECHNOLOGY.—There is established within the Office of  
5   the Secretary an Office of the National Coordinator of  
6   Health Information Technology (referred to in this section  
7   as the ‘Office’). The Office shall be headed by a National  
8   Coordinator who shall be appointed by the Secretary, in  
9   consultation with the President, and shall report directly  
10  to the Secretary.

11          “(b) Purpose.—It shall be the purpose of the Office  
12  to coordinate with relevant Federal agencies and oversee  
13  programs and activities to develop a nationwide interoper-  
14  able health information technology infrastructure that—

15               “(1) ensures that patients’ individually identifi-  
16               able health information is secure and protected;

17               “(2) improves health care quality, reduces med-  
18               ical errors, and advances the delivery of patient-cen-  
19               tered medical care;

20               “(3) reduces health care costs resulting from  
21               inefficiency, medical errors, inappropriate care, and  
22               incomplete information;

23               “(4) ensures that appropriate information to  
24               help guide medical decisions is available at the time  
25               and place of care;

1           “(5) promotes a more effective marketplace,  
2           greater competition, and increased choice through  
3           the wider availability of accurate information on  
4           health care costs, quality, and outcomes; and

5           “(6) improves the coordination of care and in-  
6           formation among hospitals, laboratories, physician  
7           offices, and other entities through an effective infra-  
8           structure for the secure and authorized exchange of  
9           health care information.

10          “(c) DUTIES OF THE NATIONAL COORDI-  
11          NATOR.—The National Coordinator shall—

12           “(1) provide support to the public-private  
13           American Health Information Collaborative estab-  
14           lished under section 2903;

15           “(2) serve as the principal advisor to the Sec-  
16           retary concerning the development, application, and  
17           use of health information technology, and coordinate  
18           and oversee the health information technology pro-  
19           grams of the Department;

20           “(3) facilitate the adoption of a nationwide,  
21           interoperable system for the electronic exchange of  
22           health information;

23           “(4) ensure the adoption and implementation of  
24           standards for the electronic exchange of health infor-

1       mation to reduce cost and improve health care qual-  
2       ity;

3           “(5) ensure that health information technology  
4       policy and programs of the Department are coordi-  
5       nated with those of relevant executive branch agen-  
6       cies (including Federal commissions) with a goal of  
7       avoiding duplication of efforts and of helping to en-  
8       sure that each agency undertakes health information  
9       technology activities primarily within the areas of its  
10      greatest expertise and technical capability;

11          “(6) to the extent permitted by law, coordinate  
12      outreach and consultation by the relevant executive  
13      branch agencies (including Federal commissions)  
14      with public and private parties of interest, including  
15      consumers, payers, employers, hospitals and other  
16      health care providers, physicians, community health  
17      centers, laboratories, vendors and other stake-  
18      holders;

19          “(7) advise the President regarding specific  
20      Federal health information technology programs;  
21      and

22          “(8) submit the reports described under section  
23      2903(i) (excluding paragraph (4) of such section).

24          “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
25      tion shall be construed to require the duplication of Fed-

1 eral efforts with respect to the establishment of the Office,  
2 regardless of whether such efforts were carried out prior  
3 to or after the enactment of this title.

4 **“SEC. 2903. AMERICAN HEALTH INFORMATION COLLABO-**  
5 **RATIVE.**

6 “(a) PURPOSE.—The Secretary shall establish the  
7 public-private American Health Information Collaborative  
8 (referred to in this section as the ‘Collaborative’) to—

9 “(1) advise the Secretary and recommend spe-  
10 cific actions to achieve a nationwide interoperable  
11 health information technology infrastructure;

12 “(2) serve as a forum for the participation of  
13 a broad range of stakeholders to provide input on  
14 achieving the interoperability of health information  
15 technology; and

16 “(3) recommend standards (including content,  
17 communication, and security standards) for the elec-  
18 tronic exchange of health information for adoption  
19 by the Federal Government and voluntary adoption  
20 by private entities.

21 “(b) COMPOSITION.—

22 “(1) IN GENERAL.—The Collaborative shall be  
23 composed of—

24 “(A) the Secretary, who shall serve as the  
25 chairperson of the Collaborative;



1           “(B) the Secretary of Defense, or his or  
2 her designee;

3           “(C) the Secretary of Veterans Affairs, or  
4 his or her designee;

5           “(D) the Secretary of Commerce, or his or  
6 her designee;

7           “(E) representatives of other relevant Fed-  
8 eral agencies, as determined appropriate by the  
9 Secretary; and

10           “(F) representatives from among the fol-  
11 lowing categories to be appointed by the Sec-  
12 retary from nominations submitted by the  
13 public—

14           “(i) consumer and patient organizations;

15           “(ii) experts in health information privacy  
16 and security;

17           “(iii) health care providers;

18           “(iv) health insurance plans or other third  
19 party payors;

20           “(v) standards development organizations;

21           “(vi) information technology vendors;

22           “(vii) purchasers or employers; and

23           “(viii) State or local government agencies  
24 or Indian tribe or tribal organizations.

1                   “(2) CONSIDERATIONS.—In appointing  
2                   members under paragraph (1)(F), the Secretary  
3                   shall select individuals with expertise in—

4                   “(A) health information privacy;

5                   “(B) health information security;

6                   “(C) health care quality and patient safety,  
7                   including those individuals with experience in  
8                   utilizing health information technology to im-  
9                   prove health care quality and patient safety;

10                  “(D) data exchange; and

11                  “(E) developing health information tech-  
12                  nology standards and new health information  
13                  technology.

14                  “(3) TERMS.—Members appointed under para-  
15                  graph (1)(G) shall serve for 2 year terms, except  
16                  that any member appointed to fill a vacancy for an  
17                  unexpired term shall be appointed for the remainder  
18                  of such term. A member may serve for not to exceed  
19                  180 days after the expiration of such member’s term  
20                  or until a successor has been appointed.

21                  “(c) RECOMMENDATIONS AND POLICIES.—The Col-  
22                  laborative shall make recommendations to identify uni-  
23                  form national policies for adoption by the Federal Govern-  
24                  ment and voluntary adoption by private entities to support

1 the widespread adoption of health information technology,  
2 including—

3 “(1) protection of individually identifiable  
4 health information through privacy and security  
5 practices;

6 “(2) measures to prevent unauthorized access  
7 to health information;

8 “(3) methods to facilitate secure patient access  
9 to health information;

10 “(4) the ongoing harmonization of industry-  
11 wide health information technology standards;

12 “(5) recommendations for a nationwide inter-  
13 operable health information technology infrastruc-  
14 ture;

15 “(6) the identification and prioritization of spe-  
16 cific use cases for which health information tech-  
17 nology is valuable, beneficial, and feasible;

18 “(7) recommendations for the establishment of  
19 an entity to ensure the continuation of the functions  
20 of the Collaborative; and

21 “(8) other policies determined to be necessary  
22 by the Collaborative.

23 “(d) STANDARDS.—

24 “(1) EXISTING STANDARDS.—The standards  
25 adopted by the Consolidated Health Informatics Ini-

1       tiative shall be deemed to have been recommended  
2       by the Collaborative under this section.

3               “(2) FIRST YEAR REVIEW.—Not later than 1  
4       year after the date of enactment of this title, the  
5       Collaborative shall—

6               “(A) review existing standards (including  
7       content, communication, and security stand-  
8       ards) for the electronic exchange of health in-  
9       formation, including such standards adopted by  
10      the Secretary under paragraph (2)(A);

11              “(B) identify deficiencies and omissions in  
12      such existing standards; and

13              “(C) identify duplication and overlap in  
14      such existing standards;

15      and recommend modifications to such standards as  
16      necessary.

17              “(3) ONGOING REVIEW.—Beginning 1 year  
18      after the date of enactment of this title, and annu-  
19      ally thereafter, the Collaborative shall—

20              “(A) review existing standards (including  
21      content, communication, and security stand-  
22      ards) for the electronic exchange of health in-  
23      formation, including such standards adopted by  
24      the Secretary under paragraph (2)(A);

1                   “(B) identify deficiencies and omissions in  
2                   such existing standards; and

3                   “(C) identify duplication and overlap in  
4                   such existing standards;  
5                   and recommend modifications to such standards as  
6                   necessary.

7                   “(4) LIMITATION.—The standards described in  
8                   this section shall be consistent with any standards  
9                   developed pursuant to the Health Insurance Port-  
10                  ability and Accountability Act of 1996.

11                  “(e) FEDERAL ACTION.—Not later than 60 days  
12                  after the issuance of a recommendation from the Collabo-  
13                  rative under subsection (d)(2), the Secretary of Health  
14                  and Human Services, in consultation with the Secretary  
15                  of Veterans Affairs, the Secretary of Defense, and rep-  
16                  resentatives of other relevant Federal agencies, as deter-  
17                  mined appropriate by the Secretary, shall review such rec-  
18                  ommendations. The Secretary shall provide for the adop-  
19                  tion by the Federal Government of any standard or stand-  
20                  ards contained in such recommendation.

21                  “(f) COORDINATION OF FEDERAL SPENDING.—Not  
22                  later than 1 year after the adoption by the Federal Gov-  
23                  ernment of a recommendation as provided for in sub-  
24                  section (e), and in compliance with chapter 113 of title  
25                  40, United States Code, no Federal agency shall expend

1 Federal funds for the purchase of any form of health in-  
2 formation technology or health information technology  
3 system for clinical care or for the electronic retrieval, stor-  
4 age, or exchange of health information that is not con-  
5 sistent with applicable standards adopted by the Federal  
6 Government under subsection (e).

7 “(g) COORDINATION OF FEDERAL DATA COLLEC-  
8 TION.—Not later than 3 years after the adoption by the  
9 Federal Government of a recommendation as provided for  
10 in subsection (e), all Federal agencies collecting health  
11 data for the purposes of surveillance, epidemiology, ad-  
12 verse event reporting, research, or for other purposes de-  
13 termined appropriate by the Secretary shall comply with  
14 standards adopted under subsection (e).

15 “(h) VOLUNTARY ADOPTION.—

16 “(1) IN GENERAL.—Any standards adopted by  
17 the Federal Government under subsection (e) shall  
18 be voluntary with respect to private entities.

19 “(2) RULE OF CONSTRUCTION.—Nothing in  
20 this section shall be construed to require that a pri-  
21 vate entity that enters into a contract with the Fed-  
22 eral Government adopt the standards adopted by the  
23 Federal Government under section 2903 with re-  
24 spect to activities not related to the contract.

1           “(3) LIMITATION.—Private entities that enter  
2           into a contract with the Federal Government shall  
3           adopt the standards adopted under section 2903 for  
4           the purpose of activities under such Federal con-  
5           tract.

6           “(i) EFFECT ON OTHER PROVISIONS.—Nothing in  
7           this title shall be construed to effect the scope or sub-  
8           stance of—

9           “(1) section 264 of the Health Insurance Port-  
10          ability and Accountability Act of 1996;

11          “(2) sections 1171 through 1179 of the Social  
12          Security Act; and

13          “(3) any regulation issued pursuant to any such  
14          section;

15          and such sections shall remain in effect and shall apply  
16          to the implementation of standards, programs and activi-  
17          ties under this title.

18          “(j) REPORTS.—The Secretary shall submit to the  
19          Committee on Health, Education, Labor, and Pensions  
20          and the Committee on Finance of the Senate and the  
21          Committee on Energy and Commerce and the Committee  
22          on Ways and Means of the House of Representatives, on  
23          an annual basis, a report that—

24          “(1) describes the specific actions that have  
25          been taken by the Federal Government and private

1 entities to facilitate the adoption of an interoperable  
2 nationwide system for the electronic exchange of  
3 health information;

4 “(2) describes barriers to the adoption of such  
5 a nationwide system;

6 “(3) contains recommendations to achieve full  
7 implementation of such a nationwide system; and

8 “(4) contains a plan and progress toward the  
9 establishment of an entity to ensure the continuation  
10 of the functions of the Collaborative.

11 “(k) APPLICATION OF FACA.—The Federal Advisory  
12 Committee Act (5 U.S.C. App.) shall apply to the Collabo-  
13 rative, except that the term provided for under section  
14 14(a)(2) shall be 5 years.

15 “(l) RULE OF CONSTRUCTION.—Nothing in this sec-  
16 tion shall be construed to require the duplication of Fed-  
17 eral efforts with respect to the establishment of the Col-  
18 laborative, regardless of whether such efforts were carried  
19 out prior to or after the enactment of this title.

20 **“SEC. 2904. IMPLEMENTATION AND CERTIFICATION OF**  
21 **HEALTH INFORMATION STANDARDS.**

22 “(a) IMPLEMENTATION.—

23 “(1) IN GENERAL.—The Secretary, based upon  
24 the recommendations of the Collaborative, shall de-  
25 velop criteria to ensure uniform and consistent im-



1       plementation of any standards for the electronic ex-  
2       change of health information voluntarily adopted by  
3       private entities in technical conformance with such  
4       standards adopted under this title.

5               “(2) IMPLEMENTATION ASSISTANCE.—The Sec-  
6       retary may recognize a private entity or entities to  
7       assist private entities in the implementation of the  
8       standards adopted under this title using the criteria  
9       developed by the Secretary under this section.

10       “(b) CERTIFICATION.—

11               “(1) IN GENERAL.—The Secretary, based upon  
12       the recommendations of the Collaborative, shall de-  
13       velop criteria to ensure and certify that hardware,  
14       software, and support services that claim to be in  
15       compliance with any standard for the electronic ex-  
16       change of health information adopted under this title  
17       have established and maintained such compliance in  
18       technical conformance with such standards.

19               “(2) CERTIFICATION ASSISTANCE.—The Sec-  
20       retary may recognize a private entity or entities to  
21       assist in the certification described under paragraph  
22       (1) using the criteria developed by the Secretary  
23       under this section.

24       “(c) DELEGATION AUTHORITY.—The Secretary,  
25       through consultation with the Collaborative, may delegate

1 the development of the criteria under subsections (a) and  
2 (b) to a private entity.

3 **“SEC. 2905. STUDY OF STATE HEALTH INFORMATION LAWS**  
4 **AND PRACTICES.**

5 “(a) IN GENERAL.—The Secretary shall carry out,  
6 or contract with a private entity to carry out, a study that  
7 examines—

8 “(1) the variation among State laws and prac-  
9 tices that relate to the privacy, confidentiality, and  
10 security of health information;

11 “(2) how such variation among State laws and  
12 practices may impact the electronic exchange of  
13 health information—

14 “(A) among the States;

15 “(B) between the States and the Federal  
16 Government; and

17 “(C) among private entities; and

18 “(3) how such laws and practices may be har-  
19 monized to permit the secure electronic exchange of  
20 health information.

21 “(b) REPORT AND RECOMMENDATIONS.—Not later  
22 than 1 year after the date of enactment of this title, the  
23 Secretary shall submit to Congress a report that—

24 “(1) describes the results of the study carried  
25 out under subsection (a); and

1           “(2) makes recommendations based on the re-  
2           sults of such study.

3   **“SEC. 2906. SECURE EXCHANGE OF HEALTH INFORMATION;**  
4           **INCENTIVE GRANTS.**

5           “(a) IN GENERAL.—The Secretary may make grants  
6   to States to carry out programs under which such States  
7   cooperate with other States to develop and implement  
8   State policies that will facilitate the secure electronic ex-  
9   change of health information utilizing the standards  
10  adopted under section 2903—

11           “(1) among the States;

12           “(2) between the States and the Federal Gov-  
13   ernment; and

14           “(3) among private entities.

15           “(b) PRIORITY.—In awarding grants under sub-  
16   section (a), the Secretary shall give priority to States that  
17   provide assurance that any funding awarded under such  
18   a grant shall be used to harmonize privacy laws and prac-  
19   tices between the States, the States and the Federal Gov-  
20   ernment, and among private entities related to the privacy,  
21   confidentiality, and security of health information.

22           “(c) DISSEMINATION OF INFORMATION.—The Sec-  
23   retary shall disseminate information regarding the efficacy  
24   of efforts of a recipient of a grant under this section.

1       “(d) TECHNICAL ASSISTANCE.—The Secretary may  
2 provide technical assistance to recipients of a grant under  
3 this section.

4       “(e) AUTHORIZATION OF APPROPRIATIONS.—For the  
5 purpose of carrying out subsection (a), there are author-  
6 ized to be appropriated such sums as may be necessary  
7 for each of the fiscal years 2006 through 2010.

8       **“SEC. 2907. LICENSURE AND THE ELECTRONIC EXCHANGE**  
9                   **OF HEALTH INFORMATION.**

10       “(a) IN GENERAL.—The Secretary shall carry out,  
11 or contract with a private entity to carry out, a study that  
12 examines—

13               “(1) the variation among State laws that relate  
14 to the licensure, registration, and certification of  
15 medical professionals; and

16               “(2) how such variation among State laws im-  
17 pacts the secure electronic exchange of health  
18 information—

19                       “(A) among the States; and

20                       “(B) between the States and the Federal  
21 Government.

22       “(b) REPORT AND RECOMMENDATIONS.—Not later  
23 than 1 year after the date of enactment of this title, the  
24 Secretary shall publish a report that—

1 “(1) describes the results of the study carried  
2 out under subsection (a); and

3 “(2) makes recommendations to States regard-  
4 ing the harmonization of State laws based on the re-  
5 sults of such study.

6 **“SEC. 2908. AUTHORIZATION OF APPROPRIATIONS.**

7 “(a) IN GENERAL.—For the purpose of carrying out  
8 this title, there is authorized to be appropriated  
9 \$125,000,000 for fiscal year 2006, and such sums as may  
10 be necessary for each of fiscal years 2007 through 2010.

11 “(b) AVAILABILITY.—Amounts appropriated under  
12 subsection (a) shall remain available through fiscal year  
13 2010.”.

14 **SEC. 122. HIPAA REPORT.**

15 (a) STUDY.—Not later than 2 years after the date  
16 of enactment of this Act, the Secretary of Health and  
17 Human Services shall carry out, or contract with a private  
18 entity to carry out, a study that examines the integration  
19 of the standards adopted under the amendments made by  
20 this subtitle with the standards adopted under the Health  
21 Insurance Portability and Accountability Act of 1996  
22 (Public Law 104–191).

23 (b) PLAN; REPORT.—

24 (1) PLAN.—Not later than 3 years after the  
25 date of enactment of this Act, the Secretary of

1 Health and Human Services shall, based on the re-  
2 sults of the study carried out under subsection (a),  
3 develop a plan for the integration of the standards  
4 described under such subsection and submit a report  
5 to Congress describing such plan.

6 (2) PERIODIC REPORTS.—The Secretary shall  
7 submit periodic reports to Congress that describe the  
8 progress of the integration described under para-  
9 graph (1).

10 **SEC. 123. STUDY OF REIMBURSEMENT INCENTIVES.**

11 The Secretary of Health and Human Services shall  
12 carry out, or contract with a private entity to carry out,  
13 a study that examines methods to create efficient reim-  
14 bursement incentives for improving health care quality in  
15 Federally qualified health centers, rural health clinics, and  
16 free clinics.

17 **SEC. 124. REAUTHORIZATION OF INCENTIVE GRANTS RE-**  
18 **GARDING TELEMEDICINE.**

19 Section 330L(b) of the Public Health Service Act (42  
20 U.S.C. 254c–18(b)) is amended by striking “2002 through  
21 2006” and inserting “2006 through 2010”.

22 **SEC. 125. SENSE OF THE SENATE ON PHYSICIAN PAYMENT.**

23 It is the sense of the Senate that modifications to  
24 the medicare fee schedule for physicians’ services under  
25 section 1848 of the Social Security Act (42 U.S.C.

1 1394w–4) should include provisions based on the reporting  
2 of quality measures pursuant to those adopted in section  
3 2909 of the Public Health Service Act (as added by sec-  
4 tion 121) and the overall improvement of healthcare qual-  
5 ity through the use of the electronic exchange of health  
6 information pursuant to the standards adopted under sec-  
7 tion 2903 of such Act (as added by section 121).

8 **SEC. 126. ESTABLISHMENT OF QUALITY MEASUREMENT**  
9 **SYSTEMS FOR MEDICARE VALUE-BASED PUR-**  
10 **CHASING PROGRAMS.**

11 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
12 seq.) is amended—

13 (1) by redesignating part E as part F; and

14 (2) by inserting after part D the following new  
15 part:

16 “PART E—VALUE-BASED PURCHASING  
17 “QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED  
18 PURCHASING PROGRAMS

19 “SEC. 1860E–1. (a) ESTABLISHMENT.—

20 “(1) IN GENERAL.—The Secretary shall develop  
21 quality measurement systems for purposes of pro-  
22 viding value-based payments to—

23 “(A) hospitals pursuant to section 1860E–  
24 2;

1                   “(B) physicians and practitioners pursuant  
2                   to section 1860E-3;

3                   “(C) plans pursuant to section 1860E-4;

4                   “(D) end stage renal disease providers and  
5                   facilities pursuant to section 1860E-5; and

6                   “(E) home health agencies pursuant to  
7                   section 1860E-6.

8                   “(2) QUALITY.—The systems developed under  
9                   paragraph (1) shall measure the quality of the care  
10                  furnished by the provider involved.

11                  “(3) HIGH QUALITY HEALTH CARE DEFINED.—  
12                  In this part, the term ‘high quality health care’  
13                  means health care that is safe, effective, patient-cen-  
14                  tered, timely, equitable, efficient, necessary, and ap-  
15                  propriate.

16                  “(b) REQUIREMENTS FOR SYSTEMS.—Under each  
17                  quality measurement system described in subsection  
18                  (a)(1), the Secretary shall do the following:

19                         “(1) MEASURES.—

20                                 “(A) IN GENERAL.—Subject to subpara-  
21                                 graph (B), the Secretary shall select measures  
22                                 of quality to be used by the Secretary under  
23                                 each system.

24                                 “(B) REQUIREMENTS.—In selecting the  
25                                 measures to be used under each system pursu-



1 ant to subparagraph (A), the Secretary shall, to  
2 the extent feasible, ensure that—

3 “(i) such measures are evidence-  
4 based, reliable and valid, and feasible to  
5 collect and report;

6 “(ii) measures of process, structure,  
7 outcomes, beneficiary experience, effi-  
8 ciency, and equity are included;

9 “(iii) measures of overuse and  
10 underuse of health care items and services  
11 are included;

12 “(iv)(I) at least 1 measure of health  
13 information technology infrastructure that  
14 enables the provision of high quality health  
15 care and facilitates the exchange of health  
16 information, such as the use of one or  
17 more elements of a qualified health infor-  
18 mation system (as defined in subparagraph  
19 (E)), is included during the first year each  
20 system is implemented; and

21 “(II) additional measures of health in-  
22 formation technology infrastructure are in-  
23 cluded in subsequent years;

24 “(v) in the case of the system that is  
25 used to provide value-based payments to

1 hospitals under section 1860E–2, by not  
2 later than January 1, 2008, at least 5  
3 measures that take into account the unique  
4 characteristics of small hospitals located in  
5 rural areas and frontier areas are included;  
6 and

7 “(vi) measures that assess the quality  
8 of care furnished to frail individuals over  
9 the age of 75 and to individuals with mul-  
10 tiple complex chronic conditions are in-  
11 cluded.

12 “(C) REQUIREMENT FOR COLLECTION OF  
13 DATA ON A MEASURE FOR 1 YEAR PRIOR TO  
14 USE UNDER THE SYSTEMS.—Data on any  
15 measure selected by the Secretary under sub-  
16 paragraph (A) must be collected by the Sec-  
17 retary for at least a 12-month period before  
18 such measure may be used to determine wheth-  
19 er a provider receives a value-based payment  
20 under a program described in subsection (a)(1).

21 “(D) AUTHORITY TO VARY MEASURES.—

22 “(i) UNDER SYSTEM APPLICABLE TO  
23 HOSPITALS.—In the case of the system ap-  
24 plicable to hospitals under section 1860E–  
25 2, the Secretary may vary the measures se-

1 lected under subparagraph (A) by hospital  
2 depending on the size of, and the scope of  
3 services provided by, the hospital.

4 “(ii) UNDER SYSTEM APPLICABLE TO  
5 PHYSICIANS AND PRACTITIONERS.—In the  
6 case of the system applicable to physicians  
7 and practitioners under section 1860E–3,  
8 the Secretary may vary the measures se-  
9 lected under subparagraph (A) by physi-  
10 cian or practitioner depending on the spe-  
11 cialty of the physician, the type of practi-  
12 tioner, or the volume of services furnished  
13 to beneficiaries by the physician or practi-  
14 tioner.

15 “(iii) UNDER SYSTEM APPLICABLE TO  
16 ESRD PROVIDERS AND FACILITIES.—In the  
17 case of the system applicable to providers  
18 of services and renal dialysis facilities  
19 under section 1860E–5, the Secretary may  
20 vary the measures selected under subpara-  
21 graph (A) by provider or facility depending  
22 on the type of, the size of, and the scope  
23 of services provided by, the provider or fa-  
24 cility.

1                   “(iv) UNDER SYSTEM APPLICABLE TO  
2                   HOME HEALTH AGENCIES.—In the case of  
3                   the system applicable to home health agen-  
4                   cies under section 1860E–6, the Secretary  
5                   may vary the measures selected under sub-  
6                   paragraph (A) by agency depending on the  
7                   size of, and the scope of services provided  
8                   by, the agency.

9                   “(E) QUALIFIED HEALTH INFORMATION  
10                  SYSTEM DEFINED.—For purposes of subpara-  
11                  graph (B)(iv)(I), the term ‘qualified health in-  
12                  formation system’ means a computerized sys-  
13                  tem (including hardware, software, and train-  
14                  ing) that—

15                   “(i) protects the privacy and security  
16                   of health information and properly  
17                   encrypts such health information;

18                   “(ii) maintains and provides access to  
19                   patients’ health records in an electronic  
20                   format;

21                   “(iii) incorporates decision support  
22                   software to reduce medical errors and en-  
23                   hance health care quality;

1 “(iv) is consistent with data standards  
2 and certification processes recommended  
3 by the Secretary;

4 “(v) allows for the reporting of quality  
5 measures; and

6 “(vi) includes other features deter-  
7 mined appropriate by the Secretary.

8 “(2) WEIGHTS OF MEASURES.—

9 “(A) IN GENERAL.—The Secretary shall  
10 assign weights to the measures used by the Sec-  
11 retary under each system.

12 “(B) CONSIDERATION.—If the Secretary  
13 determines appropriate, in assigning the  
14 weights under subparagraph (A)—

15 “(i) measures of clinical effectiveness  
16 shall be weighted more heavily than meas-  
17 ures of beneficiary experience; and

18 “(ii) measures of risk adjusted out-  
19 comes shall be weighted more heavily than  
20 measures of process; and

21 “(3) RISK ADJUSTMENT.—The Secretary shall  
22 establish procedures, as appropriate, to control for  
23 differences in beneficiary health status and bene-  
24 ficiary characteristics. To the extent feasible, such

1 procedures may be based on existing models for con-  
2 trolling for such differences.

3 “(4) MAINTENANCE.—

4 “(A) IN GENERAL.—The Secretary shall,  
5 as determined appropriate, but not more often  
6 than once each 12-month period, update each  
7 system, including through—

8 “(i) the addition of more accurate and  
9 precise measures under the systems and  
10 the retirement of existing outdated meas-  
11 ures under the system;

12 “(ii) the refinement of the weights as-  
13 signed to measures under the system; and

14 “(iii) the refinement of the risk ad-  
15 justment procedures established pursuant  
16 to paragraph (3) under the system.

17 “(B) UPDATE SHALL ALLOW FOR COM-  
18 PARISON OF DATA.—Each update under sub-  
19 paragraph (A) of a quality measurement system  
20 shall allow for the comparison of data from one  
21 year to the next for purposes of providing  
22 value-based payments under the programs de-  
23 scribed in subsection (a)(1).

24 “(5) USE OF MOST RECENT QUALITY DATA.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (B), the Secretary shall use the  
3           most recent quality data with respect to the  
4           provider involved that is available to the Sec-  
5           retary.

6           “(B) INSUFFICIENT DATA DUE TO LOW  
7           VOLUME.—If the Secretary determines that  
8           there is insufficient data with respect to a  
9           measure or measures because of a low number  
10          of services provided, the Secretary may aggre-  
11          gate data across more than 1 fiscal or calendar  
12          year, as the case may be.

13          “(c) REQUIREMENTS FOR DEVELOPING AND UPDAT-  
14          ING THE SYSTEMS.—In developing and updating each  
15          quality measurement system under this section, the Sec-  
16          retary shall—

17               “(1) take into account the quality measures de-  
18               veloped by nationally recognized quality measure-  
19               ment organizations, researchers, health care provider  
20               organizations, and other appropriate groups;

21               “(2) consult with, and take into account the  
22               recommendations of, the entity that the Secretary  
23               has an arrangement with under subsection (e);

24               “(3) consult with provider-based groups and  
25               clinical specialty societies;

1           “(4) take into account existing quality measure-  
2           ment systems that have been developed through a  
3           rigorous process of validation and with the involve-  
4           ment of entities and persons described in subsection  
5           (e)(2)(B); and

6           “(5) take into account—

7                   “(A) each of the reports by the Medicare  
8                   Payment Advisory Commission that are re-  
9                   quired under the Medicare Value Purchasing  
10                  Act of 2005;

11                  “(B) the results of—

12                          “(i) the demonstrations required  
13                          under such Act;

14                          “(ii) the demonstration program  
15                          under section 1866A;

16                          “(iii) the demonstration program  
17                          under section 1866C; and

18                          “(iv) any other demonstration or pilot  
19                          program conducted by the Secretary relat-  
20                          ing to measuring and rewarding quality  
21                          and efficiency of care; and

22                  “(C) the report by the Institute of Medi-  
23                  cine of the National Academy of Sciences under  
24                  section 238(b) of the Medicare Prescription



1 Drug, Improvement, and Modernization Act of  
2 2003 (Public Law 108–173).

3 “(d) REQUIREMENTS FOR IMPLEMENTING THE SYS-  
4 TEMS.—In implementing each quality measurement sys-  
5 tem under this section, the Secretary shall consult with  
6 entities—

7 “(1) that have joined together to develop strate-  
8 gies for quality measurement and reporting, includ-  
9 ing the feasibility of collecting and reporting mean-  
10 ingful data on quality measures; and

11 “(2) that involve representatives of health care  
12 providers, health plans, consumers, employers, pur-  
13 chasers, quality experts, government agencies, and  
14 other individuals and groups that are interested in  
15 quality of care.

16 “(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE  
17 ADVICE AND RECOMMENDATIONS.—

18 “(1) ARRANGEMENT.—On and after July 1,  
19 2006, the Secretary shall have in place an arrange-  
20 ment with an entity that meets the requirements de-  
21 scribed in paragraph (2) under which such entity  
22 provides the Secretary with advice on, and rec-  
23 ommendations with respect to, the development and  
24 updating of the quality measurement systems under

1       this section, including the assigning of weights to  
2       the measures under subsection (b)(2).

3               “(2) REQUIREMENTS DESCRIBED.—The re-  
4       quirements described in this paragraph are the fol-  
5       lowing:

6               “(A) The entity is a private nonprofit enti-  
7       ty governed by an executive director and a  
8       board.

9               “(B) The members of the entity include  
10      representatives of—

11              “(i)(I) health plans and providers re-  
12      ceiving reimbursement under this title for  
13      the provision of items and services, includ-  
14      ing health plans and providers with experi-  
15      ence in the care of the frail elderly and in-  
16      dividuals with multiple complex chronic  
17      conditions; or

18              “(II) groups representing such health  
19      plans and providers;

20              “(ii) groups representing individuals  
21      receiving benefits under this title;

22              “(iii) purchasers and employers or  
23      groups representing purchasers or employ-  
24      ers;

1 “(iv) organizations that focus on qual-  
2 ity improvement as well as the measure-  
3 ment and reporting of quality measures;

4 “(v) State government health pro-  
5 grams;

6 “(vi) persons skilled in the conduct  
7 and interpretation of biomedical, health  
8 services, and health economics research  
9 and with expertise in outcomes and effec-  
10 tiveness research and technology assess-  
11 ment; and

12 “(vii) persons or entities involved in  
13 the development and establishment of  
14 standards and certification for health in-  
15 formation technology systems and clinical  
16 data.

17 “(C) The membership of the entity is rep-  
18 resentative of individuals with experience  
19 with—

20 “(i) urban health care issues;

21 “(ii) safety net health care issues; and

22 “(iii) rural and frontier health care  
23 issues.

24 “(D) The entity does not charge a fee for  
25 membership for participation in the work of the

1           entity related to the arrangement with the Sec-  
2           retary under paragraph (1). If the entity does  
3           require a fee for membership for participation  
4           in other functions of the entity, there shall be  
5           no linkage between such fee and participation  
6           in the work of the entity related to such ar-  
7           rangement with the Secretary.

8           “(E) The entity—

9                   “(i) permits any member described in  
10                  subparagraph (B) to vote on matters of  
11                  the entity related to the arrangement with  
12                  the Secretary under paragraph (1); and

13                   “(ii) ensures that such members have  
14                  an equal vote on such matters .

15           “(F) With respect to matters related to the  
16           arrangement with the Secretary under para-  
17           graph (1), the entity conducts its business in an  
18           open and transparent manner and provides the  
19           opportunity for public comment.

20           “(G) The entity operates as a voluntary  
21           consensus standards setting organization as de-  
22           fined for purposes of section 12(d) of the Na-  
23           tional Technology Transfer and Advancement  
24           Act of 1995 (Public Law 104–113) and Office  
25           of Management and Budget Revised Circular

1           A-119 (published in the Federal Register on  
2           February 10, 1998).”.

3           (b) CONFORMING REFERENCES TO PREVIOUS PART  
4   E.—Any reference in law (in effect before the date of the  
5   enactment of this Act) to part E of title XVIII of the So-  
6   cial Security Act is deemed a reference to part F of such  
7   title (as in effect after such date).

8   **SEC. 127. EXCEPTION TO FEDERAL ANTI-KICKBACK AND**  
9                           **PHYSICIAN SELF REFERRAL LAWS FOR THE**  
10                          **PROVISION OF PERMITTED SUPPORT.**

11          (a) ANTI-KICKBACK.—Section 1128B(b) (42 U.S.C.  
12   1320a-7b(b)(3)) is amended—

13               (1) in paragraph (3)—

14                       (A) in subparagraph (G), by striking  
15                       “and” at the end;

16                       (B) in subparagraph (H), as added by sec-  
17                       tion 237(d) of the Medicare Prescription Drug,  
18                       Improvement, and Modernization Act of 2003  
19                       (Public Law 108-173; 117 Stat. 2213)—

20                               (i) by moving such subparagraph 2  
21                               ems to the left; and

22                               (ii) by striking the period at the end  
23                               and inserting a semicolon;

24                       (C) by redesignating subparagraph (H), as  
25                       added by section 431(a) of the Medicare Pre-

1           scription Drug, Improvement, and Moderniza-  
2           tion Act of 2003 (Public Law 108–173; 117  
3           Stat. 2287), as subparagraph (I);

4                   (D)    in    subparagraph   (I),    as    so  
5           redesignated—

6                           (i) by moving such subparagraph 2  
7                           ems to the left; and

8                           (ii) by striking the period at the end  
9                           and inserting “; and”; and

10                   (E) by adding at the end the following  
11           new:

12                           “(J) during the 5-year period beginning on  
13                           the date the Secretary issues the interim final  
14                           rule under section 801(c)(1) of the Medicare  
15                           Value Purchasing Act of 2005, the provision,  
16                           with or without charge, of any permitted sup-  
17                           port (as defined in paragraph (4)).”; and

18                   (2) by adding at the end the following new  
19           paragraph:

20                           “(4) PERMITTED SUPPORT.—

21                                   “(A) DEFINITION OF PERMITTED SUP-  
22                                   PORT.—Subject to subparagraph (B), in this  
23                                   section, the term ‘permitted support’ means the  
24                                   provision of any equipment, item, information,  
25                                   right, license, intellectual property, software,

1 training, or service used for developing, imple-  
2 menting, operating, or facilitating the use of  
3 systems designed to improve the quality of  
4 health care and to promote the electronic ex-  
5 change of health information.

6 “(B) EXCEPTION.—The term ‘permitted  
7 support’ shall not include the provision of—

8 “(i) any support that is determined in  
9 a manner that is related to the volume or  
10 value of any referrals or other business  
11 generated between the parties for which  
12 payment may be made in whole or in part  
13 under a Federal health care program;

14 “(ii) any support that has more than  
15 incidental utility or value to the recipient  
16 beyond the exchange of health care infor-  
17 mation; or

18 “(iii) any health information tech-  
19 nology system, product, or service that is  
20 not capable of exchanging health care in-  
21 formation in compliance with data stand-  
22 ards consistent with interoperability.

23 “(C) DETERMINATION.—In establishing  
24 regulations with respect to the requirement

1 under subparagraph (B)(iii), the Secretary shall  
2 take in account—

3 “(I) whether the health information  
4 technology system, product, or service is  
5 widely accepted within the industry and  
6 whether there is sufficient industry experi-  
7 ence to ensure successful implementation  
8 of the system, product, or service; and

9 “(II) whether the health information  
10 technology system, product, or service im-  
11 proves quality of care, enhances patient  
12 safety, or provides greater administrative  
13 efficiencies.”.

14 (b) PHYSICIAN SELF-REFERRAL.—Section 1877(e)  
15 (42 U.S.C. 1395nn(e)) is amended by adding at the end  
16 the following new paragraph:

17 “(9) PERMITTED SUPPORT.—During the 5-year  
18 period beginning on the date the Secretary issues  
19 the interim final rule under section 801(c)(1) of the  
20 Medicare Value Purchasing Act of 2005, the provi-  
21 sion, with or without charge, of any permitted sup-  
22 port (as defined in section 1128B(b)(4)).”.

23 (c) REGULATIONS.—In order to carry out the amend-  
24 ments made by this section—



1           (1) the Secretary shall issue an interim final  
2 rule with comment period by not later than the date  
3 that is 180 days after the date of enactment of this  
4 Act;

5           (2) the Secretary shall issue a final rule by not  
6 later than the date that is 180 days after the date  
7 that the interim final rule under paragraph (1) is  
8 issued.

9       **CHAPTER 2—VALUE BASED PURCHASING**

10   **SEC. 131. VALUE BASED PURCHASING PROGRAMS; SENSE**  
11                           **OF THE SENATE.**

12       (a) MEDICARE VALUE BASED PURCHASING PILOT  
13 PROGRAM.—

14           (1) IN GENERAL.—The Secretary of Health and  
15 Human Services (referred to in this section as the  
16 “Secretary”) shall establish under title XVIII of the  
17 Social Security Act (42 U.S.C. 1395 et seq.) a value  
18 based purchasing pilot program based on the report-  
19 ing of quality measures pursuant to those adopted in  
20 section 1860E-1 of the Social Security Act (as  
21 added by section 126). Such pilot program should be  
22 based on experience gained through previous dem-  
23 onstration projects conducted by the Secretary, in-  
24 cluding demonstration projects conducted under sec-  
25 tions 1866A and 1866C of the Social Security Act

1 (42 U.S.C. 1395cc–1; 1395cc–3), section 649 of the  
2 Medicare Prescription Drug, Improvement, and  
3 Modernization Act of 2003 (Public Law 108–173;  
4 117 Stat. 2322), and other relevant work conducted  
5 by private entities.

6 (2) EXPANSION.—Not later than 2 years after  
7 conducting the pilot program under paragraph (1),  
8 the Secretary shall transition and implement such  
9 program on a national basis.

10 (3) INFORMATION TECHNOLOGY.—Providers re-  
11 porting quality measurement data electronically  
12 under this section shall report such data pursuant to  
13 the standards adopted under title XXIX of the Pub-  
14 lic Health Service Act (as added by section 121).

15 (4) FUNDING.—The Secretary shall ensure that  
16 the total amount of expenditures under this Act in  
17 a year does not exceed the total amount of expendi-  
18 tures that would have been expended in such year  
19 under this Act if this subsection had not been en-  
20 acted.

21 (b) MEDICAID VALUE BASED PURCHASING PRO-  
22 GRAMS.—

23 (1) IN GENERAL.—The Secretary shall author-  
24 ize waivers under section 1115 of the Social Security  
25 Act (42 U.S.C. 1315) for States to establish value

1       based purchasing programs for State medicaid pro-  
2       grams established under title XIX of such Act (42  
3       U.S.C. 1396 et seq.). Such programs shall be based  
4       on the reporting of quality measures pursuant to  
5       those adopted in section 1860E-1 of the Social Secu-  
6       rity Act (as added by section 126).

7               (2) INFORMATION TECHNOLOGY.—Providers re-  
8       porting quality measurement data electronically  
9       under this section shall report such data pursuant to  
10      the standards adopted under title XXIX of the Pub-  
11      lic Health Service Act (as added by section 121).

12              (3) WAIVER.—In authorizing such waivers, the  
13      Secretary shall waive any provisions of title XI or  
14      XIX of the Social Security Act that would otherwise  
15      prevent a State from establishing a value based pur-  
16      chasing program in accordance with paragraph (1).

17       **Subtitle C—Patient Safety and**  
18       **Quality Improvement**

19      **SEC. 141. SHORT TITLE.**

20              This subtitle may be cited as the “Patient Safety and  
21      Quality Improvement Act of 2005”.

22      **SEC. 142. FINDINGS AND PURPOSES.**

23              (a) FINDINGS.—Congress makes the following find-  
24      ings:

1           (1) In 1999, the Institute of Medicine released  
2           a report entitled To Err is Human that described  
3           medical errors as the eighth leading cause of death  
4           in the United States, with as many as 98,000 people  
5           dying as a result of medical errors each year.

6           (2) To address these deaths and injuries due to  
7           medical errors, the health care system must identify  
8           and learn from such errors so that systems of care  
9           can be improved.

10          (3) In their report, the Institute of Medicine  
11          called on Congress to provide legal protections with  
12          respect to information reported for the purposes of  
13          quality improvement and patient safety.

14          (4) The Health, Education, Labor, and Pen-  
15          sions Committee of the Senate held 4 hearings in  
16          the 106th Congress and 1 hearing in the 107th Con-  
17          gress on patient safety where experts in the field  
18          supported the recommendation of the Institute of  
19          Medicine for congressional action.

20          (5) Myriad public and private patient safety ini-  
21          tiatives have begun. The Quality Interagency Coordi-  
22          nation Taskforce has recommended steps to improve  
23          patient safety that may be taken by each Federal  
24          agency involved in health care and activities relating  
25          to these steps are ongoing.

1           (6) The research on patient safety unequivocally calls for a learning environment, rather than a  
2           punitive environment, in order to improve patient  
3           safety.

4           (7) Voluntary data gathering systems are more  
5           supportive than mandatory systems in creating the  
6           learning environment referred to in paragraph (6) as  
7           stated in the Institute of Medicine's report.

8           (8) Promising patient safety reporting systems  
9           have been established throughout the United States  
10          and the best ways to structure and use these systems are currently being determined, largely through  
11          projects funded by the Agency for Healthcare Research and Quality.

12          (9) Many organizations currently collecting patient safety data have expressed a need for legal protections that will allow them to review protected information and collaborate in the development and  
13          implementation of patient safety improvement strategies. Currently, the State peer review protections  
14          are inadequate to allow the sharing of information to  
15          promote patient safety.

16          (b) PURPOSES.—It is the purpose of this subtitle  
17          to—  
18          to—

1           (1) encourage a culture of safety and quality in  
2           the United States health care system by providing  
3           for legal protection of information reported volun-  
4           tarily for the purposes of quality improvement and  
5           patient safety; and

6           (2) ensure accountability by raising standards  
7           and expectations for continuous quality improve-  
8           ments in patient safety.

9   **SEC. 143. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.**

10          Title IX of the Public Health Service Act (42 U.S.C.  
11   299 et seq.) is amended—

12           (1) in section 912(c), by inserting “, in accord-  
13           ance with part C,” after “The Director shall”;

14           (2) by redesignating part C as part D;

15           (3) by redesignating sections 921 through 928,  
16           as sections 931 through 938, respectively;

17           (4) in 934(d) (as so redesignated), by striking  
18           the second sentence and inserting the following:

19           “Penalties provided for under this section shall be  
20           imposed and collected by the Secretary using the ad-  
21           ministrative and procedural processes used to impose  
22           and collect civil money penalties under section  
23           1128A of the Social Security Act (other than sub-  
24           sections (a) and (b), the second sentence of sub-  
25           section (f), and subsections (i), (m), and (n)), unless

1 the Secretary determines that a modification of pro-  
2 cedures would be more suitable or reasonable to  
3 carry out this subsection and provides for such  
4 modification by regulation.”;

5 (5) in section 938(1) (as so redesignated), by  
6 striking “921” and inserting “931”; and

7 (6) by inserting after part B the following:

8 **“PART C—PATIENT SAFETY IMPROVEMENT**

9 **“SEC. 921. DEFINITIONS.**

10 “In this part:

11 “(1) NON-IDENTIFIABLE INFORMATION.—

12 “(A) IN GENERAL.—The term ‘non-identi-  
13 fiable information’ means, with respect to infor-  
14 mation, that the information is presented in a  
15 form and manner that prevents the identifica-  
16 tion of a provider, a patient, or a reporter of  
17 patient safety data.

18 “(B) IDENTIFIABILITY OF PATIENT.—For  
19 purposes of subparagraph (A), the term ‘pre-  
20 sented in a form and manner that prevents the  
21 identification of a patient’ means, with respect  
22 to information that has been subject to rules  
23 promulgated pursuant to section 264(c) of the  
24 Health Insurance Portability and Accountability  
25 Act of 1996 (42 U.S.C. 1320d–2 note), that the

1 information has been de-identified so that it is  
2 no longer individually identifiable health infor-  
3 mation as defined in such rules.

4 “(2) PATIENT SAFETY DATA.—

5 “(A) IN GENERAL.—The term ‘patient  
6 safety data’ means—

7 “(i) any data, reports, records, memo-  
8 randa, analyses (such as root cause anal-  
9 yses), or written or oral statements that  
10 are—

11 “(I) collected or developed by a  
12 provider for reporting to a patient  
13 safety organization, provided that they  
14 are reported to the patient safety or-  
15 ganization within 60 days;

16 “(II) requested by a patient safe-  
17 ty organization (including the con-  
18 tents of such request), if they are re-  
19 ported to the patient safety organiza-  
20 tion within 60 days;

21 “(III) reported to a provider by a  
22 patient safety organization; or

23 “(IV) collected by a patient safe-  
24 ty organization from another patient



1 safety organization, or developed by a  
2 patient safety organization;  
3 that could result in improved patient safe-  
4 ty, health care quality, or health care out-  
5 comes; or

6 “(ii) any deliberative work or process  
7 with respect to any patient safety data de-  
8 scribed in clause (i).

9 “(B) LIMITATION.—

10 “(i) COLLECTION.—If the original  
11 material from which any data, reports,  
12 records, memoranda, analyses (such as  
13 root case analyses), or written or oral  
14 statements referred to in subclause (I) or  
15 (IV) of subparagraph (A)(i) are collected  
16 and is not patient safety data, the act of  
17 such collection shall not make such original  
18 material patient safety data for purposes  
19 of this part.

20 “(ii) SEPARATE DATA.—The term ‘pa-  
21 tient safety data’ shall not include infor-  
22 mation (including a patient’s medical  
23 record, billing and discharge information  
24 or any other patient or provider record)  
25 that is collected or developed separately

1 from and that exists separately from pa-  
2 tient safety data. Such separate informa-  
3 tion or a copy thereof submitted to a pa-  
4 tient safety organization shall not itself be  
5 considered as patient safety data. Nothing  
6 in this part, except for section 922(f)(1),  
7 shall be construed to limit—

8 “(I) the discovery of or admissi-  
9 bility of information described in this  
10 subparagraph in a criminal, civil, or  
11 administrative proceeding;

12 “(II) the reporting of information  
13 described in this subparagraph to a  
14 Federal, State, or local governmental  
15 agency for public health surveillance,  
16 investigation, or other public health  
17 purposes or health oversight purposes;  
18 or

19 “(III) a provider’s recordkeeping  
20 obligation with respect to information  
21 described in this subparagraph under  
22 Federal, State, or local law.

23 “(3) PATIENT SAFETY ORGANIZATION.—The  
24 term ‘patient safety organization’ means a private or

1 public entity or component thereof that is currently  
2 listed by the Secretary pursuant to section 924(c).

3 “(4) PATIENT SAFETY ORGANIZATION ACTIVITIES.—The term ‘patient safety organization activities’ means the following activities, which are  
4 deemed to be necessary for the proper management  
5 and administration of a patient safety organization:  
6

7 “(A) The conduct, as its primary activity,  
8 of efforts to improve patient safety and the  
9 quality of health care delivery.  
10

11 “(B) The collection and analysis of patient  
12 safety data that are submitted by more than  
13 one provider.

14 “(C) The development and dissemination  
15 of information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best  
16 practices.  
17

18 “(D) The utilization of patient safety data  
19 for the purposes of encouraging a culture of  
20 safety and of providing direct feedback and assistance to providers to effectively minimize patient risk.  
21  
22  
23

1           “(E) The maintenance of procedures to  
2           preserve confidentiality with respect to patient  
3           safety data.

4           “(F) The provision of appropriate security  
5           measures with respect to patient safety data.

6           “(G) The utilization of qualified staff.

7           “(5) PERSON.—The term ‘person’ includes Fed-  
8           eral, State, and local government agencies.

9           “(6) PROVIDER.—The term ‘provider’ means—  
10          “(A) a person licensed or otherwise author-  
11          ized under State law to provide health care  
12          services, including—

13               “(i) a hospital, nursing facility, com-  
14               prehensive outpatient rehabilitation facil-  
15               ity, home health agency, hospice program,  
16               renal dialysis facility, ambulatory surgical  
17               center, pharmacy, physician or health care  
18               practitioner’s office, long term care facility,  
19               behavior health residential treatment facil-  
20               ity, clinical laboratory, or health center; or

21               “(ii) a physician, physician assistant,  
22               nurse practitioner, clinical nurse specialist,  
23               certified registered nurse anesthetist, cer-  
24               tified nurse midwife, psychologist, certified  
25               social worker, registered dietitian or nutri-

1                   tion professional, physical or occupational  
2                   therapist, pharmacist, or other individual  
3                   health care practitioner; or  
4                   “(B) any other person specified in regula-  
5                   tions promulgated by the Secretary.

6   **“SEC. 922. PRIVILEGE AND CONFIDENTIALITY PROTEC-**  
7                   **TIONS.**

8           “(a) PRIVILEGE.—Notwithstanding any other provi-  
9   sion of Federal, State, or local law, patient safety data  
10 shall be privileged and, subject to the provisions of sub-  
11 section (c)(1), shall not be—

12           “(1) subject to a Federal, State, or local civil,  
13   criminal, or administrative subpoena;

14           “(2) subject to discovery in connection with a  
15   Federal, State, or local civil, criminal, or administra-  
16   tive proceeding;

17           “(3) disclosed pursuant to section 552 of title  
18   5, United States Code (commonly known as the  
19   Freedom of Information Act) or any other similar  
20   Federal, State, or local law;

21           “(4) admitted as evidence or otherwise disclosed  
22   in any Federal, State, or local civil, criminal, or ad-  
23   ministrative proceeding; or

24           “(5) utilized in a disciplinary proceeding  
25   against a provider.

1       “(b) CONFIDENTIALITY.—Notwithstanding any other  
2 provision of Federal, State, or local law, and subject to  
3 the provisions of subsections (c) and (d), patient safety  
4 data shall be confidential and shall not be disclosed.

5       “(c) EXCEPTIONS TO PRIVILEGE AND CONFIDEN-  
6 TIALITY.—Nothing in this section shall be construed to  
7 prohibit one or more of the following uses or disclosures:

8           “(1) Disclosure by a provider or patient safety  
9 organization of relevant patient safety data for use  
10 in a criminal proceeding only after a court makes an  
11 in camera determination that such patient safety  
12 data contains evidence of a wanton and criminal act  
13 to directly harm the patient.

14           “(2) Voluntary disclosure of non-identifiable pa-  
15 tient safety data by a provider or a patient safety  
16 organization.

17       “(d) PROTECTED DISCLOSURE AND USE OF INFOR-  
18 MATION.—Nothing in this section shall be construed to  
19 prohibit one or more of the following uses or disclosures:

20           “(1) Disclosure of patient safety data by a per-  
21 son that is a provider, a patient safety organization,  
22 or a contractor of a provider or patient safety orga-  
23 nization, to another such person, to carry out pa-  
24 tient safety organization activities.

1           “(2) Disclosure of patient safety data by a pro-  
2           vider or patient safety organization to grantees or  
3           contractors carrying out patient safety research,  
4           evaluation, or demonstration projects authorized by  
5           the Director.

6           “(3) Disclosure of patient safety data by a pro-  
7           vider to an accrediting body that accredits that pro-  
8           vider.

9           “(4) Voluntary disclosure of patient safety data  
10          by a patient safety organization to the Secretary for  
11          public health surveillance if the consent of each pro-  
12          vider identified in, or providing, such data is ob-  
13          tained prior to such disclosure. Nothing in the pre-  
14          ceding sentence shall be construed to prevent the re-  
15          lease of patient safety data that is provided by, or  
16          that relates solely to, a provider from which the con-  
17          sent described in such sentence is obtained because  
18          one or more other providers do not provide such con-  
19          sent with respect to the disclosure of patient safety  
20          data that relates to such nonconsenting providers.  
21          Consent for the future release of patient safety data  
22          for such purposes may be requested by the patient  
23          safety organization at the time the data is sub-  
24          mitted.

1           “(5) Voluntary disclosure of patient safety data  
2           by a patient safety organization to State of local  
3           government agencies for public health surveillance if  
4           the consent of each provider identified in, or pro-  
5           viding, such data is obtained prior to such disclo-  
6           sure. Nothing in the preceding sentence shall be con-  
7           strued to prevent the release of patient safety data  
8           that is provided by, or that relates solely to, a pro-  
9           vider from which the consent described in such sen-  
10          tence is obtained because one or more other pro-  
11          viders do not provide such consent with respect to  
12          the disclosure of patient safety data that relates to  
13          such nonconsenting providers. Consent for the fu-  
14          ture release of patient safety data for such purposes  
15          may be requested by the patient safety organization  
16          at the time the data is submitted.

17          “(e) CONTINUED PROTECTION OF INFORMATION  
18 AFTER DISCLOSURE.—

19           “(1) IN GENERAL.—Except as provided in para-  
20          graph (2), patient safety data that is used or dis-  
21          closed shall continue to be privileged and confiden-  
22          tial as provided for in subsections (a) and (b), and  
23          the provisions of such subsections shall apply to  
24          such data in the possession or control of—



1           “(A) a provider or patient safety organiza-  
2           tion that possessed such data before the use or  
3           disclosure; or

4           “(B) a person to whom such data was dis-  
5           closed.

6           “(2) EXCEPTION.—Notwithstanding paragraph  
7           (1), and subject to paragraph (3)—

8           “(A) if patient safety data is used or dis-  
9           closed as provided for in subsection (c)(1), and  
10          such use or disclosure is in open court, the con-  
11          fidentiality protections provided for in sub-  
12          section (b) shall no longer apply to such data;  
13          and

14          “(B) if patient safety data is used or dis-  
15          closed as provided for in subsection (c)(2), the  
16          privilege and confidentiality protections pro-  
17          vided for in subsections (a) and (b) shall no  
18          longer apply to such data.

19          “(3) CONSTRUCTION.—Paragraph (2) shall not  
20          be construed as terminating or limiting the privilege  
21          or confidentiality protections provided for in sub-  
22          section (a) or (b) with respect to data other than the  
23          specific data used or disclosed as provided for in  
24          subsection (c).

25          “(f) LIMITATION ON ACTIONS.—

1           “(1) PATIENT SAFETY ORGANIZATIONS.—Ex-  
2       cept to enforce disclosures pursuant to subsection  
3       (c)(1), no action may be brought or process served  
4       against a patient safety organization to compel dis-  
5       closure of information collected or developed under  
6       this part whether or not such information is patient  
7       safety data unless such information is specifically  
8       identified, is not patient safety data, and cannot oth-  
9       erwise be obtained.

10          “(2) PROVIDERS.—An accrediting body shall  
11       not take an accrediting action against a provider  
12       based on the good faith participation of the provider  
13       in the collection, development, reporting, or mainte-  
14       nance of patient safety data in accordance with this  
15       part. An accrediting body may not require a provider  
16       to reveal its communications with any patient safety  
17       organization established in accordance with this  
18       part.

19          “(g) REPORTER PROTECTION.—

20          “(1) IN GENERAL.—A provider may not take an  
21       adverse employment action, as described in para-  
22       graph (2), against an individual based upon the fact  
23       that the individual in good faith reported  
24       information—

1           “(A) to the provider with the intention of  
2           having the information reported to a patient  
3           safety organization; or

4           “(B) directly to a patient safety organiza-  
5           tion.

6           “(2) ADVERSE EMPLOYMENT ACTION.—For  
7           purposes of this subsection, an ‘adverse employment  
8           action’ includes—

9           “(A) loss of employment, the failure to  
10          promote an individual, or the failure to provide  
11          any other employment-related benefit for which  
12          the individual would otherwise be eligible; or

13          “(B) an adverse evaluation or decision  
14          made in relation to accreditation, certification,  
15          credentialing, or licensing of the individual.

16          “(h) ENFORCEMENT.—

17          “(1) PROHIBITION.—Except as provided in sub-  
18          sections (c) and (d) and as otherwise provided for in  
19          this section, it shall be unlawful for any person to  
20          negligently or intentionally disclose any patient safe-  
21          ty data, and any such person shall, upon adjudica-  
22          tion, be assessed in accordance with section 934(d).

23          “(2) RELATION TO HIPAA.—The penalty pro-  
24          vided for under paragraph (1) shall not apply if the  
25          defendant would otherwise be subject to a penalty

1 under the regulations promulgated under section  
2 264(c) of the Health Insurance Portability and Ac-  
3 countability Act of 1996 (42 U.S.C. 1320d-2 note)  
4 or under section 1176 of the Social Security Act (42  
5 U.S.C. 1320d-5) for the same disclosure.

6 “(3) EQUITABLE RELIEF.—

7 “(A) IN GENERAL.—Without limiting rem-  
8 edies available to other parties, a civil action  
9 may be brought by any aggrieved individual to  
10 enjoin any act or practice that violates sub-  
11 section (g) and to obtain other appropriate eq-  
12 uitable relief (including reinstatement, back  
13 pay, and restoration of benefits) to redress such  
14 violation.

15 “(B) AGAINST STATE EMPLOYEES.—An  
16 entity that is a State or an agency of a State  
17 government may not assert the privilege de-  
18 scribed in subsection (a) unless before the time  
19 of the assertion, the entity or, in the case of  
20 and with respect to an agency, the State has  
21 consented to be subject to an action as de-  
22 scribed by this paragraph, and that consent has  
23 remained in effect.

24 “(i) RULE OF CONSTRUCTION.—Nothing in this sec-  
25 tion shall be construed to—

1           “(1) limit other privileges that are available  
2           under Federal, State, or local laws that provide  
3           greater confidentiality protections or privileges than  
4           the privilege and confidentiality protections provided  
5           for in this section;

6           “(2) limit, alter, or affect the requirements of  
7           Federal, State, or local law pertaining to informa-  
8           tion that is not privileged or confidential under this  
9           section;

10          “(3) alter or affect the implementation of any  
11          provision of section 264(c) of the Health Insurance  
12          Portability and Accountability Act of 1996 (Public  
13          Law 104–191; 110 Stat. 2033), section 1176 of the  
14          Social Security Act (42 U.S.C. 1320d–5), or any  
15          regulation promulgated under such sections;

16          “(4) limit the authority of any provider, patient  
17          safety organization, or other person to enter into a  
18          contract requiring greater confidentiality or dele-  
19          gating authority to make a disclosure or use in ac-  
20          cordance with subsection (c) or (d); and

21          “(5) prohibit a provider from reporting a crime  
22          to law enforcement authorities, regardless of whether  
23          knowledge of the existence of, or the description of,  
24          the crime is based on patient safety data, so long as

1 the provider does not disclose patient safety data in  
2 making such report.

3 **“SEC. 923. PATIENT SAFETY NETWORK OF DATABASES.**

4 “(a) IN GENERAL.—The Secretary shall maintain a  
5 patient safety network of databases that provides an inter-  
6 active evidence-based management resource for providers,  
7 patient safety organizations, and other persons. The net-  
8 work of databases shall have the capacity to accept, aggre-  
9 gate, and analyze nonidentifiable patient safety data vol-  
10 untarily reported by patient safety organizations, pro-  
11 viders, or other persons.

12 “(b) NETWORK OF DATABASE STANDARDS.—The  
13 Secretary may determine common formats for the report-  
14 ing to the patient safety network of databases maintained  
15 under subsection (a) of nonidentifiable patient safety data,  
16 including necessary data elements, common and consistent  
17 definitions, and a standardized computer interface for the  
18 processing of such data. To the extent practicable, such  
19 standards shall be consistent with the administrative sim-  
20 plification provisions of Part C of title XI of the Social  
21 Security Act.

22 **“SEC. 924. PATIENT SAFETY ORGANIZATION CERTIFI-**  
23 **CATION AND LISTING.**

24 “(a) CERTIFICATION.—

1           “(1) INITIAL CERTIFICATION.—Except as pro-  
2           vided in paragraph (2), an entity that seeks to be a  
3           patient safety organization shall submit an initial  
4           certification to the Secretary that the entity intends  
5           to perform the patient safety organization activities.

6           “(2) DELAYED CERTIFICATION OF COLLECTION  
7           FROM MORE THAN ONE PROVIDER.—An entity that  
8           seeks to be a patient safety organization may—

9                   “(A) submit an initial certification that it  
10           intends to perform patient safety organization  
11           activities other than the activities described in  
12           subparagraph (B) of section 921(4); and

13                   “(B) within 2 years of submitting the ini-  
14           tial certification under subparagraph (A), sub-  
15           mit a supplemental certification that it per-  
16           forms the patient safety organization activities  
17           described in subparagraphs (A) through (F) of  
18           section 921(4).

19           “(3) EXPIRATION AND RENEWAL.—

20                   “(A) EXPIRATION.—An initial certification  
21           under paragraph (1) or (2)(A) shall expire on  
22           the date that is 3 years after it is submitted.

23                   “(B) RENEWAL.—

24                   “(i) IN GENERAL.—An entity that  
25           seeks to remain a patient safety organiza-

1                   tion after the expiration of an initial cer-  
2                   tification under paragraph (1) or (2)(A)  
3                   shall, within the 3-year period described in  
4                   subparagraph (A), submit a renewal cer-  
5                   tification to the Secretary that the entity  
6                   performs the patient safety organization  
7                   activities described in section 921(4).

8                   “(ii) TERM OF RENEWAL.—A renewal  
9                   certification under clause (i) shall expire  
10                  on the date that is 3 years after the date  
11                  on which it is submitted, and may be re-  
12                  newed in the same manner as an initial  
13                  certification.

14               “(b) ACCEPTANCE OF CERTIFICATION.—Upon the  
15               submission by an organization of an initial certification  
16               pursuant to subsection (a)(1) or (a)(2)(A), a supplemental  
17               certification pursuant to subsection (a)(2)(B), or a re-  
18               newal certification pursuant to subsection (a)(3)(B), the  
19               Secretary shall review such certification and—

20               “(1) if such certification meets the require-  
21               ments of subsection (a)(1), (a)(2)(A), (a)(2)(B), or  
22               (a)(3)(B), as applicable, the Secretary shall notify  
23               the organization that such certification is accepted;  
24               or



1           “(2) if such certification does not meet such re-  
2           quirements, as applicable, the Secretary shall notify  
3           the organization that such certification is not accept-  
4           ed and the reasons therefor.

5           “(c) LISTING.—

6           “(1) IN GENERAL.—Except as otherwise pro-  
7           vided in this subsection, the Secretary shall compile  
8           and maintain a current listing of patient safety or-  
9           ganizations with respect to which the Secretary has  
10          accepted a certification pursuant to subsection (b).

11          “(2) REMOVAL FROM LISTING.—The Secretary  
12          shall remove from the listing under paragraph (1)—

13               “(A) an entity with respect to which the  
14               Secretary has accepted an initial certification  
15               pursuant to subsection (a)(2)(A) and which  
16               does not submit a supplemental certification  
17               pursuant to subsection (a)(2)(B) that is accept-  
18               ed by the Secretary;

19               “(B) an entity whose certification expires  
20               and which does not submit a renewal applica-  
21               tion that is accepted by the Secretary; and

22               “(C) an entity with respect to which the  
23               Secretary revokes the Secretary’s acceptance of  
24               the entity’s certification, pursuant to subsection  
25               (d).

1 “(d) REVOCATION OF ACCEPTANCE.—

2 “(1) IN GENERAL.—Except as provided in para-  
3 graph (2), if the Secretary determines (through a re-  
4 view of patient safety organization activities) that a  
5 patient safety organization does not perform one of  
6 the patient safety organization activities described in  
7 subparagraph (A) through (F) of section 921(4), the  
8 Secretary may, after notice and an opportunity for  
9 a hearing, revoke the Secretary’s acceptance of the  
10 certification of such organization.

11 “(2) DELAYED CERTIFICATION OF COLLECTION  
12 FROM MORE THAN ONE PROVIDER.—A revocation  
13 under paragraph (1) may not be based on a deter-  
14 mination that the organization does not perform the  
15 activity described in section 921(4)(B) if—

16 “(A) the listing of the organization is  
17 based on its submittal of an initial certification  
18 under subsection (a)(2)(A);

19 “(B) the organization has not submitted a  
20 supplemental certification under subsection  
21 (a)(2)(B); and

22 “(C) the 2-year period described in sub-  
23 section (a)(2)(B) has not expired.

24 “(e) NOTIFICATION OF REVOCATION OR REMOVAL  
25 FROM LISTING.—

1           “(1) SUPPLYING CONFIRMATION OF NOTIFICA-  
2           TION TO PROVIDERS.—Within 15 days of a revoca-  
3           tion under subsection (d)(1), a patient safety organi-  
4           zation shall submit to the Secretary a confirmation  
5           that the organization has taken all reasonable ac-  
6           tions to notify each provider whose patient safety  
7           data is collected or analyzed by the organization of  
8           such revocation.

9           “(2) PUBLICATION.—Upon the revocation of an  
10          acceptance of an organization’s certification under  
11          subsection (d)(1), or upon the removal of an organi-  
12          zation from the listing under subsection (c)(2), the  
13          Secretary shall publish notice of the revocation or  
14          removal in the Federal Register.

15          “(f) STATUS OF DATA AFTER REMOVAL FROM LIST-  
16          ING.—

17               “(1) NEW DATA.—With respect to the privilege  
18               and confidentiality protections described in section  
19               922, data submitted to an organization within 30  
20               days after the organization is removed from the list-  
21               ing under subsection (c)(2) shall have the same sta-  
22               tus as data submitted while the organization was  
23               still listed.

24               “(2) PROTECTION TO CONTINUE TO APPLY.—If  
25               the privilege and confidentiality protections de-

1       scribed in section 922 applied to data while an orga-  
2       nization was listed, or during the 30-day period de-  
3       scribed in paragraph (1), such protections shall con-  
4       tinue to apply to such data after the organization is  
5       removed from the listing under subsection (c)(2).

6       “(g) DISPOSITION OF DATA.—If the Secretary re-  
7       moves an organization from the listing as provided for in  
8       subsection (c)(2), with respect to the patient safety data  
9       that the organization received from providers, the organi-  
10      zation shall—

11           “(1) with the approval of the provider and an-  
12      other patient safety organization, transfer such data  
13      to such other organization;

14           “(2) return such data to the person that sub-  
15      mitted the data; or

16           “(3) if returning such data to such person is  
17      not practicable, destroy such data.

18      **“SEC. 925. TECHNICAL ASSISTANCE.**

19           “The Secretary, acting through the Director, may  
20      provide technical assistance to patient safety organiza-  
21      tions, including convening annual meetings for patient  
22      safety organizations to discuss methodology, communica-  
23      tion, data collection, or privacy concerns.

1 **“SEC. 926. PROMOTING THE INTEROPERABILITY OF**  
2 **HEALTH CARE INFORMATION TECHNOLOGY**  
3 **SYSTEMS.**

4 “(a) DEVELOPMENT.—Not later than 36 months  
5 after the date of enactment of the Patient Safety and  
6 Quality Improvement Act of 2005, the Secretary shall de-  
7 velop or adopt voluntary standards that promote the elec-  
8 tronic exchange of health care information.

9 “(b) UPDATES.—The Secretary shall provide for the  
10 ongoing review and periodic updating of the standards de-  
11 veloped under subsection (a).

12 “(c) DISSEMINATION.—The Secretary shall provide  
13 for the dissemination of the standards developed and up-  
14 dated under this section.

15 **“SEC. 927. AUTHORIZATION OF APPROPRIATIONS.**

16 “There is authorized to be appropriated such sums  
17 as may be necessary to carry out this part.”.

18 **SEC. 144. STUDIES AND REPORTS.**

19 (a) IN GENERAL.—The Secretary of Health and  
20 Human Services shall enter into a contract (based upon  
21 a competitive contracting process) with an appropriate re-  
22 search organization for the conduct of a study to assess  
23 the impact of medical technologies and therapies on pa-  
24 tient safety, patient benefit, health care quality, and the  
25 costs of care as well as productivity growth. Such study  
26 shall examine—

1 (1) the extent to which factors, such as the use  
2 of labor and technological advances, have contrib-  
3 uted to increases in the share of the gross domestic  
4 product that is devoted to health care and the im-  
5 pact of medical technologies and therapies on such  
6 increases;

7 (2) the extent to which early and appropriate  
8 introduction and integration of innovative medical  
9 technologies and therapies may affect the overall  
10 productivity and quality of the health care delivery  
11 systems of the United States; and

12 (3) the relationship of such medical technologies  
13 and therapies to patient safety, patient benefit,  
14 health care quality, and cost of care.

15 (b) REPORT.—Not later than 18 months after the  
16 date of enactment of this Act, the Secretary of Health and  
17 Human Services shall prepare and submit to the appro-  
18 priate committees of Congress a report containing the re-  
19 sults of the study conducted under subsection (a).

## 20 **Subtitle D—Fraud and Abuse**

### 21 **SEC. 151. NATIONAL EXPANSION OF THE MEDICARE-MED-** 22 **ICAID DATA MATCH PILOT PROGRAM.**

23 (a) REQUIREMENT OF THE MEDICARE INTEGRITY  
24 PROGRAM.—Section 1893 of the Social Security Act (42  
25 U.S.C. 1395ddd) is amended—

1           (1) in subsection (b), by adding at the end the  
2     following:

3           “(6) The Medicare-Medicaid data match pro-  
4     gram in accordance with subsection (g).”; and

5           (2) by adding at the end the following:

6     “(g) MEDICARE-MEDICAID DATA MATCH PRO-  
7     GRAM.—

8           “(1) EXPANSION OF PROGRAM.—

9           “(A) IN GENERAL.—The Secretary shall  
10     enter into contracts with eligible entities for the  
11     purpose of ensuring that, beginning with 2006,  
12     the Medicare-Medicaid data match program  
13     (commonly referred to as the ‘Medi-Medi Pro-  
14     gram’) is conducted with respect to the pro-  
15     gram established under this title and the appli-  
16     cable number of State Medicaid programs  
17     under title XIX for the purpose of—

18           “(i) identifying vulnerabilities in both  
19     such programs;

20           “(ii) assisting States, as appropriate,  
21     to take action to protect the Federal share  
22     of expenditures under the Medicaid pro-  
23     gram; and

24           “(iii) increasing the effectiveness and  
25     efficiency of both such programs through

1 cost avoidance, savings, and recoupments  
2 of fraudulent, wasteful, or abusive expendi-  
3 tures.

4 “(B) APPLICABLE NUMBER.—For pur-  
5 poses of subparagraph (A), the term ‘applicable  
6 number’ means—

7 “(i) in the case of fiscal year 2006, 10  
8 State Medicaid programs;

9 “(ii) in the case of fiscal year 2007,  
10 12 State Medicaid programs; and

11 “(iii) in the case of fiscal year 2008,  
12 15 State Medicaid programs.

13 “(2) LIMITED WAIVER AUTHORITY.—The Sec-  
14 retary shall waive only such requirements of this sec-  
15 tion and of titles XI and XIX as are necessary to  
16 carry out paragraph (1).”.

17 (b) FUNDING.—Section 1817(k)(4) of the Social Se-  
18 curity Act (42 U.S.C. 1395i(k)(4)) is amended—

19 (1) in subparagraph (A), by striking “subpara-  
20 graph (B)” and inserting “subparagraphs (B) and  
21 (C)”; and

22 (2) by adding at the end the following:

23 “(C) EXPANSION OF THE MEDICARE-MED-  
24 ICAID DATA MATCH PROGRAM.—Of the amount  
25 appropriated under subparagraph (A) for a fis-



1 cal year, the following amounts shall be used to  
2 carry out section 1893(b)(6) for that year:

3 “(i) \$10,000,000 of the amount ap-  
4 propriated for fiscal year 2006.

5 “(ii) \$12,200,000 of the amount ap-  
6 propriated for fiscal year 2007.

7 “(iii) \$15,800,000 of the amount ap-  
8 propriated for fiscal year 2008.”.

9 **Subtitle E—Miscellaneous**  
10 **Provisions**

11 **SEC. 161. SENSE OF THE SENATE ON ESTABLISHING A MAN-**  
12 **DATED BENEFITS COMMISSION.**

13 It is the Sense of the Senate that—

14 (1) there should be established an independent  
15 Federal entity to study and provide advice to Con-  
16 gress on existing and proposed federally mandated  
17 health insurance benefits offered by employer-spon-  
18 sored health plans and insurance issuers; and

19 (2) advice provided under paragraph (1) should  
20 be evidence- and actuarially-based, and take into  
21 consideration the population costs and benefits, in-  
22 cluding the health, financial, and social impact on  
23 affected populations, safety and medical efficacy, the  
24 impact on costs and access to insurance generally,  
25 and to different types of insurance products, the im-

1 pact on labor costs and jobs, and any other relevant  
2 factors.

3 **SEC. 162. ENFORCEMENT OF REIMBURSEMENT PROVI-**  
4 **SIONS BY FIDUCIARIES.**

5 Section 502(a)(3) of the Employee Retirement In-  
6 come Security Act of 1974 (29 U.S.C. 1132(a)(3)) is  
7 amended by inserting before the semicolon the following:  
8 “(which may include the recovery of amounts on behalf  
9 of the plan by a fiduciary enforcing the terms of the plan  
10 that provide a right of recovery by reimbursement or sub-  
11 rogation with respect to benefits provided to a participant  
12 or beneficiary)”.

13 **TITLE II—EXPANDING ACCESS**  
14 **TO AFFORDABLE HEALTH**  
15 **COVERAGE THROUGH TAX IN-**  
16 **CENTIVES AND OTHER INI-**  
17 **TIATIVES**

18 **Subtitle A—Refundable Health**  
19 **Insurance Credit**

20 **SEC. 201. REFUNDABLE HEALTH INSURANCE COSTS CRED-**  
21 **IT.**

22 (a) ALLOWANCE OF CREDIT.—

23 (1) IN GENERAL.—Subpart C of part IV of sub-  
24 chapter A of chapter 1 of the Internal Revenue Code  
25 of 1986 (relating to refundable personal credits) is

1       amended by redesignating section 36 as section 37  
2       and by inserting after section 35 the following new  
3       section:

4       **“SEC. 36. HEALTH INSURANCE COSTS FOR UNINSURED IN-**  
5                   **DIVIDUALS.**

6       “(a) ALLOWANCE OF CREDIT.—In the case of an in-  
7       dividual, there shall be allowed as a credit against the tax  
8       imposed by this subtitle for the taxable year an amount  
9       equal to the amount paid by the taxpayer during such tax-  
10      able year for qualified health insurance for the taxpayer  
11      and the taxpayer’s spouse and dependents.

12      “(b) LIMITATIONS.—

13              “(1) IN GENERAL.—Except as provided in para-  
14      graphs (2) and (3), the amount allowed as a credit  
15      under subsection (a) to the taxpayer for the taxable  
16      year shall not exceed the lesser of—

17                      “(A) 90 percent of the sum of the amounts  
18                      paid by the taxpayer for qualified health insur-  
19                      ance for each individual referred to in sub-  
20                      section (a) for coverage months of the indi-  
21                      vidual during the taxable year, or

22                      “(B) \$3,000.

23      “(2) MONTHLY LIMITATION.—

24                      “(A) IN GENERAL.—For purposes of para-  
25                      graph (1), amounts paid by the taxpayer for

1 qualified health insurance for an individual for  
2 any coverage month of such individual during  
3 the taxable year shall not be taken into account  
4 to the extent such amounts exceed the amount  
5 equal to  $\frac{1}{12}$  of—

6 “(i) \$1,111 if such individual is the  
7 taxpayer,

8 “(ii) \$1,111 if—

9 “(I) such individual is the spouse  
10 of the taxpayer,

11 “(II) the taxpayer and such  
12 spouse are married as of the first day  
13 of such month, and

14 “(III) the taxpayer files a joint  
15 return for the taxable year,

16 “(iii) \$1,111 if such individual has at-  
17 tained the age of 24 as of the close of the  
18 taxable year and is a dependent of the tax-  
19 payer for such taxable year, and

20 “(iv) one-half of the amount described  
21 in clause (i) if such individual has not at-  
22 tained the age of 24 as of the close of the  
23 taxable year and is a dependent of the tax-  
24 payer for such taxable year.

1           “(B) LIMITATION TO 2 YOUNG DEPEND-  
2           ENTS.—If there are more than 2 individuals de-  
3           scribed in subparagraph (A)(iv) with respect to  
4           the taxpayer for any coverage month, the aggre-  
5           gate amounts paid by the taxpayer for qualified  
6           health insurance for such individuals which may  
7           be taken into account under paragraph (1) shall  
8           not exceed 1/12 of the dollar amount in effect  
9           under subparagraph (A)(i) for the coverage  
10          month.

11          “(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of a taxpayer—

12                 “(i) who is married (within the mean-  
13                 ing of section 7703) as of the close of the  
14                 taxable year but does not file a joint return  
15                 for such year, and  
16                 for such year, and

17                 “(ii) who does not live apart from  
18                 such taxpayer’s spouse at all times during  
19                 the taxable year,

20                 any dollar limitation imposed under this para-  
21                 graph on amounts paid for qualified health in-  
22                 surance for individuals described in subpara-  
23                 graph (A)(iv) shall be divided equally between  
24                 the taxpayer and the taxpayer’s spouse unless  
25                 they agree on a different division.

1           “(3) INCOME PHASEOUT OF CREDIT PERCENT-  
2           AGE FOR ONE-PERSON COVERAGE.—

3           “(A) PHASEOUT FOR UNMARRIED INDIVID-  
4           UALS (OTHER THAN SURVIVING SPOUSES AND  
5           HEADS OF HOUSEHOLDS).—In the case of an  
6           individual (other than a surviving spouse, the  
7           head of a household, or a married individual)  
8           with one-person coverage, if such individual has  
9           modified adjusted gross income—

10           “(i) in excess of \$15,000 for a taxable  
11           year but not in excess of \$20,000, the 90  
12           percent under paragraph (1)(B) shall be  
13           reduced by the number of percentage  
14           points which bears the same ratio to 40  
15           percentage points as—

16           “(I) the excess of modified ad-  
17           justed gross income in excess of  
18           \$15,000, bears to

19           “(II) \$5,000, or

20           “(ii) in excess of \$20,000 for a tax-  
21           able year, the 90 percent under paragraph  
22           (1)(B) shall be reduced by the sum of 40  
23           percentage points plus the number of per-  
24           centage points which bears the same ratio  
25           to 50 percentage points as—

1                   “(I) the excess of modified ad-  
2                   justed gross income in excess of  
3                   \$20,000, bears to

4                   “(II) \$10,000.

5                   “(B) PHASEOUT FOR OTHER INDIVID-  
6                   UALS.—In the case of a taxpayer (other than  
7                   an individual described in subparagraph (A) or  
8                   (C)) with one-person coverage, if the taxpayer  
9                   has modified adjusted gross income in excess of  
10                  \$25,000 for a taxable year, the 90 percent  
11                  under paragraph (1)(B) shall be reduced by the  
12                  number of percentage points which bears the  
13                  same ratio to 90 percentage points as—

14                  “(i) the excess of modified adjusted  
15                  gross income in excess of \$25,000, bears to

16                  “(ii) \$15,000.

17                  “(C) MARRIED FILING SEPARATE RE-  
18                  TURN.—In the case of a taxpayer who is mar-  
19                  ried filing a separate return for the taxable year  
20                  and who has one-person coverage, if the tax-  
21                  payer has modified adjusted gross income in ex-  
22                  cess of \$12,500 for the taxable year, the 90  
23                  percent under paragraph (1)(B) shall be re-  
24                  duced by the number of percentage points

1 which bears the same ratio to 90 percentage  
2 points as—

3 “(i) the excess of modified adjusted  
4 gross income in excess of \$12,500, bears to  
5 “(ii) \$7,500.

6 “(4) INCOME PHASEOUT OF CREDIT PERCENT-  
7 AGE FOR COVERAGE OF MORE THAN ONE PERSON.—

8 “(A) IN GENERAL.—Except as provided in  
9 subparagraph (B), in the case of a taxpayer  
10 with coverage of more than one person, if the  
11 taxpayer has modified adjusted gross income in  
12 excess of \$25,000 for a taxable year, the 90  
13 percent under paragraph (1)(B) shall be re-  
14 duced by the number of percentage points  
15 which bears the same ratio to 90 percentage  
16 points as—

17 “(i) the excess of modified adjusted  
18 gross income in excess of \$25,000, bears to  
19 “(ii) \$35,000.

20 “(B) MARRIED FILING SEPARATE RE-  
21 TURN.—In the case of a taxpayer who is mar-  
22 ried filing a separate return for the taxable year  
23 and who has coverage of more than one person,  
24 if the taxpayer has modified adjusted gross in-  
25 come in excess of \$12,500 for the taxable year,



1 the 90 percent under paragraph (1)(B) shall be  
2 reduced by the number of percentage points  
3 which bears the same ratio to 90 percentage  
4 points as—

5 “(i) the excess of modified adjusted  
6 gross income in excess of \$12,500, bears to

7 “(ii) \$17,500.

8 “(5) ROUNDING.—Any percentage resulting  
9 from a reduction under paragraphs (3) and (4) shall  
10 be rounded to the nearest one-tenth of a percent.

11 “(6) MODIFIED ADJUSTED GROSS INCOME.—  
12 The term ‘modified adjusted gross income’ means  
13 adjusted gross income determined—

14 “(A) without regard to this section and  
15 sections 911, 931, and 933, and

16 “(B) after application of sections 86, 135,  
17 137, 219, 221, and 469.

18 “(c) COVERAGE MONTH.—For purposes of this  
19 section—

20 “(1) IN GENERAL.—The term ‘coverage month’  
21 means, with respect to an individual, any month if—

22 “(A) as of the first day of such month  
23 such individual is covered by qualified health in-  
24 surance, and

1 “(B) the premium for coverage under such  
2 insurance for such month is paid by the tax-  
3 payer.

4 “(2) GROUP HEALTH PLAN COVERAGE.—

5 “(A) IN GENERAL.—The term ‘coverage  
6 month’ shall not include any month for which  
7 if, as of the first day of the month, the indi-  
8 vidual participates in any group health plan  
9 (within the meaning of section 5000 without re-  
10 gard to section 5000(d)).

11 “(B) EXCEPTION FOR CERTAIN PER-  
12 MITTED COVERAGE.—Subparagraph (A) shall  
13 not apply to an individual if the individual’s  
14 only coverage for a month is coverage described  
15 in clause (i) or (ii) of section 223(c)(1)(B).

16 “(3) EMPLOYER-PROVIDED COVERAGE.—The  
17 term ‘coverage month’ shall not include any month  
18 during a taxable year if any amount is not includible  
19 in the gross income of the taxpayer for such year  
20 under section 106 (other than coverage described in  
21 clause (i) or (ii) of section 223(c)(1)(B)).

22 “(4) MEDICARE, MEDICAID, AND SCHIP.—The  
23 term ‘coverage month’ shall not include any month  
24 with respect to an individual if, as of the first day  
25 of such month, such individual—

1           “(A) is entitled to any benefits under part  
2           A of title XVIII of the Social Security Act or  
3           is enrolled under part B of such title, or

4           “(B) is enrolled in the program under title  
5           XIX or XXI of such Act (other than under sec-  
6           tion 1928 of such Act).

7           “(5) CERTAIN OTHER COVERAGE.—The term  
8           ‘coverage month’ shall not include any month during  
9           a taxable year with respect to an individual if, as of  
10          the first day of such month at any time during such  
11          month, such individual is enrolled in a program  
12          under—

13           “(A) chapter 89 of title 5, United States  
14          Code, or

15           “(B) chapter 55 of title 10, United States  
16          Code.

17           “(6) PRISONERS.—The term ‘coverage month’  
18          shall not include any month with respect to an indi-  
19          vidual if, as of the first day of such month, such in-  
20          dividual is imprisoned under Federal, State, or local  
21          authority.

22           “(7) INSUFFICIENT PRESENCE IN UNITED  
23          STATES.—The term ‘coverage month’ shall not in-  
24          clude any month during a taxable year with respect  
25          to an individual if such individual is present in the

1 United States on fewer than 183 days during such  
2 year (determined in accordance with section  
3 7701(b)(7)).

4 “(d) QUALIFIED HEALTH INSURANCE.—For pur-  
5 poses of this section—

6 “(1) IN GENERAL.—The term ‘qualified health  
7 insurance’ means health insurance coverage (as de-  
8 fined in section 9832(b)(1)) which—

9 “(A) is coverage described in paragraph  
10 (2), and

11 “(B) meets the requirements of paragraph  
12 (3).

13 “(2) ELIGIBLE COVERAGE.—Coverage described  
14 in this paragraph is the following:

15 “(A) Coverage under individual health in-  
16 surance.

17 “(B) Coverage through a private sector  
18 health care coverage purchasing pool.

19 “(C) Coverage through a State care cov-  
20 erage purchasing pool.

21 “(D) Coverage under a State high-risk  
22 pool described in subparagraph (C) of section  
23 35(e)(1).

24 “(E) Coverage after December 31, 2006,  
25 under an eligible State buy in program.

1           “(3) REQUIREMENTS.—The requirements of  
2 this paragraph are as follows:

3           “(A) COST LIMITS.—The coverage meets  
4 the requirements of section 223(c)(2)(A)(ii).

5           “(B) MAXIMUM BENEFITS.—Under the  
6 coverage, the annual and lifetime maximum  
7 benefits are not less than \$700,000.

8           “(C) BROAD COVERAGE.—The coverage in-  
9 cludes inpatient and outpatient care, emergency  
10 benefits, and physician care.

11           “(D) GUARANTEED RENEWABILITY.—Such  
12 coverage is guaranteed renewable by the pro-  
13 vider.

14           “(4) ELIGIBLE STATE BUY IN PROGRAM.—For  
15 purposes of paragraph (2)(E)—

16           “(A) IN GENERAL.—The term ‘eligible  
17 State buy in program’ means a State program  
18 under which an individual who—

19           “(i) is not eligible for assistance under  
20 the State medicaid program under title  
21 XIX of the Social Security Act,

22           “(ii) is not eligible for assistance  
23 under the State children’s health insurance  
24 program under title XXI of such Act, or

25           “(iii) is not a State employee,

1 is able to buy health insurance coverage  
2 through a purchasing arrangement entered into  
3 between the State and a private sector health  
4 care purchasing group or health plan.

5 “(B) REQUIREMENTS.—Subparagraph (A)  
6 shall only apply to a State program if—

7 “(i) the program uses private sector  
8 health care purchasing groups or health  
9 plans, and

10 “(ii) the State maintains separate risk  
11 pools for participants under the State buy  
12 in program and other participants.

13 “(C) SUBSIDIES.—

14 “(i) IN GENERAL.—A State program  
15 shall not fail to be treated as an eligible  
16 State buy in program merely because the  
17 State subsidizes the costs of an individual  
18 in buying health insurance coverage under  
19 the program.

20 “(ii) EXCEPTION.—Clause (i) shall  
21 not apply if the State subsidy under the  
22 program for any adult for any consecutive  
23 12-month period exceeds the applicable  
24 dollar amount.

1                   “(iii)           APPLICABLE           DOLLAR  
2                   AMOUNT.—

3                   “(I) IN GENERAL.—For purposes  
4                   of clause (ii), the applicable dollar  
5                   amount is \$2,000.

6                   “(II) REDUCTION.—In the case  
7                   of a family with annual income in ex-  
8                   cess of 133 percent of the applicable  
9                   poverty line (as determined in accord-  
10                  ance with criteria established by the  
11                  Director of the Office of Management  
12                  and Budget) but not in excess of 200  
13                  percent of such line, the dollar  
14                  amount under clause (i) shall be rat-  
15                  ably reduced (but not below zero) for  
16                  each dollar of such excess. In the case  
17                  of a family with annual income in ex-  
18                  cess of 200 percent of such line, the  
19                  applicable dollar amount shall be zero.

20                  “(e) ARRANGEMENTS UNDER WHICH INSURERS  
21                  CONTRIBUTE TO HSA.—

22                  “(1) IN GENERAL.—For purposes of this sec-  
23                  tion, health insurance shall not be treated as quali-  
24                  fied health insurance if the insurer makes contribu-  
25                  tions to a health savings account of the taxpayer un-

1 less such insurance is provided under an arrange-  
2 ment described in paragraph (2).

3 “(2) ARRANGEMENTS DESCRIBED.—

4 “(A) AMOUNTS PAID FOR COVERAGE EX-  
5 CEED MONTHLY LIMITATION.—In the case of  
6 amounts paid under an arrangement for health  
7 insurance for a coverage month in excess of the  
8 amount in effect under subsection (b)(2)(A) for  
9 such month, an arrangement is described in  
10 this subparagraph if under the arrangement—

11 “(i) the aggregate amount contributed  
12 by the insurer to any health savings ac-  
13 count of the taxpayer does not exceed 90  
14 percent of the excess of—

15 “(I) the amount paid by the tax-  
16 payer for qualified health insurance  
17 under such arrangement for such  
18 month, over

19 “(II) the amount in effect under  
20 subsection (b)(2)(A) for such month,  
21 and

22 “(ii) the amount contributed by the  
23 insurer to a qualified health savings ac-  
24 count of the taxpayer, reduced by the  
25 amount of the excess under clause (i), does



1 not exceed 27 percent of the amount in ef-  
2 fect under subsection (b)(2)(A) for such  
3 month.

4 “(B) AMOUNTS PAID FOR COVERAGE LESS  
5 THAN MONTHLY LIMITATION.—In the case of  
6 an arrangement under which the amount paid  
7 for qualified health insurance for a coverage  
8 month does not exceed the amount in effect  
9 under subsection (b)(2)(A) for such month, an  
10 arrangement is described in this subparagraph  
11 if—

12 “(i) under the arrangement the value  
13 of the insured benefits (excluding over-  
14 head) exceeds 65 percent of the amount  
15 paid for qualified health insurance for such  
16 month, and

17 “(ii) the amount contributed by the  
18 insurer to a qualified health savings ac-  
19 count of the taxpayer does not exceed 27  
20 percent of the amount in effect under sub-  
21 section (b)(2)(A) for such month.

22 “(3) QUALIFIED HEALTH SAVINGS ACCOUNT.—

23 “(A) IN GENERAL.—The term ‘qualified  
24 health savings account’ means a health savings  
25 account (as defined in section 223(d))—

1 “(i) which is designated (in such form  
2 as the Secretary may prescribe) as a quali-  
3 fied account for purposes of this section,

4 “(ii) which may not include any  
5 amount other than contributions described  
6 in this subsection and earnings on such  
7 contributions, and

8 “(iii) with respect to which section  
9 223(f)(4)(A) is applied by substituting  
10 ‘100 percent’ for ‘10 percent’.

11 “(B) SUBACCOUNTS AND SEPARATE AC-  
12 COUNTING.—The Secretary may prescribe rules  
13 under which a subaccount within a health sav-  
14 ings account, or separate accounting with re-  
15 spect to contributions and earnings described in  
16 subparagraph (A)(ii), may be treated in the  
17 same manner as a qualified health savings ac-  
18 count.

19 “(C) ROLLOVERS.—A contribution of a  
20 distribution from a qualified health savings ac-  
21 count to another health savings account shall be  
22 treated as a rollover contribution for purposes  
23 of section 223(f)(5) only if the other account is  
24 a qualified health savings account.

25 “(f) DEPENDENTS.—For purposes of this section—

1           “(1) DEPENDENT DEFINED.—The term ‘de-  
2           pendent’ has the meaning given such term by section  
3           152 (determined without regard to subsections  
4           (b)(1), (b)(2), and (d)(1)(B) thereof).

5           “(2) SPECIAL RULE FOR DEPENDENT CHILD OF  
6           DIVORCED PARENTS.—An individual who is a child  
7           to whom section 152(e) applies shall be treated as  
8           a dependent of the custodial parent for a coverage  
9           month unless the custodial and noncustodial parent  
10          provide otherwise.

11          “(3) DENIAL OF CREDIT TO DEPENDENTS.—No  
12          credit shall be allowed under this section to any indi-  
13          vidual with respect to whom a deduction under sec-  
14          tion 151(c) is allowable to another taxpayer for a  
15          taxable year beginning in the calendar year in which  
16          such individual’s taxable year begins.

17          “(g) INFLATION ADJUSTMENTS.—

18          “(1) CREDIT AND HEALTH INSURANCE  
19          AMOUNTS.—In the case of any taxable year begin-  
20          ning after 2006, each dollar amount referred to in  
21          subsections (b)(1)(B), (b)(2)(A), (d)(3)(B), and  
22          (d)(4)(C)(iii)(I) shall be increased by an amount  
23          equal to—

24                 “(A) such dollar amount, multiplied by

1           “(B) the cost-of-living adjustment deter-  
2           mined under section 213(d)(10)(B)(ii) for the  
3           calendar year in which the taxable year begins,  
4           determined by substituting ‘2005’ for ‘1996’ in  
5           subclause (II) thereof.

6           If any amount as adjusted under the preceding sen-  
7           tence is not a multiple of \$10, such amount shall be  
8           rounded to the nearest multiple of \$10.

9           “(2) INCOME PHASEOUT AMOUNTS.—In the  
10          case of any taxable year beginning after 2006, each  
11          dollar amount referred to in paragraph (3) and (4)  
12          of subsection (b) shall be increased by an amount  
13          equal to—

14               “(A) such dollar amount, multiplied by

15               “(B) the cost-of-living adjustment deter-  
16               mined under section 1(f)(3) for the calendar  
17               year in which the taxable year begins, deter-  
18               mined by substituting ‘calendar year 2005’ for  
19               ‘calendar year 1992’ in subparagraph (B)  
20               thereof.

21          If any amount as adjusted under the preceding sen-  
22          tence is not a multiple of \$50, such amount shall be  
23          rounded to the next lowest multiple of \$50.

24          “(h) ARCHER MSA CONTRIBUTIONS; HSA CON-  
25          TRIBUTIONS.—If a deduction would be allowed under sec-

1 tion 220 to the taxpayer for a payment for the taxable  
2 year to the Archer MSA of an individual or under section  
3 223 to the taxpayer for a payment for the taxable year  
4 to the Health Savings Account of such individual, sub-  
5 section (a) shall not apply to the taxpayer for any month  
6 during such taxable year for which the taxpayer, spouse,  
7 or dependent is an eligible individual for purposes of either  
8 such section.

9 “(i) OTHER RULES.—For purposes of this section—

10 “(1) COORDINATION WITH MEDICAL EXPENSE  
11 AND PREMIUM DEDUCTIONS FOR HIGH DEDUCTIBLE  
12 HEALTH PLANS.—The amount which would (but for  
13 this paragraph) be taken into account by the tax-  
14 payer under section 213 or 224 for the taxable year  
15 shall be reduced by the credit (if any) allowed by  
16 this section to the taxpayer for such year.

17 “(2) COORDINATION WITH DEDUCTION FOR  
18 HEALTH INSURANCE COSTS OF SELF-EMPLOYED IN-  
19 DIVIDUALS.—No credit shall be allowable under this  
20 section for a taxable year if a deduction is allowed  
21 under section 162(l) for the taxable year.

22 “(3) COORDINATION WITH ADVANCE PAY-  
23 MENT.—Rules similar to the rules of section  
24 35(g)(1) shall apply to any credit to which this sec-  
25 tion applies.

1           “(4) COORDINATION WITH SECTION 35.—If a  
2           taxpayer is eligible for the credit allowed under this  
3           section and section 35 for any taxable year, the tax-  
4           payer shall elect which credit is to be allowed.

5           “(j) EXPENSES MUST BE SUBSTANTIATED.—A pay-  
6           ment for insurance to which subsection (a) applies may  
7           be taken into account under this section only if the tax-  
8           payer substantiates such payment in such form as the Sec-  
9           retary may prescribe.

10          “(k) REGULATIONS.—The Secretary shall prescribe  
11          such regulations as may be necessary to carry out the pur-  
12          poses of this section.”.

13          (b) INFORMATION REPORTING.—

14               (1) IN GENERAL.—Subpart B of part III of  
15               subchapter A of chapter 61 of the Internal Revenue  
16               Code of 1986 (relating to information concerning  
17               transactions with other persons) is amended by in-  
18               serting after section 6050T the following:

19       **“SEC. 6050U. RETURNS RELATING TO PAYMENTS FOR**  
20               **QUALIFIED HEALTH INSURANCE.**

21               “(a) IN GENERAL.—Any person who, in connection  
22               with a trade or business conducted by such person, re-  
23               ceives payments during any calendar year from any indi-  
24               vidual for coverage of such individual or any other indi-  
25               vidual under creditable health insurance, shall make the

1 return described in subsection (b) (at such time as the  
2 Secretary may by regulations prescribe) with respect to  
3 each individual from whom such payments were received.

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

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

8 “(2) contains—

9 “(A) the name, address, and TIN of the  
10 individual from whom payments described in  
11 subsection (a) were received,

12 “(B) the name, address, and TIN of each  
13 individual who was provided by such person  
14 with coverage under creditable health insurance  
15 by reason of such payments and the period of  
16 such coverage,

17 “(C) the aggregate amount of payments  
18 described in subsection (a), and

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

21 “(c) CREDITABLE HEALTH INSURANCE.—For pur-  
22 poses of this section, the term ‘creditable health insurance’  
23 means qualified health insurance (as defined in section  
24 36(d)).

1       “(d) STATEMENTS TO BE FURNISHED TO INDIVID-  
2       UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
3       QUIRED.—Every person required to make a return under  
4       subsection (a) shall furnish to each individual whose name  
5       is required under subsection (b)(2)(A) to be set forth in  
6       such return a written statement showing—

7               “(1) the name and address of the person re-  
8       quired to make such return and the phone number  
9       of the information contact for such person,

10              “(2) the aggregate amount of payments de-  
11       scribed in subsection (a) received by the person re-  
12       quired to make such return from the individual to  
13       whom the statement is required to be furnished, and

14              “(3) the information required under subsection  
15       (b)(2)(B) with respect to such payments.

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

20       “(e) RETURNS WHICH WOULD BE REQUIRED TO BE  
21       MADE BY 2 OR MORE PERSONS.—Except to the extent  
22       provided in regulations prescribed by the Secretary, in the  
23       case of any amount received by any person on behalf of  
24       another person, only the person first receiving such



1 amount shall be required to make the return under sub-  
2 section (a).”.

3 (2) ASSESSABLE PENALTIES.—

4 (A) Subparagraph (B) of section  
5 6724(d)(1) of such Code (relating to defini-  
6 tions) is amended by redesignating clauses (xiii)  
7 through (xviii) as clauses (xiv) through (xix),  
8 respectively, and by inserting after clause (xii)  
9 the following:

10 “(xiii) section 6050U (relating to re-  
11 turns relating to payments for qualified  
12 health insurance),”.

13 (B) Paragraph (2) of section 6724(d) of  
14 such Code is amended by striking “or” at the  
15 end of subparagraph (AA), by striking the pe-  
16 riod at the end of the subparagraph (BB) and  
17 inserting “, or”, and by adding at the end the  
18 following:

19 “(CC) section 6050U(d) (relating to re-  
20 turns relating to payments for qualified health  
21 insurance).”.

22 (3) CLERICAL AMENDMENT.—The table of sec-  
23 tions for subpart B of part III of subchapter A of  
24 chapter 61 of such Code is amended by inserting

1 after the item relating to section 6050T the fol-  
2 lowing:

“Sec. 6050U. Returns relating to payments for qualified health insurance.”.

3 (c) CRIMINAL PENALTY FOR FRAUD.—Subchapter B  
4 of chapter 75 of the Internal Revenue Code of 1986 (relat-  
5 ing to other offenses) is amended by adding at the end  
6 the following:

7 **“SEC. 7276. PENALTIES FOR OFFENSES RELATING TO**  
8 **HEALTH INSURANCE TAX CREDIT.**

9 “Any person who knowingly misuses Department of  
10 the Treasury names, symbols, titles, or initials to convey  
11 the false impression of association with, or approval or en-  
12 dorsement by, the Department of the Treasury of any in-  
13 surance products or group health coverage in connection  
14 with the credit for health insurance costs under section  
15 36 shall on conviction thereof be fined not more than  
16 \$10,000, or imprisoned not more than 1 year, or both.”.

17 (d) CONFORMING AMENDMENTS.—

18 (1) Section 162(l) of the Internal Revenue Code  
19 of 1986 is amended by adding at the end the fol-  
20 lowing:

21 “(6) ELECTION TO HAVE SUBSECTION  
22 APPLY.—No deduction shall be allowed under para-  
23 graph (1) for a taxable year unless the taxpayer  
24 elects to have this subsection apply for such year.”.

1           (2) Paragraph (2) of section 1324(b) of title  
2           31, United States Code, is amended by inserting be-  
3           fore the period “, or from section 36 of such Code”.

4           (3) The table of sections for subpart C of part  
5           IV of subchapter A of chapter 1 of the Internal Rev-  
6           enue Code of 1986 is amended by striking “35” and  
7           inserting “36” and by inserting after the item relat-  
8           ing to section 35 the following:

“Sec. 36. Health insurance costs for uninsured individuals.”.

9           (4) The table of sections for subchapter B of  
10          chapter 75 of such Code is amended by adding at  
11          the end the following:

“Sec. 7276. Penalties for offenses relating to health insurance tax credit.”.

12         (e) EFFECTIVE DATES.—

13           (1) IN GENERAL.—Except as provided in para-  
14          graph (2), the amendments made by this section  
15          shall apply to taxable years beginning after Decem-  
16          ber 31, 2005.

17           (2) PENALTIES.—The amendments made by  
18          subsections (c) and (d)(4) shall take effect on the  
19          date of the enactment of this Act.

20         **SEC. 202. ADVANCE PAYMENT OF CREDIT TO ISSUERS OF**  
21                 **QUALIFIED HEALTH INSURANCE.**

22           (a) IN GENERAL.—Chapter 77 of the Internal Rev-  
23          enue Code of 1986 (relating to miscellaneous provisions)  
24          is amended by adding at the end the following:

1 **“SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR HEALTH**  
2 **INSURANCE COSTS OF ELIGIBLE INDIVID-**  
3 **UALS.**

4 “Not later than July 1, 2007, the Secretary shall es-  
5 tablish a program for making payments to providers of  
6 qualified health insurance (as defined in section 36(d)) on  
7 behalf of individuals eligible for the credit under section  
8 36. Such payments shall be made on the basis of modified  
9 adjusted gross income of eligible individuals for the pre-  
10 ceding taxable year.”.

11 (b) CLERICAL AMENDMENT.—The table of sections  
12 for chapter 77 of the Internal Revenue Code of 1986 is  
13 amended by adding at the end the following:

“Sec. 7529. Advance payment of health insurance credit for purchasers of  
qualified health insurance.”.

14 **Subtitle B—High Deductible Health**  
15 **Plans and Health Savings Accounts**

16 **SEC. 211. DEDUCTION OF PREMIUMS FOR HIGH DEDUCT-**  
17 **IBLE HEALTH PLANS.**

18 (a) IN GENERAL.—Part VII of subchapter B of chap-  
19 ter 1 of the Internal Revenue Code of 1986 (relating to  
20 additional itemized deductions for individuals) is amended  
21 by redesignating section 224 as section 225 and by insert-  
22 ing after section 223 the following new section:

1   **“SEC. 224. PREMIUMS FOR HIGH DEDUCTIBLE HEALTH**  
2                   **PLANS.**

3           “(a) DEDUCTION ALLOWED.—In the case of an indi-  
4   vidual, there shall be allowed as a deduction for the tax-  
5   able year the aggregate amount paid by or on behalf of  
6   such individual as premiums under a high deductible  
7   health plan with respect to months during such year for  
8   which such individual is an eligible individual with respect  
9   to such health plan.

10          “(b) DEFINITIONS.—For purposes of this section—

11               “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
12   individual’ has the meaning given such term by sec-  
13   tion 223(c)(1).

14               “(2) HIGH DEDUCTIBLE HEALTH PLAN.—The  
15   term ‘high deductible health plan’ has the meaning  
16   given such term by section 223(c)(2).

17          “(c) SPECIAL RULES.—

18               “(1) DEDUCTION ALLOWABLE FOR ONLY 1  
19   PLAN.—For purposes of this section, in the case of  
20   an individual covered by more than 1 high deductible  
21   health plan for any month, the individual may only  
22   take into account amounts paid for 1 of such plans  
23   for such month.

24               “(2) GROUP HEALTH PLAN COVERAGE.—

25                   “(A) IN GENERAL.—No deduction shall be  
26   allowed to an individual under subsection (a)

1           for any amount paid for coverage under a high  
2           deductible health plan for a month if, as of the  
3           first day of that month, that individual partici-  
4           pates in any coverage under a group health  
5           plan (within the meaning of section 5000 with-  
6           out regard to section 5000(d)).

7           “(B) EXCEPTION FOR CERTAIN PER-  
8           MITTED COVERAGE.—Subparagraph (A) shall  
9           not apply to an individual if the individual’s  
10          only coverage under a group health plan for a  
11          month is coverage described in clause (i) or (ii)  
12          of section 223(c)(1)(B).

13          “(3) MEDICARE ELIGIBLE INDIVIDUALS.—No  
14          deduction shall be allowed under subsection (a) with  
15          respect to any individual for any month if the indi-  
16          vidual is entitled to benefits under title XVIII of the  
17          Social Security Act for the month.

18          “(4) HEALTH SAVINGS ACCOUNT REQUIRED.—  
19          A deduction shall not be allowed under subsection  
20          (a) for a taxable year with respect to an individual  
21          unless the individual is an account beneficiary of a  
22          health savings account during a portion of the tax-  
23          able year.

24          “(5) MEDICAL AND HEALTH SAVINGS AC-  
25          COUNTS.—Subsection (a) shall not apply with re-

1       spect to any amount which is paid or distributed out  
2       of an Archer MSA or a health savings account which  
3       is not included in gross income under section 220(f)  
4       or 223(f), as the case may be.

5           “(6) COORDINATION WITH DEDUCTION FOR  
6       HEALTH INSURANCE OF SELF-EMPLOYED INDIVID-  
7       UALS.—The amount taken into account by the tax-  
8       payer in computing the deduction under section  
9       162(l) shall not be taken into account under this  
10      section.

11          “(7) COORDINATION WITH MEDICAL EXPENSE  
12      DEDUCTION.—The amount taken into account by  
13      the taxpayer in computing the deduction under this  
14      section shall not be taken into account under section  
15      213.”.

16      (b) DEDUCTION ALLOWED WHETHER OR NOT INDIV-  
17      IDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
18      of section 62 of the Internal Revenue Code of 1986 (defin-  
19      ing adjusted gross income) is amended by inserting before  
20      the last sentence at the end the following new paragraph:

21           “(21) PREMIUMS FOR HIGH DEDUCTIBLE  
22      HEALTH PLANS.—The deduction allowed by section  
23      224.”.

24      (c) COORDINATION WITH HEALTH INSURANCE  
25      COSTS CREDIT.—Section 35(g)(2) of the Internal Rev-

1 enue Code of 1986 is amended by striking “or 213” and  
2 inserting “,213, or 224”.

3 (d) CLERICAL AMENDMENT.—The table of sections  
4 for part VII of subchapter B of chapter 1 of the Internal  
5 Revenue Code of 1986 is amended by redesignating sec-  
6 tion 224 as section 225 and by inserting before such item  
7 the following new item:

“Sec. 224. Premiums for high deductible health plans.”.

8 (e) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to taxable years beginning after  
10 December 31, 2005.

11 **SEC. 212. REFUNDABLE CREDIT FOR CONTRIBUTIONS TO**  
12 **HEALTH SAVINGS ACCOUNTS OF SMALL BUSI-**  
13 **NESS EMPLOYEES.**

14 (a) IN GENERAL.—Subpart C of part IV of sub-  
15 chapter A of chapter 1 of the Internal Revenue Code of  
16 1986, as amended by subtitle A, is amended by inserting  
17 after section 36 the following new section:

18 **“SEC. 36A. SMALL EMPLOYER CONTRIBUTIONS TO HEALTH**  
19 **SAVINGS ACCOUNTS.**

20 “(a) GENERAL RULE.—In the case of an eligible em-  
21 ployer, there shall be allowed as a credit against the tax  
22 imposed by this subtitle an amount equal to the lesser of—

23 “(1) the amount contributed by such employer  
24 to any qualified health savings account of any em-



1        ployee who is an eligible individual (as defined in  
2        section 223(c)(1)) during the taxable year, or

3            “(2) an amount equal to the product of—

4            “(A) \$200 (\$500 if coverage for all months  
5        described in subparagraph (B)(i) is family cov-  
6        erage), and

7            “(B) a fraction—

8            “(i) the numerator of which is the  
9        number of months that the employee was  
10       covered under a high deductible health  
11       plan maintained by the employer, and

12            “(ii) the denominator of which is the  
13        number of months in the taxable year.

14        “(b) ELIGIBLE EMPLOYER.—For purposes of this  
15        section—

16            “(1) IN GENERAL.—The term ‘eligible em-  
17        ployer’ means, with respect to any taxable year, an  
18        employer which—

19            “(A) is a small employer, and

20            “(B) maintains a high deductible health  
21        plan under which all employees of the employer  
22        reasonably expected to receive at least \$5,000  
23        of compensation during the taxable year are eli-  
24        gible to participate.

1 An employer may exclude from consideration under  
2 subparagraph (B) employees who are covered by an  
3 agreement described in section 410(b)(3)(A) if there  
4 is evidence that health benefits were the subject of  
5 good faith bargaining.

6 “(2) EXCEPTION FOR GOVERNMENTAL AND  
7 TAX-EXEMPT EMPLOYERS.—The term ‘eligible em-  
8 ployer’ shall not include the Federal Government or  
9 any employer described in section 457(e)(1).

10 “(3) SMALL EMPLOYER.—

11 “(A) IN GENERAL.—The term ‘small em-  
12 ployer’ means, with respect to any calendar  
13 year, any employer if such employer employed  
14 an average of 100 or fewer employees on busi-  
15 ness days during either of the 2 preceding cal-  
16 endar years. For purposes of the preceding sen-  
17 tence, a preceding calendar year may be taken  
18 into account only if the employer was in exist-  
19 ence throughout such year.

20 “(B) EMPLOYERS NOT IN EXISTENCE IN  
21 PRECEDING YEAR.—In the case of an employer  
22 which was not in existence throughout the 1st  
23 preceding calendar year, the determination  
24 under subparagraph (A) shall be based on the  
25 average number of employees that it is reason-

1 ably expected such employer will employ on  
2 business days in the current calendar year.

3 “(C) SPECIAL RULE.—Any reference in  
4 this paragraph to an employer shall include a  
5 reference to any predecessor of such employer.

6 “(c) DEFINITIONS.—For purposes of this section—

7 “(1) HIGH DEDUCTIBLE HEALTH PLAN.—The  
8 term ‘high deductible health plan’ has the meaning  
9 given such term by section 223(c)(2).

10 “(2) QUALIFIED HEALTH SAVINGS ACCOUNT.—

11 “(A) IN GENERAL.—The term ‘qualified  
12 health savings account’ means a health savings  
13 account (as defined in section 223(d))—

14 “(i) which is designated (in such form  
15 as the Secretary may prescribe) as a quali-  
16 fied account for purposes of this section,

17 “(ii) which may not include any  
18 amount other than contributions described  
19 in subsection (a) and earnings on such  
20 contributions, and

21 “(iii) with respect to which section  
22 223(f)(4)(A) is applied by substituting  
23 ‘100 percent’ for ‘10 percent’.

24 “(B) SUBACCOUNTS AND SEPARATE AC-  
25 COUNTING.—The Secretary may prescribe rules

1 under which a subaccount within a health sav-  
2 ings account, or separate accounting with re-  
3 spect to contributions and earnings described in  
4 subparagraph (A)(ii), may be treated in the  
5 same manner as a qualified health savings ac-  
6 count.

7 “(C) ROLLOVERS.—A contribution of a  
8 distribution from a qualified health savings ac-  
9 count to another health savings account shall be  
10 treated as a rollover contribution for purposes  
11 of section 223(f)(5) only if the other account is  
12 a qualified health savings account.

13 “(d) SPECIAL RULES.—For purposes of this  
14 section—

15 “(1) AGGREGATION RULES.—All persons treat-  
16 ed as a single employer under subsection (a) or (b)  
17 of section 52, or subsection (n) or (o) of section 414,  
18 shall be treated as one person.

19 “(2) DISALLOWANCE OF DEDUCTION.—No de-  
20 duction shall be allowed for that portion of contribu-  
21 tions to any health savings accounts for the taxable  
22 year which is equal to the credit determined under  
23 subsection (a).

24 “(3) ELECTION NOT TO CLAIM CREDIT.—This  
25 section shall not apply to a taxpayer for any taxable

1 year if such taxpayer elects to have this section not  
2 apply for such taxable year.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Paragraph (2) of section 1324(b) of title  
5 31, United States Code, is amended by inserting be-  
6 fore the period “, or from section 36A of such  
7 Code”.

8 (2) The table of sections for subpart C of part  
9 IV of chapter 1 of the Internal Revenue Code of  
10 1986, as amended by subtitle A, is amended by in-  
11 serting after the item relating to section 36 the fol-  
12 lowing new item:

“Sec. 36A. Small employer contributions to health savings accounts.”.

13 (c) EFFECTIVE DATE.—The amendments made by  
14 this section shall apply to contributions made in taxable  
15 years beginning after December 31, 2005.

16 **Subtitle C—Improvement of the**  
17 **Health Coverage Tax Credit**

18 **SEC. 221. CHANGE IN STATE-BASED COVERAGE RULES RE-**  
19 **LATED TO PREEXISTING CONDITIONS.**

20 (a) IN GENERAL.—Section 35(e)(2) of the Internal  
21 Revenue Code of 1986 (relating to requirements for State-  
22 based coverage) is amended by adding at the end the fol-  
23 lowing:

24 “(C) LIMITATION ON PREEXISTING CONDI-  
25 TION EXCLUSION PERIOD.—The term ‘qualified

1 health insurance’ does not include any coverage  
2 described in subparagraphs (C) through (H) of  
3 paragraph (1) that imposes a pre-existing con-  
4 dition exclusion with respect to any individual  
5 unless—

6 “(i) such exclusion relates to a phys-  
7 ical or mental condition, regardless of the  
8 cause of the condition, for which medical  
9 advice, diagnosis, care, or treatment was  
10 recommended or received within the 6-  
11 month period ending on the date the indi-  
12 vidual seeks to enroll in the coverage,

13 “(ii) such exclusion extends for a pe-  
14 riod of not more than 12 months after the  
15 individual seeks to enroll in the coverage,

16 “(iii) the period of any such pre-  
17 existing condition exclusion is reduced by  
18 the length of the aggregate of the periods  
19 of creditable coverage (as defined in sec-  
20 tion 9801(c)) applicable to the individual  
21 as of the enrollment date, and

22 “(iv) such exclusion is not an exclu-  
23 sion described in section 9801(d).”.

24 (b) CONFORMING AMENDMENTS.—

1           (1) INTERNAL REVENUE CODE OF 1986.—Sub-  
2       paragraph (A) of section 35(e)(2) of such Code is  
3       amended—

4           (A) by striking clause (ii); and

5           (B) by redesignating clauses (iii) and (iv)  
6       as clauses (ii) and (iii), respectively.

7           (2) WORKFORCE INVESTMENT ACT OF 1998  
8       AMENDMENTS.—Section 173(f)(2)(B) of the Work-  
9       force Investment Act of 1998 (29 U.S.C.  
10      2918(f)(2)(B)) is amended—

11          (A) in clause (i)—

12           (i) by striking subclause (II); and

13           (ii) by redesignating subclauses (III)  
14       and (IV) as subclauses (II) and (III), re-  
15       spectively; and

16          (B) by adding at the end the following:

17           “(iii) LIMITATION ON PREEXISTING  
18       CONDITION EXCLUSION PERIOD.—The  
19       term ‘qualified health insurance’ does not  
20       include any coverage described in clauses  
21       (iii) through (ix) of subparagraph (A) that  
22       imposes a pre-existing condition exclusion  
23       with respect to any individual unless—

24           “(I) such exclusion relates to a  
25       physical or mental condition, regard-

1 less of the cause of the condition, for  
2 which medical advice, diagnosis, care,  
3 or treatment was recommended or re-  
4 ceived within the 6-month period end-  
5 ing on the date the individual seeks to  
6 enroll in the coverage;

7 “(II) such exclusion extends for a  
8 period of not more than 12 months  
9 after the individual seeks to enroll in  
10 the coverage;

11 “(III) the period of any such pre-  
12 existing condition exclusion is reduced  
13 by the length of the aggregate of the  
14 periods of creditable coverage (as de-  
15 fined in section 9801(c) of the Inter-  
16 nal Revenue Code of 1986) applicable  
17 to the individual as of the enrollment  
18 date; and

19 “(IV) such exclusion is not an ex-  
20 clusion described in section 9801(d) of  
21 such Code.”.

22 (c) EFFECTIVE DATE.—The amendments made by  
23 this section apply to taxable years beginning after Decem-  
24 ber 31, 2005.



1 **SEC. 222. ELIGIBILITY OF SPOUSE OF CERTAIN INDIVID-**  
2 **UALS ENTITLED TO MEDICARE.**

3 (a) IN GENERAL.—Subsection (b) of section 35 of  
4 such Code (defining eligible coverage month) is amended  
5 by adding at the end the following:

6 “(3) SPECIAL RULE FOR SPOUSE OF INDI-  
7 VIDUAL ENTITLED TO MEDICARE.—Any month  
8 which would be an eligible coverage month with re-  
9 spect to a taxpayer (determined without regard to  
10 subsection (f)(2)(A)) shall be an eligible coverage  
11 month for any spouse of such taxpayer, provided the  
12 spouse has attained age 55 and meets the require-  
13 ments of clauses (ii), (iii), and (iv) of paragraph  
14 (1)(A).”.

15 (b) EFFECTIVE DATE.—The amendment made by  
16 subsection (a) applies to taxable years beginning after De-  
17 cember 31, 2005.

18 **SEC. 223. ELIGIBLE PBGC PENSION RECIPIENT.**

19 (a) IN GENERAL.—Subparagraph (B) of section  
20 35(c)(4) of such Code (relating to eligible PBGC pension  
21 recipients) is amended by inserting before the period the  
22 following “, or, after August 6, 2002, received from such  
23 Corporation a one-time single-sum pension payment in  
24 lieu of an annuity”.

25 (b) EFFECTIVE DATE.—The amendment made by  
26 subsection (a) shall take effect as if included in the enact-

1 ment of section 201 of the Trade Act of 2002 (Public Law  
2 107–210, 116 Stat. 954).

3 **SEC. 224. APPLICATION OF OPTION TO OFFER STATE-**  
4 **BASED COVERAGE TO PUERTO RICO, NORTH-**  
5 **ERN MARIANA ISLANDS, AMERICAN SAMOA,**  
6 **GUAM, AND THE UNITED STATES VIRGIN IS-**  
7 **LANDS.**

8 (a) IN GENERAL.—Section 35(e) of such Code (relat-  
9 ing to requirements for qualified health insurance) is  
10 amended by adding at the end the following:

11 “(4) APPLICATION TO PUERTO RICO, NORTH-  
12 ERN MARIANA ISLANDS, AMERICAN SAMOA, GUAM,  
13 AND THE UNITED STATES VIRGIN ISLANDS.—For  
14 purposes of this section, Puerto Rico, Northern Mar-  
15 iana Islands, American Samoa, Guam, and the  
16 United States Virgin Islands shall be considered  
17 States.”.

18 (b) CONFORMING AMENDMENT.—Section 173(f)(2)  
19 of the Workforce Investment Act of 1998 (29 U.S.C.  
20 2918(f)(2)) is amended by adding at the end the following:

21 “(D) APPLICATION TO NORTHERN MAR-  
22 IANA ISLANDS, AMERICAN SAMOA, GUAM, AND  
23 THE UNITED STATES VIRGIN ISLANDS.—For  
24 purposes of subsection (a)(4)(A) and this sub-  
25 section, the term ‘State’ shall include the

1 Northern Mariana Islands, American Samoa,  
2 Guam, and the United States Virgin Islands.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section apply to taxable years beginning after Decem-  
5 ber 31, 2005.

6 **SEC. 225. CLARIFICATION OF DISCLOSURE RULES.**

7 (a) IN GENERAL.—Subsection (k) of section 6103 of  
8 such Code (relating to disclosure of certain returns and  
9 return information for tax administration purposes) is  
10 amended by adding at the end the following:

11 “(10) DISCLOSURE OF CERTAIN RETURN IN-  
12 FORMATION FOR PURPOSES OF CARRYING OUT A  
13 PROGRAM FOR ADVANCE PAYMENT OF CREDIT FOR  
14 HEALTH INSURANCE COSTS OF ELIGIBLE INDIVID-  
15 UALS.—The Secretary may disclose to providers of  
16 health insurance, administrators of health plans, or  
17 contractors of such providers or administrators, for  
18 any certified individual (as defined in section  
19 7527(c)) the taxpayer identity and health insurance  
20 member and group numbers of the certified indi-  
21 vidual (and any qualifying family member as defined  
22 in section 35(d), if applicable) and the amount and  
23 period of the payment, to the extent the Secretary  
24 deems necessary for the administration of the pro-  
25 gram established by section 7527 (relating to ad-

1 vance payment of credit for health insurance costs of  
2 eligible individuals).”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) Section 6103 of such Code (relating to con-  
5 fidentiality and disclosure of returns and return in-  
6 formation) is amended—

7 (A) in subsection (a)(3), by inserting  
8 “(k)(10),” after “(e)(1)(D)(iii),”;

9 (B) in subsection (l), by striking para-  
10 graph (18); and

11 (C) in subsection (p)—

12 (i) in paragraph (3)(A)—

13 (I) by striking “or (9)” and in-  
14 serting “(9), or (10)”; and

15 (II) by striking “(17), or (18)”  
16 and inserting “or (17)”; and

17 (ii) in paragraph (4), by striking  
18 “(18)” after “(l)(16)” each place it ap-  
19 pears.

20 (2) Section 7213(a)(2) of such Code (relating  
21 to unauthorized disclosure of information) is amend-  
22 ed by inserting “(k)(10)” before “(l)(6)”.

23 (3) Section 7213A(a)(1)(B) of such Code (re-  
24 lating to unauthorized inspection of returns or re-  
25 turn information) is amended by striking “sub-

1 section (l)(18) or (n) of section 6103” and inserting  
2 “section 6103(n)”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section apply to taxable years beginning after Decem-  
5 ber 31, 2005.

6 **SEC. 226. CLARIFICATION THAT STATE-BASED COBRA CON-**  
7 **TINUATION COVERAGE IS SUBJECT TO SAME**  
8 **RULES AS FEDERAL COBRA.**

9 (a) IN GENERAL.—Section 35(e)(2) of such Code (re-  
10 lating to state-based coverage requirements) is amended—

11 (1) in subparagraph (A), in the matter pre-  
12 ceding clause (i), by striking “(B)” and inserting  
13 “(C)”; and

14 (2) in subparagraph(B)(i), by striking “(B)”  
15 and inserting “(C)”.

16 (b) CONFORMING AMENDMENTS.—Section  
17 173(f)(2)(B) of the Workforce Investment Act of 1998 (29  
18 U.S.C. 2918(f)(2)(B)) is amended—

19 (1) in clause (i), in the matter preceding sub-  
20 clause (I), by striking “(ii)” and inserting “(iii)”;  
21 and

22 (2) in clause (ii)(I), by striking “(ii)” and in-  
23 serting “(iii)”.

24 (c) EFFECTIVE DATE.—The amendments made by  
25 this section shall take effect as if included in the enact-

1 ment of sections 201 and 203, respectively, of the Trade  
2 Act of 2002 (Public Law 107–210, 116 Stat. 954).

3 **SEC. 227. APPLICATION OF RULES FOR OTHER SPECIFIED**  
4 **COVERAGE TO ELIGIBLE ALTERNATIVE TAA**  
5 **RECIPIENTS CONSISTENT WITH RULES FOR**  
6 **OTHER ELIGIBLE INDIVIDUALS.**

7 (a) IN GENERAL.—Section 35(f)(1) of such Code (re-  
8 lating to subsidized coverage) is amended by striking sub-  
9 paragraph (B) and redesignating subparagraph (C) as  
10 subparagraph (B).

11 (b) CONFORMING AMENDMENTS.—Section  
12 173(f)(7)(A) of the Workforce Investment Act of 1998 (29  
13 U.S.C. 2918(f)(7)(A)) is amended by striking clause (ii)  
14 and redesignating clause (iii) as clause (ii).

15 **Subtitle D—Long-Term Care**  
16 **Insurance**

17 **SEC. 231. SENSE OF THE SENATE CONCERNING LONG-TERM**  
18 **CARE.**

19 It is the sense of the Senate that Congress should  
20 take steps to make long-term care more affordable by pro-  
21 viding tax incentives for the purchase of long-term care  
22 insurance, support for family caregivers, and making nec-  
23 essary public program reforms.

1           **Subtitle E—Other Provisions**

2   **SEC. 241. DISPOSITION OF UNUSED HEALTH BENEFITS IN**  
3                   **CAFETERIA PLANS AND FLEXIBLE SPENDING**  
4                   **ARRANGEMENTS.**

5           (a) IN GENERAL.—Section 125 of the Internal Rev-  
6   enue Code of 1986 (relating to cafeteria plans) is amended  
7   by redesignating subsections (h) and (i) as subsections (i)  
8   and (j), respectively, and by inserting after subsection (g)  
9   the following:

10          “(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH  
11   BENEFITS.—

12               “(1) IN GENERAL.—For purposes of this title,  
13   a plan or other arrangement shall not fail to be  
14   treated as a cafeteria plan solely because qualified  
15   benefits under such plan include a health flexible  
16   spending arrangement under which not more than  
17   \$500 of unused health benefits may be—

18               “(A) carried forward to the succeeding  
19   plan year of such health flexible spending ar-  
20   rangement, or

21               “(B) to the extent permitted by section  
22   106(c), contributed by the employer to a health  
23   savings account (as defined in section 223(d))  
24   maintained for the benefit of the employee.

1           “(2) HEALTH FLEXIBLE SPENDING ARRANGE-  
2       MENT.—

3           “(A) IN GENERAL.—For purposes of this  
4       subsection, the term ‘health flexible spending  
5       arrangement’ means a flexible spending ar-  
6       rangement (as defined in section 106(c)) that is  
7       a qualified benefit and only permits reimburse-  
8       ment for expenses for medical care (as defined  
9       in section 213(d)(1), without regard to subpara-  
10      graphs (C) and (D) thereof).

11          “(B) FLEXIBLE SPENDING ARRANGE-  
12      MENT.—A flexible spending arrangement is a  
13      benefit program which provides employees with  
14      coverage under which—

15           “(i) specified incurred expenses may  
16       be reimbursed (subject to reimbursement  
17       maximums and other reasonable condi-  
18       tions), and

19           “(ii) the maximum amount of reim-  
20       bursement which is reasonably available to  
21       a participant for such coverage is less than  
22       500 percent of the value of such coverage.  
23      In the case of an insured plan, the maximum  
24      amount reasonably available shall be deter-  
25      mined on the basis of the underlying coverage.



1           “(3) UNUSED HEALTH BENEFITS.—For pur-  
2           poses of this subsection, with respect to an em-  
3           ployee, the term ‘unused health benefits’ means the  
4           excess of—

5                   “(A) the maximum amount of reimburse-  
6                   ment allowable to the employee for a plan year  
7                   under a health flexible spending arrangement,  
8                   over

9                   “(B) the actual amount of reimbursement  
10                  for such year under such arrangement.”.

11          (b) EFFECTIVE DATE.—The amendments made by  
12          subsection (a) shall apply to taxable years beginning after  
13          December 31, 2004.

14      **SEC. 242. MICROENTREPRENEURS.**

15          (Section 404(8) of the Assets for Independence Act  
16          (42 U.S.C. 604 note) is amended by adding at the end  
17          the following:

18                   “(F) HIGH DEDUCTIBLE HEALTH INSUR-  
19                  ANCE.—

20                   “(i) IN GENERAL.—The eligible indi-  
21                  vidual’s contribution (as an employer or  
22                  employee) for coverage under a high de-  
23                  ductible health plan (as defined in section  
24                  223(c)(2) of the Internal Revenue Code of  
25                  1986).

1 “(ii) DEFINITION OF EMPLOYEE.—

2 For purposes of clause (i), the term ‘em-  
3 ployee’ includes an individual described in  
4 section 401(c)(1) of the Internal Revenue  
5 Code of 1986.’’.

6 **SEC. 243. STUDY ON ACCESS TO AFFORDABLE HEALTH IN-**  
7 **SURANCE FOR FULL-TIME COLLEGE AND UNI-**  
8 **VERSITY STUDENTS.**

9 (a) SENSE OF THE SENATE.—It is the sense of the  
10 Senate that, because a considerable number of the United  
11 States’ uninsured population are young adults who are en-  
12 rolled full-time at an institution of higher education, Con-  
13 gress should determine whether health care coverage pro-  
14 posals targeting this population would be effective.

15 (b) STUDY REQUIRED.—The Government Account-  
16 ability Office shall provide for the conduct of a study to  
17 evaluate existing and potential sources of affordable health  
18 insurance coverage for graduate and undergraduate stu-  
19 dents enrolled at an institution of higher education (as de-  
20 fined in section 1201 of the Higher Education Act of 1965  
21 (20 U.S.C. 1141)).

22 (c) REQUIRED ELEMENTS OF STUDY.—In con-  
23 ducting the study under subsection (b), the Government  
24 Accountability Office shall, at a minimum, examine the  
25 following:

1 (1) STUDENT DEMOGRAPHICS.—

2 (A) IN GENERAL.—The size and character-  
3 istics of the insured and uninsured population  
4 of undergraduate and graduate students en-  
5 rolled at institutions of higher education. Such  
6 data shall be differentiated as provided for in  
7 subparagraphs (B) and (C).

8 (B) STATISTICAL BREAKDOWN.—The data  
9 concerning the uninsured student population  
10 collected under subparagraph (A) shall be dif-  
11 ferentiated by—

12 (i) the full-time, full-time equivalent,  
13 and part-time enrollment status of the stu-  
14 dents involved;

15 (ii) the type of institution involved  
16 (such as a public, private, non-profit, or  
17 community institution);

18 (iii) the length and type of educational  
19 program involved (such as a certificate or  
20 diploma program, a 2-year or 4-year de-  
21 gree program, a masters degree program,  
22 or a doctoral degree program); and

23 (iv) the undergraduate and graduate  
24 student populations involved.

1 (C) COVERAGE.—The data concerning the  
2 insured student population collected under sub-  
3 paragraph (A) shall be differentiated by the  
4 sources of coverage for such students, including  
5 the number and percentage of such insured stu-  
6 dents who lose parental (or other) coverage dur-  
7 ing the course of their enrollment at such insti-  
8 tutions and the age at which such coverage is  
9 lost.

10 (2) IMPACT ANALYSIS.—The financial and other  
11 impact of uninsured students at such institutions, as  
12 compared to insured students, on—

13 (A) the health of students;

14 (B) the student's family;

15 (C) the student's educational progress; and

16 (D) education and health care institutions  
17 and facilities.

18 (3) ASSESSMENT OF EXISTING PROGRAMS.—  
19 The effect of mandatory and voluntary programs on  
20 the access of students to health insurance coverage,  
21 including—

22 (A) the level and type of coverage provided  
23 through mandatory and voluntary State and in-  
24stitutionally-sponsored health care programs

1 currently providing health care insurance cov-  
2 erage to students;

3 (B) the average premium paid with respect  
4 to students covered under such plans;

5 (C) the extent to which any State or insti-  
6 tutional health insurance plan may serve as a  
7 model for the expansion of access to health in-  
8 surance for all full-time undergraduate and  
9 graduate students attending an institution of  
10 higher education; and

11 (D) whether such programs targeted to the  
12 student population would be more effective in  
13 reducing the overall rate of uninsured relative  
14 to proposals targeted to broader populations.

15 (4) INCENTIVES AND DISINCENTIVES.—The ex-  
16 istence of incentives and disincentives offered to in-  
17 stitutions of higher education to expand access to  
18 health care coverage for students, including—

19 (A) an assessment of the types of incen-  
20 tives and disincentives that may be used to en-  
21 courage or require an institution of higher edu-  
22 cation to include health care coverage for all of  
23 its students on a mandatory basis, including fi-  
24 nancial, regulatory, administrative, and other  
25 incentives or disincentives;

1 (B) a list of burdensome regulatory or ad-  
2 ministrative reporting and other requirements  
3 (from the Department of Education or other  
4 governmental agencies) that could be waived  
5 without compromising program integrity as a  
6 means of encouraging institutions of higher  
7 education to provide uninsured students with  
8 access to health care coverage;

9 (C) other incentives or disincentives that  
10 would increase the level of institutional partici-  
11 pation in health care coverage programs; and

12 (D) an analysis of the costs and effective-  
13 ness (to reduce the number of uninsured stu-  
14 dents) of including the cost of health insurance  
15 as an allowable cost of attendance under the  
16 Higher Education Act of 1965, and the impact  
17 of such inclusion on the student's financial aid  
18 package.

19 (e) CONSULTATION WITH CONGRESS.—In carrying  
20 out the study under subsection (b), the Government Ac-  
21 countability Office shall consult on a regular basis with  
22 the Secretary of Education, the Secretary of Health and  
23 Human Services, the Committee on the Budget of the  
24 Senate, the Committee on Health, Education, Labor, and

1 Pensions of the Senate, and the Committee on Education  
2 and the Workforce of the House of Representatives.

3 (f) REPORT.—Not later than 1 year after the date  
4 of enactment of this Act, the Government Accountability  
5 Office shall prepare and submit to the Committee on the  
6 Budget and the Committee on Health, Education, Labor,  
7 and Pensions of the Senate, and the Committee on Edu-  
8 cation and the Workforce of the House of Representatives,  
9 a report concerning the results of the study conducted  
10 under this section.

11 **SEC. 244. EXTENSION OF FUNDING FOR OPERATION OF**  
12 **STATE HIGH RISK HEALTH INSURANCE**  
13 **POOLS.**

14 Section 2745 of the Public Health Service Act (42  
15 U.S.C. 300gg–45) is amended to read as follows:

16 **“SEC. 2745. PROMOTION OF QUALIFIED HIGH RISK POOLS.**

17 “(a) EXTENSION OF SEED GRANTS TO STATES.—  
18 The Secretary shall provide from the funds appropriated  
19 under subsection (d)(1)(A) a grant of up to \$1,000,000  
20 to each State that has not created a qualified high risk  
21 pool as of the date of enactment of this section for the  
22 State’s costs of creation and initial operation of such a  
23 pool.

24 “(b) GRANTS FOR OPERATIONAL LOSSES.—

1           “(1) IN GENERAL.—In the case of a State that  
2           has established a qualified high risk pool that—

3                   “(A) restricts premiums charged under the  
4                   pool to no more than 150 percent of the pre-  
5                   mium for applicable standard risk rates;

6                   “(B) offers a choice of two or more cov-  
7                   erage options through the pool; and

8                   “(C) has in effect a mechanism reasonably  
9                   designed to ensure continued funding of losses  
10                  incurred by the State after the end of fiscal  
11                  year 2004 in connection with operation of the  
12                  pool;

13           the Secretary shall provide, from the funds appro-  
14           priated under subsection (d)(1)(B)(i) and allotted to  
15           the State under paragraph (2), a grant for the losses  
16           incurred by the State in connection with the oper-  
17           ation of the pool.

18           “(2) ALLOTMENT.—The amounts appropriated  
19           under subsection (d)(1)(B)(i) for a fiscal year shall  
20           be made available to the States (or the entities that  
21           operate the high risk pool under applicable State  
22           law) as follows:

23                   “(A) An amount equal to 50 percent of the  
24                   appropriated amount for the fiscal year shall be  
25                   allocated in equal amounts among each eligible



1 State that applies for assistance under this sub-  
2 section.

3 “(B) An amount equal to 25 percent of the  
4 appropriated amount for the fiscal year shall be  
5 allocated among the States so that the amount  
6 provided to a State bears the same ratio to  
7 such available amount as the number of unin-  
8 insured individuals in the State bears to the total  
9 number of uninsured individuals in all States  
10 (as determined by the Secretary).

11 “(C) An amount equal to 25 percent of the  
12 appropriated amount for the fiscal year shall be  
13 allocated among the States so that the amount  
14 provided to a State bears the same ratio to  
15 such available amount as the number of individ-  
16 uals enrolled in health care coverage through  
17 the qualified high risk pool of the State bears  
18 to the total number of individuals so enrolled  
19 through qualified high risk pools in all States  
20 (as determined by the Secretary).

21 “(c) BONUS GRANTS FOR SUPPLEMENTAL CON-  
22 SUMER BENEFITS.—

23 “(1) IN GENERAL.—In the case of a State that  
24 has established a qualified high risk pool, the Sec-  
25 retary shall provide, from the funds appropriated

1 under subsection (d)(1)(B)(ii) and allotted to the  
2 State under paragraph (3), a grant to be used to  
3 provide supplemental consumer benefits to enrollees  
4 or potential enrollees (or defined subsets of such en-  
5 rollees or potential enrollees) in qualified high risk  
6 pools.

7 “(2) BENEFITS.—A State shall use amounts re-  
8 ceived under a grant under this subsection to pro-  
9 vide one or more of the following benefits:

10 “(A) Low-income premium subsidies.

11 “(B) A reduction in premium trends, ac-  
12 tual premiums, or other cost-sharing require-  
13 ments.

14 “(C) An expansion or broadening of the  
15 pool of individuals eligible for coverage, includ-  
16 ing eliminating waiting lists, increasing enroll-  
17 ment caps, or providing flexibility in enrollment  
18 rules.

19 “(D) Less stringent rules, or additional  
20 waiver authority, with respect to coverage of  
21 pre-existing conditions.

22 “(E) Increased benefits.

23 “(F) The establishment of disease manage-  
24 ment programs.

1           “(3) LIMITATION.—In allotting amounts under  
2           this subsection, the Secretary shall ensure that no  
3           State receives an amount that exceeds 10 percent of  
4           the amount appropriated for the fiscal year involved  
5           under subsection (d)(1)(B)(ii).

6           “(4) RULE OF CONSTRUCTION.—Nothing in  
7           this subsection shall be construed to prohibit States  
8           that, on the date of enactment of the State High  
9           Risk Pool Funding Extension Act of 2005, are in  
10          the process of implementing programs to provide  
11          benefits of the type described in paragraph (2), from  
12          being eligible for a grant under this subsection.

13          “(d) FUNDING.—

14                 “(1) IN GENERAL.—Out of any money in the  
15                 Treasury of the United States not otherwise appro-  
16                 priated, there are authorized and appropriated—

17                         “(A) \$15,000,000 for the period of fiscal  
18                         years 2005 and 2006 to carry out subsection  
19                         (a); and

20                         “(B) \$75,000,000 for each of fiscal years  
21                         2005 through 2009, of which—

22                                 “(i) two-thirds of the amount appro-  
23                                 priated for a fiscal year shall be made  
24                                 available for allotments under subsection  
25                                 (b)(2); and

1                   “(ii) one-third of the amount appro-  
2                   priated for a fiscal year shall be made  
3                   available for allotments under subsection  
4                   (c)(2).

5                   “(2) AVAILABILITY.—Funds appropriated  
6                   under this subsection for a fiscal year shall remain  
7                   available for obligation through the end of the fol-  
8                   lowing fiscal year.

9                   “(3) REALLOTMENT.—If, on June 30 of each  
10                  fiscal year, the Secretary determines that all  
11                  amounts appropriated under paragraph (1)(B)(ii)  
12                  for the fiscal year are not allotted, such remaining  
13                  amounts shall be allotted among States receiving  
14                  grants under subsection (b) for the fiscal year in  
15                  amounts determined appropriate by the Secretary.

16                  “(4) NO ENTITLEMENT.—Nothing in this sec-  
17                  tion shall be construed as providing a State with an  
18                  entitlement to a grant under this section.

19                  “(e) APPLICATIONS.—To be eligible for a grant under  
20                  this section, a State shall submit to the Secretary an appli-  
21                  cation at such time, in such manner, and containing such  
22                  information as the Secretary may require.

23                  “(f) DEFINITIONS.—In this section:

24                  “(1) QUALIFIED HIGH RISK POOL.—

1           “(A) IN GENERAL.—The term ‘qualified  
2           high risk pool’ has the meaning given such term  
3           in section 2744(c)(2), except that with respect  
4           to subparagraph (A) of such section a State  
5           may elect to provide for the enrollment of eligi-  
6           ble individuals through—

7                   “(i) a combination of a qualified high  
8                   risk pool and an acceptable alternative  
9                   mechanism; or

10                   “(ii) other health insurance coverage  
11                   described in subparagraph (B).

12           “(B) HEALTH INSURANCE COVERAGE.—  
13           Health insurance coverage described in this  
14           subparagraph is individual health insurance  
15           coverage—

16                   “(i) that meets the requirements of  
17                   section 2741;

18                   “(ii) that is subject to limits on the  
19                   rates charged to individuals;

20                   “(iii) that is available to all individ-  
21                   uals eligible for health insurance coverage  
22                   under this title who are not able to partici-  
23                   pate in a qualified high risk pool; and

24                   “(iv) the defined rate limit of which  
25                   does not exceed the limit allowed for a

1 qualified risk pool that is otherwise eligible  
2 to receive assistance under a grant under  
3 this section.

4 “(C) OTHER COVERAGE.—In addition to  
5 coverage described in subparagraph (B), a  
6 State may provide for the offering of health in-  
7 surance coverage that provides first dollar cov-  
8 erage, limits on cost-sharing, and comprehen-  
9 sive medical, hospital and surgical coverage, if  
10 the limits on rates for such coverage do not ex-  
11 ceed 125 percent of the limit described in sub-  
12 paragraph (B)(iv).

13 “(2) STANDARD RISK RATE.—The term ‘stand-  
14 ard risk rate’ means a rate—

15 “(A) determined under the State high risk  
16 pool by considering the premium rates charged  
17 by other health insurers offering health insur-  
18 ance coverage to individuals in the insurance  
19 market served;

20 “(B) that is established using reasonable  
21 actuarial techniques; and

22 “(C) that reflects anticipated claims expe-  
23 rience and expenses for the coverage involved.

24 “(3) STATE.—The term ‘State’ means any of  
25 the 50 States and the District of Columbia.”.

1   **SEC. 245. SENSE OF THE SENATE ON AFFORDABLE HEALTH**  
2                   **COVERAGE FOR SMALL EMPLOYERS.**

3           It is the sense of the Senate that Congress should  
4   pass legislation to support expanded, affordable health  
5   coverage options for individuals, particularly those who  
6   work for small businesses, by streamlining and reducing  
7   regulations and expanding the role of associations and  
8   other group purchasing arrangements.

9                   **Subtitle F—Covering Kids**

10   **SEC. 251. SHORT TITLE.**

11           This subtitle may be cited as the “Covering Kids Act  
12   of 2005”.

13   **SEC. 252. GRANTS TO PROMOTE INNOVATIVE OUTREACH**  
14                   **AND ENROLLMENT UNDER MEDICAID AND**  
15                   **SCHIP.**

16           (a) GRANTS FOR EXPANDED OUTREACH ACTIVI-  
17   TIES.—Title XXI of the Social Security Act (42 U.S.C.  
18   1397aa et seq.) is amended by adding at the end the fol-  
19   lowing:

20   **“SEC. 2111. EXPANDED OUTREACH ACTIVITIES.**

21           “(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH  
22   AND ENROLLMENT EFFORTS.—

23                   “(1) IN GENERAL.—The Secretary shall award  
24   grants to eligible entities to—

25                           “(A) conduct innovative outreach and en-  
26   rollment efforts that are designed to increase

1 the enrollment and participation of eligible chil-  
2 dren under this title and title XIX; and

3 “(B) promote understanding of the impor-  
4 tance of health insurance coverage for prenatal  
5 care and children.

6 “(2) PERFORMANCE BONUSES.—The Secretary  
7 may reserve a portion of the funds appropriated  
8 under subsection (g) for a fiscal year for the purpose  
9 of awarding performance bonuses during the suc-  
10 ceeding fiscal year to eligible entities that meet en-  
11 rollment goals or other criteria established by the  
12 Secretary.

13 “(b) PRIORITY FOR AWARD OF GRANTS.—

14 “(1) IN GENERAL.—In making grants under  
15 subsection (a)(1), the Secretary shall give priority  
16 to—

17 “(A) eligible entities that propose to target  
18 geographic areas with high rates of—

19 “(i) eligible but unenrolled children,  
20 including such children who reside in rural  
21 areas; or

22 “(ii) racial and ethnic minorities and  
23 health disparity populations, including  
24 those proposals that address cultural and  
25 linguistic barriers to enrollment; and



1 “(B) eligible entities that plan to engage in  
2 outreach efforts with respect to individuals de-  
3 scribed in subparagraph (A) and that are—

4 “(i) Federal health safety net organi-  
5 zations; or

6 “(ii) faith-based organizations or con-  
7 sortia.

8 “(2) 10 PERCENT SET ASIDE FOR OUTREACH  
9 TO INDIAN CHILDREN.—An amount equal to 10 per-  
10 cent of the funds appropriated under subsection (g)  
11 for a fiscal year shall be used by the Secretary to  
12 award grants to Indian Health Service providers and  
13 urban Indian organizations receiving funds under  
14 title V of the Indian Health Care Improvement Act  
15 (25 U.S.C. 1651 et seq.) for outreach to, and enroll-  
16 ment of, children who are Indians.

17 “(c) APPLICATION.—An eligible entity that desires to  
18 receive a grant under subsection (a)(1) shall submit an  
19 application to the Secretary in such form and manner, and  
20 containing such information, as the Secretary may decide.  
21 Such application shall include—

22 “(1) quality and outcomes performance meas-  
23 ures to evaluate the effectiveness of activities funded  
24 by a grant awarded under this section to ensure that  
25 the activities are meeting their goals; and

1 “(2) an assurance that the entity shall—

2 “(A) conduct an assessment of the effec-  
3 tiveness of such activities against such perform-  
4 ance measures; and

5 “(B) cooperate with the collection and re-  
6 porting of enrollment data and other informa-  
7 tion determined as a result of conducting such  
8 assessments to the Secretary, in such form and  
9 manner as the Secretary shall require.

10 “(d) DISSEMINATION OF ENROLLMENT DATA AND  
11 INFORMATION DETERMINED FROM EFFECTIVENESS AS-  
12 SESSMENTS; ANNUAL REPORT.—The Secretary shall—

13 “(1) disseminate to eligible entities and make  
14 publicly available the enrollment data and informa-  
15 tion collected and reported in accordance with sub-  
16 section (c)(2)(B); and

17 “(2) submit an annual report to Congress on  
18 the outreach activities funded by grants awarded  
19 under this section.

20 “(e) SUPPLEMENT, NOT SUPPLANT.—Federal funds  
21 awarded under this section shall be used to supplement,  
22 not supplant, non-Federal funds that are otherwise avail-  
23 able for activities funded under this section.

24 “(f) DEFINITIONS.—In this section:

1           “(1) ELIGIBLE ENTITY.—The term ‘eligible en-  
2           tity’ means any of the following:

3                   “(A) A State or local government.

4                   “(B) A Federal health safety net organiza-  
5           tion.

6                   “(C) A national, local, or community-based  
7           public or nonprofit private organization.

8                   “(D) A faith-based organization or con-  
9           sortia, to the extent that a grant awarded to  
10          such an entity is consistent with the require-  
11          ments of section 1955 of the Public Health  
12          Service Act (42 U.S.C. 300x–65) relating to a  
13          grant award to non-governmental entities.

14                  “(E) An elementary or secondary school.

15           “(2) FEDERAL HEALTH SAFETY NET ORGANI-  
16          ZATION.—The term ‘Federal health safety net orga-  
17          nization’ means—

18                   “(A) an Indian tribe, tribal organization,  
19           or an urban Indian organization receiving funds  
20           under title V of the Indian Health Care Im-  
21           provement Act (25 U.S.C. 1651 et seq.), or an  
22           Indian Health Service provider;

23                   “(B) a Federally-qualified health center  
24           (as defined in section 1905(l)(2)(B));

1           “(C) a hospital defined as a dispropor-  
2           tionate share hospital for purposes of section  
3           1923;

4           “(D) a covered entity described in section  
5           340B(a)(4) of the Public Health Service Act  
6           (42 U.S.C. 256b(a)(4)); and

7           “(E) any other entity or a consortium that  
8           serves children under a federally-funded pro-  
9           gram, including the special supplemental nutri-  
10          tion program for women, infants, and children  
11          (WIC) established under section 17 of the Child  
12          Nutrition Act of 1966 (42 U.S.C. 1786), the  
13          head start and early head start programs under  
14          the Head Start Act (42 U.S.C. 9801 et seq.),  
15          the school lunch program established under the  
16          Richard B. Russell National School Lunch Act,  
17          and an elementary or secondary school.

18          “(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANI-  
19          ZATION; URBAN INDIAN ORGANIZATION.—The terms  
20          ‘Indian’, ‘Indian tribe’, ‘tribal organization’, and  
21          ‘urban Indian organization’ have the meanings given  
22          such terms in section 4 of the Indian Health Care  
23          Improvement Act (25 U.S.C. 1603).

24          “(g) APPROPRIATION.—There is appropriated, out of  
25          any money in the Treasury not otherwise appropriated,

1 \$50,000,000 for each of fiscal years 2006 and 2007 for  
2 the purpose of awarding grants under this section.  
3 Amounts appropriated and paid under the authority of  
4 this section shall be in addition to amounts appropriated  
5 under section 2104 and paid to States in accordance with  
6 section 2105, including with respect to expenditures for  
7 outreach activities in accordance with subsection  
8 (a)(1)(D)(iii) of that section.”.

9 (b) EXTENDING USE OF OUTSTATIONED WORKERS  
10 TO ACCEPT TITLE XXI APPLICATIONS.—Section  
11 1902(a)(55) of the Social Security Act (42 U.S.C.  
12 1396a(a)(55)) is amended by striking “or  
13 (a)(10)(A)(ii)(IX)” and inserting “(a)(10)(A)(ii)(IX), or  
14 (a)(10)(A)(ii)(XIV), and applications for child health as-  
15 sistance under title XXI”.

16 **SEC. 253. STATE OPTION TO PROVIDE FOR SIMPLIFIED DE-**  
17 **TERMINATIONS OF A CHILD’S FINANCIAL ELI-**  
18 **GIBILITY FOR MEDICAL ASSISTANCE UNDER**  
19 **MEDICAID OR CHILD HEALTH ASSISTANCE**  
20 **UNDER SCHIP.**

21 (a) MEDICAID.—Section 1902(e) of the Social Secu-  
22 rity Act (42 U.S.C. 1396a(e)) is amended by adding at  
23 the end the following:

24 “(13)(A) At the option of the State, the plan  
25 may provide that financial eligibility requirements

1       for medical assistance are met for a child who is  
2       under an age specified by the State (not to exceed  
3       21 years of age) by using a determination made  
4       within a reasonable period (as determined by the  
5       State) before its use for this purpose, of the child's  
6       family or household income, or if applicable for pur-  
7       poses of determining eligibility under this title or  
8       title XXI, assets or resources, by a Federal or State  
9       agency, or a public or private entity making such de-  
10      termination on behalf of such agency, specified by  
11      the plan, including (but not limited to) an agency  
12      administering the State program funded under part  
13      A of title IV, the Food Stamp Act of 1977, the  
14      Richard B. Russell National School Lunch Act, or  
15      the Child Nutrition Act of 1966, notwithstanding  
16      any differences in budget unit, disregard, deeming,  
17      or other methodology, but only if—

18               “(i) the agency has fiscal liabilities or re-  
19               sponsibilities affected or potentially affected by  
20               such determination; and

21               “(ii) any information furnished by the  
22               agency pursuant to this subparagraph is used  
23               solely for purposes of determining financial eli-  
24               gibility for medical assistance under this title or  
25               for child health assistance under title XXI.

1           “(B) Nothing in subparagraph (A) shall be  
2 construed—

3           “(i) to authorize the denial of medical as-  
4 sistance under this title or of child health as-  
5 sistance under title XXI to a child who, without  
6 the application of this paragraph, would qualify  
7 for such assistance;

8           “(ii) to relieve a State of the obligation  
9 under subsection (a)(8) to furnish medical as-  
10 sistance with reasonable promptness after the  
11 submission of an initial application that is eval-  
12 uated or for which evaluation is requested pur-  
13 suant to this paragraph;

14           “(iii) to relieve a State of the obligation to  
15 determine eligibility for medical assistance  
16 under this title or for child health assistance  
17 under title XXI on a basis other than family or  
18 household income (or, if applicable, assets or re-  
19 sources) if a child is determined ineligible for  
20 such assistance on the basis of information fur-  
21 nished pursuant to this paragraph; or

22           “(iv) as affecting the applicability of any  
23 non-financial requirements for eligibility for  
24 medical assistance under this title or child  
25 health assistance under title XXI.”.

1 (b) SCHIP.—Section 2107(e)(1) of the Social Secu-  
2 rity Act (42 U.S.C. 1397gg(e)(1)) is amended by adding  
3 at the end the following:

4 “(E) Section 1902(e)(13) (relating to the  
5 State option to base a determination of child’s  
6 financial eligibility for assistance on financial  
7 determinations made by a program providing  
8 nutrition or other public assistance).”.

9 (c) EFFECTIVE DATE.—The amendments made by  
10 this section take effect on October 1, 2005.

11 **TITLE III—IMPROVING CARE**  
12 **AND STRENGTHENING THE**  
13 **SAFETY NET**  
14 **Subtitle A—High Needs Areas**

15 **SEC. 301. PURPOSE.**

16 It is the purpose of this subtitle to enhance the qual-  
17 ity of life of residents of high need areas by increasing  
18 their access to the preventive and primary healthcare serv-  
19 ices provided by community health centers and rural  
20 health centers.

21 **SEC. 302. HIGH NEED COMMUNITY HEALTH CENTERS.**

22 Section 330 of the Public Health Service Act (42  
23 U.S.C. 254b) is amended—

24 (1) by redesignating subsections (k) through (r)  
25 as subsections (l) through (s), respectively;



1           (2) by inserting after subsection (j), the fol-  
2       lowing:

3       “(k) PRIORITY FOR RESIDENTS OF HIGH NEED  
4       AREAS.—

5           “(1) IN GENERAL.—In awarding grants under  
6       this section, the Secretary shall give priority to eligi-  
7       ble health centers in high need areas.

8           “(2) ELIGIBLE HEALTH CENTERS.—A health  
9       center is described in this paragraph if such health  
10      center—

11           “(A) is a health center as defined under  
12       subsection (a) or a rural health clinic that re-  
13       ceives funds under section 330A;

14           “(B) agrees to use grant funds to provide  
15       preventive and primary healthcare services to  
16       residents of high need areas;

17           “(C) specifically requests such priority in  
18       the grant application;

19           “(D) describes how the community to be  
20       served meets the definition of high need area;  
21       and

22           “(E) otherwise meets all other grant re-  
23       quirements.

24       “(3) HIGH NEED AREA.—

1           “(A) IN GENERAL.—In this subsection, the  
2           term ‘high need area’ means a county or a re-  
3           gional area identified by the Secretary pursuant  
4           to the regulations promulgated under subpara-  
5           graph (B).

6           “(B) REGULATIONS.—The Secretary shall  
7           promulgate regulations that define the term  
8           ‘high need area’ for purposes of this subsection.  
9           Such regulations shall specify procedures that  
10          the Department shall follow in determining esti-  
11          mates on a periodic basis in the United States  
12          of the number of medically uninsured persons  
13          and the national percentage of medically unin-  
14          sured persons served by health centers (referred  
15          to in this subsection as the ‘ENP’) and for the  
16          designation of an area as a ‘high need area’ if  
17          the estimated percentage of medically uninsured  
18          individuals in the area is higher than the na-  
19          tional average and the estimated percentage of  
20          medically uninsured individuals in the area  
21          served by health centers in the area is below the  
22          ENP.

23          “(C) MEDICALLY UNDERSERVED AREA.—  
24          The Secretary shall designate residents of high

1           need areas as medically underserved for pur-  
2           poses of this section.

3           “(4) FUNDING PREFERENCE.—The Secretary  
4           may limit the amount of grants awarded to appli-  
5           cants from high need areas as provided for in this  
6           subsection to not less than 25 percent of the total  
7           amount of grants awarded under this subsection for  
8           each grant category for each grant period.”;

9           (3) in subsection (e)(1)(B), by striking “sub-  
10          section (k)(3)” and inserting “subsection (l)(3)”;

11          (4) in subsection (l)(3)(H)(iii) (as so redesign-  
12          ated), by striking “or (p)” and inserting “or (q)”;

13          (5) in subsection (m) (as so redesignated), by  
14          striking “subsection (k)(3)” and inserting “sub-  
15          section (l)(3)”;

16          (6) in subsection (q) (as so redesignated), by  
17          striking “subsection (k)(3)(G)” and inserting “sub-  
18          section (l)(3)(G)”;

19          (7) in subsection (s)(2)(A) (as so redesignated),  
20          by striking “subsection (k)” each place that such ap-  
21          pears and inserting “subsection (l)”.

22   **SEC. 303. GRANT APPLICATION PROCESS.**

23          Section 330(k) of the Public Health Service Act (42  
24   U.S.C. 254b(k)) is amended by adding at the end the fol-  
25   lowing:

1 “(5) ECONOMIC VIABILITY OF APPLICANTS.—

2 “(A) IN GENERAL.—In considering appli-  
3 cations under this section, the Secretary shall  
4 ensure that an application that demonstrates  
5 economic viability, consistent with funding  
6 guidelines established by the Secretary for pur-  
7 poses of this section, is not disadvantaged in  
8 the evaluation process on the basis that it relies  
9 solely on Federal funding.

10 “(B) QUALIFICATION OF INDIVIDUALS RE-  
11 VIEWING APPLICATIONS.—The Secretary shall  
12 require verification that all individuals who are  
13 evaluating community health center grant appli-  
14 cations have completed within the 3-year period  
15 ending on the date on which the application is  
16 being evaluated a training course on the com-  
17 munity health center program which addresses  
18 the purposes served by community health cen-  
19 ters, the critical role of community health cen-  
20 ters in the safety net, expectations for the eval-  
21 uation of applications, and the criteria for  
22 awarding grant funding.

23 “(C) MEDICALLY UNDERSERVED DESIGNA-  
24 TIONS.—Not later than 6 months after the date  
25 of enactment of this paragraph, the Adminis-

1           trator of the Health Resources and Services Ad-  
2           ministration shall submit to the appropriate  
3           committees of Congress a report concerning the  
4           process for designating an area or population as  
5           medically underserved. Such report shall con-  
6           tain recommendations for ensuring that such  
7           designations are current within the last 3 years.  
8           The report shall also detail plans for ensuring  
9           subsequent review to maintain an accurate re-  
10          flection of community needs in areas and popu-  
11          lations designated as medically underserved.  
12          Not later than 1 year after such date of enact-  
13          ment, the Secretary shall promulgate regula-  
14          tions based on the recommendations contained  
15          in the report.”.

16       **Subtitle B—Qualified Integrated**  
17       **Health Care systems**

18       **SEC. 321. GRANTS TO QUALIFIED INTEGRATED HEALTH**  
19       **CARE SYSTEMS.**

20       (a) ELIGIBILITY FOR GRANTS UNDER PHSA.—Part  
21       D of title III of the Public Health Service Act (42 U.S.C.  
22       254b et seq.) is amended by adding at the end the fol-  
23       lowing new subpart:

1    **“Subpart XI—Promotion of Integrated Health Care**  
2    **Systems Serving Medically Underserved Populations**  
3    **“SEC. 340H. GRANTS TO QUALIFIED INTEGRATED HEALTH**  
4           **CARE SYSTEMS.**

5           “(a) DEFINITIONS.—For purposes of this section:

6               “(1) QUALIFIED INTEGRATED HEALTH CARE  
7           SYSTEM.—The term ‘qualified integrated health care  
8           system’ means an integrated health care system  
9           that—

10               “(A) has a demonstrated capacity and  
11           commitment to provide a full range of primary,  
12           specialty, and hospital care to a medically un-  
13           derserved population in both inpatient and out-  
14           patient settings, as appropriate;

15               “(B) is organized to provide such care in  
16           a coordinated fashion;

17               “(C) operates one or more integrated  
18           health centers meeting the requirements of sec-  
19           tion 340I;

20               “(D) meets the requirements of subsection  
21           (c)(3); and

22               “(E) agrees to use any funds received  
23           under this section to supplement and not to  
24           supplant amounts received from other sources  
25           for the provision of such care.

1           “(2)   MEDICALLY   UNDERSERVED   POPU-  
2   LATION.—The term ‘medically underserved popu-  
3   lation’ has the meaning given such term in section  
4   330(b)(3).

5           “(b) OPERATING GRANTS.—

6           “(1) AUTHORITY.—The Secretary may make  
7   grants to private nonprofit entities for the costs of  
8   the operation of qualified integrated health care sys-  
9   tems that provide primary, specialty, and hospital  
10   care to medically underserved populations.

11          “(2) AMOUNT.—

12               “(A) IN GENERAL.—The amount of any  
13   grant made in any fiscal year under paragraph  
14   (1) to an integrated health care system shall be  
15   determined by the Secretary (taking into ac-  
16   count the full range of care, including specialty  
17   services, provided by the system), but may not  
18   exceed the amount by which the costs of oper-  
19   ation of the system in such fiscal year exceed  
20   the total of—

21                   “(i) State, local, and other operational  
22                   funding provided to the system; and

23                   “(ii) the fees, premiums, and third-  
24                   party reimbursements which the system

1           may reasonably be expected to receive for  
2           its operations in such fiscal year.

3           “(B) PAYMENTS.—Payments under grants  
4           under paragraph (1) shall be made in advance  
5           or by way of reimbursement and in such install-  
6           ments as the Secretary finds necessary and ad-  
7           justments may be made for overpayments or  
8           underpayments.

9           “(C) USE OF NONGRANT FUNDS.—  
10          Nongrant funds described in clauses (i) and (ii)  
11          of subparagraph (A), including any such funds  
12          in excess of those originally expected, shall be  
13          used as permitted under this section, and may  
14          be used for such other purposes as are not spe-  
15          cifically prohibited under this section if such  
16          use furthers the objectives of the project.

17       “(c) APPLICATIONS.—

18           “(1) SUBMISSION.—No grant may be made  
19          under this section unless an application therefore is  
20          submitted to, and approved by, the Secretary. Such  
21          an application shall be submitted in such form and  
22          manner and shall contain such information as the  
23          Secretary shall prescribe.

24           “(2) DESCRIPTION OF NEED.—



1           “(A) IN GENERAL.—An application for a  
2           grant under subsection (b)(1) for an integrated  
3           health care system shall include—

4                   “(i) a description of the need for  
5                   health care services in the area served by  
6                   the integrated health care system;

7                   “(ii) a demonstration by the applicant  
8                   that the area or the population group to be  
9                   served by the applicant has a shortage of  
10                  personal health services; and

11                  “(iii) a demonstration that the health  
12                  care system will be located so that it will  
13                  provide services to the greatest number of  
14                  individuals residing in such area or in-  
15                  cluded in such population group.

16           “(B) DEMONSTRATIONS.—A demonstra-  
17           tion shall be made under clauses (ii) or (iii) of  
18           subparagraph (A) on the basis of the criteria  
19           prescribed by the Secretary under section  
20           330(b)(3) or on the basis of any other criteria  
21           which the Secretary may prescribe to determine  
22           if the area or population group to be served by  
23           the applicant has a shortage of personal health  
24           services.

1           “(C) CONDITION OF APPROVAL.—In con-  
2           sidering an application for a grant under sub-  
3           section (b)(1), the Secretary may require as a  
4           condition to the approval of such application an  
5           assurance that any integrated health center op-  
6           erated by the applicant will provide any re-  
7           quired primary health services and any addi-  
8           tional health services (as defined in section  
9           340I) that the Secretary finds are needed to  
10          meet specific health needs of the area to be  
11          served by the applicant. Such a finding shall be  
12          made in writing and a copy shall be provided to  
13          the applicant.

14          “(3) REQUIREMENTS.—The Secretary shall ap-  
15          prove an application for a grant under subsection  
16          (b)(1) if the Secretary determines that the entity for  
17          which the application is submitted is an integrated  
18          health care system (within the meaning of subsection  
19          (a)) and that—

20                 “(A) the primary, specialty, and hospital  
21                 care provided by the system will be available  
22                 and accessible in the service area of the system  
23                 promptly, as appropriate, and in a manner  
24                 which assures continuity;

1           “(B) the system is participating (or will  
2 participate) in a community consortium of safe-  
3 ty net providers serving such area (unless other  
4 such safety net providers do not exist in a com-  
5 munity, decline or refuse to participate, or place  
6 unreasonable conditions on their participation);

7           “(C) all of the centers operated by the sys-  
8 tem are accredited by a national accreditation  
9 body recognized by the Secretary;

10           “(D) the system will demonstrate its finan-  
11 cial responsibility by the use of such accounting  
12 procedures and other requirements as may be  
13 prescribed by the Secretary;

14           “(E) the system provides or will provide  
15 services to individuals who are eligible for med-  
16 ical assistance under title XIX of the Social Se-  
17 curity Act and to individuals who are eligible  
18 for assistance under title XXI of such Act;

19           “(F) the system—

20           “(i) has prepared a schedule of fees or  
21 payments for the provision of its services  
22 consistent with locally prevailing rates or  
23 charges and designed to cover its reason-  
24 able costs of operation and has prepared a  
25 corresponding schedule of discounts to be

1 applied to the payment of such fees or pay-  
2 ments, and which discounts are adjusted  
3 on the basis of the patient's ability to pay;

4 “(ii)(I) will assure that no patient will  
5 be denied health care services due to an in-  
6 dividual's inability to pay for such services;  
7 and

8 “(II) will assure that any fees or pay-  
9 ments required by the system for such  
10 services will be reduced or waived to enable  
11 the system to fulfill the assurance de-  
12 scribed in subclause (I); and

13 “(iii) has submitted to the Secretary  
14 such reports as the Secretary may require  
15 to determine compliance with this subpara-  
16 graph;

17 “(G) the system has established a gov-  
18 erning board that selects the services to be pro-  
19 vided by the center, approves the center's an-  
20 nual budget, approves the selection of a director  
21 for the center, and establishes general policies  
22 for the center;

23 “(H) the system has developed—

1 “(i) an overall plan and budget that  
2 meets the requirements of the Secretary;  
3 and

4 “(ii) an effective procedure for com-  
5 piling and reporting to the Secretary such  
6 statistics and other information as the Sec-  
7 retary may require relating to—

8 “(I) the costs of its operations;

9 “(II) the patterns of use of its  
10 services;

11 “(III) the availability, accessi-  
12 bility, and acceptability of its services;  
13 and

14 “(IV) such other matters relating  
15 to operations of the applicant as the  
16 Secretary may require;

17 “(I) the system will review periodically its  
18 service area to—

19 “(i) ensure that the size of such area  
20 is such that the services to be provided  
21 through the system (including any sat-  
22 ellite) are available and accessible to the  
23 residents of the area promptly and as ap-  
24 propriate;

1           “(ii) ensure that the boundaries of  
2           such area conform, to the extent prac-  
3           ticable, to relevant boundaries of political  
4           subdivisions, school districts, and Federal  
5           and State health and social service pro-  
6           grams; and

7           “(iii) ensure that the boundaries of  
8           such area eliminate, to the extent possible,  
9           barriers to access to the services of the  
10          system, including barriers resulting from  
11          the area’s physical characteristics, its resi-  
12          dential patterns, its economic and social  
13          grouping, and available transportation;

14          “(J) in the case of a system which serves  
15          a substantial proportion of individuals of lim-  
16          ited English-speaking ability, the system has—

17               “(i) developed a plan and made ar-  
18               rangements for providing services, to the  
19               extent practicable, in the predominant lan-  
20               guage or languages of such individuals and  
21               in the cultural context most appropriate to  
22               such individuals; and

23               “(ii) identified one or more individuals  
24               on its staff who are fluent in such pre-  
25               dominant language or languages and in

1 English and whose responsibilities shall in-  
2 clude providing guidance to such individ-  
3 uals and to other appropriate staff mem-  
4 bers with respect to cultural sensitivities  
5 and bridging linguistic and cultural dif-  
6 ferences;

7 “(K) the system maintains appropriate re-  
8 ferral relationships between its hospitals, its  
9 physicians with hospital privileges, and any in-  
10 tegrated health center operated by the system  
11 so that primary, specialty care, and hospital  
12 care is provided in a continuous and coordi-  
13 nated way; and

14 “(L) the system encourages persons receiv-  
15 ing or seeking health services from the system  
16 to participate in any public or private (includ-  
17 ing employer-offered) health programs or plans  
18 for which the persons are eligible, so long as the  
19 center, in complying with this paragraph, does  
20 not violate the requirements of subparagraph  
21 (F)(ii)(I).

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—

23 “(1) IN GENERAL.—There are authorized to be  
24 appropriated to carry out this section such sums as

1       may be necessary for each of fiscal years 2006  
2       through 2010.

3               “(2) FUNDING REPORT.—The Secretary shall  
4       annually prepare and submit to the appropriate com-  
5       mittees of Congress a report concerning the distribu-  
6       tion of funds under this section that are provided to  
7       meet the health care needs of medically underserved  
8       populations, and the appropriateness of the delivery  
9       systems involved in responding to the needs of the  
10      particular populations. Such report shall include an  
11      assessment of the relative health care access needs  
12      of the targeted populations and the rationale for any  
13      substantial changes in the distribution of funds.

14      “(e) RECORDS.—

15              “(1) IN GENERAL.—Each entity which receives  
16      a grant under subsection (b)(1) shall establish and  
17      maintain such records as the Secretary shall require.

18              “(2) AVAILABILITY.—Each entity which is re-  
19      quired to establish and maintain records under this  
20      subsection shall make such books, documents, pa-  
21      pers, and records available to the Secretary or the  
22      Comptroller General of the United States, or any of  
23      their duly authorized representatives, for examina-  
24      tion, copying, or mechanical reproduction on or off  
25      the premises of such entity upon a reasonable re-



1       quest therefore. The Secretary and the Comptroller  
2       General of the United States, or any of their duly  
3       authorized representatives, shall have the authority  
4       to conduct such examination, copying, and reproduc-  
5       tion.

6       “(f) AUDITS.—

7               “(1) IN GENERAL.—Each entity which receives  
8       a grant under this section shall provide for an inde-  
9       pendent annual financial audit of any books, ac-  
10      counts, financial records, files, and other papers and  
11      property which relate to the disposition or use of the  
12      funds received under such grant and such other  
13      funds received by or allocated to the project for  
14      which such grant was made. For purposes of assur-  
15      ing accurate, current, and complete disclosure of the  
16      disposition or use of the funds received, each such  
17      audit shall be conducted in accordance with gen-  
18      erally accepted accounting principles. Each audit  
19      shall evaluate—

20               “(A) the entity’s implementation of the  
21      guidelines established by the Secretary respect-  
22      ing cost accounting;

23               “(B) the processes used by the entity to  
24      meet the financial and program reporting re-  
25      quirements of the Secretary; and

1           “(C) the billing and collection procedures  
2           of the entity and the relation of the procedures  
3           to its fee schedule and schedule of discounts  
4           and to the availability of health insurance and  
5           public programs to pay for the health services  
6           it provides.

7           A report of each such audit shall be filed with the  
8           Secretary at such time and in such manner as the  
9           Secretary may require.

10          “(2) RECORDS.—Each entity which receives a  
11          grant under this section shall establish and maintain  
12          such records as the Secretary shall by regulation re-  
13          quire to facilitate the audit required by paragraph  
14          (1). The Secretary may specify by regulation the  
15          form and manner in which such records shall be es-  
16          tablished and maintained.

17          “(3) AVAILABILITY OF RECORDS.—Each entity  
18          which is required to establish and maintain records  
19          or to provide for an audit under this subsection shall  
20          make such books, documents, papers, and records  
21          available to the Secretary or the Comptroller Gen-  
22          eral of the United States, or any of their duly au-  
23          thorized representatives, for examination, copying, or  
24          mechanical reproduction on or off the premises of  
25          such entity upon a reasonable request therefore. The

1 Secretary and the Comptroller General of the United  
2 States, or any of their duly authorized representa-  
3 tives, shall have the authority to conduct such exam-  
4 ination, copying, and reproduction.

5 “(4) WAIVER.—The Secretary may, under ap-  
6 propriate circumstances, waive the application of all  
7 or part of the requirements of this subsection with  
8 respect to an entity.

9 **“SEC. 340I. INTEGRATED HEALTH CENTER.**

10 “(a) INTEGRATED HEALTH CENTER .—The term ‘in-  
11 tegrated health center’ means an health center that is op-  
12 erated by an integrated health care system and that serves  
13 a medically underserved population (as defined for pur-  
14 poses of section 330(b)(3)) by providing, either through  
15 the staff and supporting resources of the center or through  
16 contracts or cooperative arrangements—

17 “(1) required primary health services (as de-  
18 fined in subsection (b)(1)); and

19 “(2) as may be appropriate for particular cen-  
20 ters additional health services (as defined in sub-  
21 section (b)(2)) necessary for the adequate support of  
22 the primary health services required under para-  
23 graph (1);

24 for all residents of the area served by the center.

25 “(b) DEFINITIONS.—For purposes of this section:

1           “(1) REQUIRED PRIMARY HEALTH SERVICES.—

2           The term ‘required primary health services’ means—

3                   “(A) basic health services which, for pur-  
4           poses of this section, shall consist of—

5                           “(i) health services related to family  
6                   medicine, internal medicine, pediatrics, ob-  
7                   stetrics, or gynecology that are furnished  
8                   by physicians and where appropriate, phy-  
9                   sician assistants, nurse practitioners, and  
10                  nurse midwives;

11                           “(ii) diagnostic laboratory and  
12                  radiologic services;

13                           “(iii) preventive health services,  
14                  including—

15                                   “(I) prenatal and perinatal serv-  
16                   ices;

17                                   “(II) appropriate cancer screen-  
18                   ing;

19                                   “(III) well-child services;

20                                   “(IV) immunizations against vac-  
21                   cine-preventable diseases;

22                                   “(V) screenings for elevated  
23                   blood lead levels, communicable dis-  
24                   eases, and cholesterol;

1                   “(VI) pediatric eye, ear, and den-  
2                   tal screenings to determine the need  
3                   for vision and hearing correction and  
4                   dental care;

5                   “(VII) voluntary family planning  
6                   services; and

7                   “(VIII) preventive dental serv-  
8                   ices;

9                   “(iv) emergency medical services; and

10                  “(v) pharmaceutical services and  
11                  medication therapy management services  
12                  as may be appropriate for particular cen-  
13                  ters;

14                  “(B) referrals to providers of medical serv-  
15                  ices (including specialty and hospital care refer-  
16                  rals when medically indicated) and other health-  
17                  related services (including substance abuse and  
18                  mental health services);

19                  “(C) patient case management services (in-  
20                  cluding counseling, referral, and follow-up serv-  
21                  ices) and other services designed to assist  
22                  health center patients in establishing eligibility  
23                  for and gaining access to Federal, State, and  
24                  local programs that provide or financially sup-

1 port the provision of medical, social, housing,  
2 educational, or other related services;

3 “(D) services that enable individuals to use  
4 the services of the center (including outreach  
5 and transportation services and, if a substantial  
6 number of the individuals in the population  
7 served by a center are of limited English-speak-  
8 ing ability, the services of appropriate personnel  
9 fluent in the languages spoken by a predomi-  
10 nant number of such individuals); and

11 “(E) education of patients and the general  
12 population served by the center regarding the  
13 availability and proper use of health services.

14 “(2) ADDITIONAL HEALTH SERVICES.—The  
15 term ‘additional health services’ means services that  
16 are not included as required primary health services  
17 and that are appropriate to meet the health needs  
18 of the population served by the center involved. Such  
19 term may include—

20 “(A) behavioral and mental health and  
21 substance abuse services;

22 “(B) recuperative care services; and

23 “(C) environmental health services.

24 (b) COVERAGE UNDER THE MEDICARE PROGRAM.—

1 (1) PART B BENEFIT.—Section 1861(s)(2)(E)  
2 of the Social Security Act (42 U.S.C.  
3 1395x(s)(2)(E)) is amended—

4 (A) by striking “services and” and insert-  
5 ing “services,”; and

6 (B) by striking “services” the second place  
7 it appears and inserting “services, and inte-  
8 grated health center services”.

9 (2) DEFINITIONS.—Section 1861(aa) of the So-  
10 cial Security Act (42 U.S.C. 1395x(aa)) is  
11 amended—

12 (A) in the heading—

13 (i) by striking “SERVICES AND” and  
14 inserting “SERVICES,”; and

15 (ii) by striking “SERVICES” the sec-  
16 ond place it appears and inserting “SERV-  
17 ICES, AND INTEGRATED HEALTH CENTER  
18 SERVICES”;

19 (B) in paragraph (1)(B), by striking  
20 “paragraph (5))” and inserting “paragraph  
21 (7));

22 (C) by redesignating paragraphs (5), (6),  
23 and (7) as paragraphs (7), (8), and (9), respec-  
24 tively; and

1 (D) by inserting after paragraph (4) the  
2 following new paragraph:

3 “(5) The term ‘integrated health center services’  
4 means—

5 “(A) services of the type described in subpara-  
6 graphs (A) through (C) of paragraph (1); and

7 “(B) preventive primary health services that a  
8 center is required to provide under section 340I of  
9 the Public Health Service Act,

10 when furnished to an individual as an outpatient of an  
11 integrated health center, and for this purpose, any ref-  
12 erence to a rural health clinic or a physician described in  
13 paragraph (2)(B) is deemed a reference to an integrated  
14 health center or a physician at the center, respectively.

15 “(6) The term ‘integrated health center’ means a cen-  
16 ter that is operated by a qualified integrated health care  
17 system (as defined in section 340H(a)(1) of the Public  
18 Health Service Act that—

19 “(A) is receiving a grant under section 340H of  
20 such Act; or

21 “(B) is determined by the Secretary to meet the  
22 requirements for receiving such a grant.”.

23 (3) PAYMENT.—



1 (A) IN GENERAL.—Section 1832(a)(2)(D)  
2 of the Social Security Act (42 U.S.C.  
3 1395k(a)(2)(D)) is amended—

4 (i) by striking “and (ii)” and inserting  
5 “, (ii)”; and

6 (ii) by striking “services” the second  
7 place it appears and inserting “services,  
8 and (iii) integrated health center serv-  
9 ices.”.

10 (B) PART B DEDUCTIBLE DOES NOT  
11 APPLY.—Section 1833(b)(4) of the Social Secu-  
12 rity Act (42 U.S.C. 13951(b)(4)) is amended by  
13 inserting “or integrated health center services”  
14 after “Federally qualified health center serv-  
15 ices”.

16 (C) EXCLUSION FROM PAYMENT RE-  
17 MOVED.—The second sentence of section  
18 1862(a) of the Social Security Act (42 U.S.C.  
19 1395y(a)) is amended by inserting “or inte-  
20 grated health center services described in sec-  
21 tion 1861 (aa)(5)(B)” after “section  
22 1861(aa)(3)(B)”.

23 (D) WAIVER OF ANTI-KICKBACK RESTRIC-  
24 TION.—Section 1128B(b)(3)(D) of the Social  
25 Security Act (42 U.S.C. 1320a–7b(b)(3)(D)) is

1           amended by inserting “or by an integrated  
2           health center” after “Federally qualified health  
3           center”.

4           (4) CONFORMING AMENDMENTS.—(A) Clauses  
5           (ii) and (iv) of section 1834(a)(1)(E) of the Social  
6           Security Act (42 U.S.C. 1395m(a)(1)(E)) are each  
7           amended by striking “section 1861(aa)(5)” and in-  
8           serting “section 1861(aa)(7)”.

9           (B) Section 1842(b)(18)(C)(i) of the Social Se-  
10          curity Act (42 U.S.C. 1395u(b)(18)(C)(i)) is amend-  
11          ed by striking “section 1861(aa)(5)” and inserting  
12          “section 1861(aa)(7)”.

13          (C) Section 1861(s)(2) of the Social Security  
14          Act (42 U.S.C. 1395x(s)(2)) is amended—

15               (i) in subparagraph (H)(i), by striking  
16               “subsection (aa)(5)” and inserting “subsection  
17               (aa)(7)”; and

18               (ii) in subparagraph (K)—

19                       (I) by striking “subsection (aa)(5)”  
20                       each place it appears and inserting “sub-  
21                       section (aa)(7)”; and

22                       (II) by striking “subsection (aa)(6)”  
23                       and inserting “subsection (aa)(8)”.

24          (D) Section 1861(dd)(3)(B) of the Social Secu-  
25          rity Act (42 U.S.C. 1395x(dd)(3)(B)) is amended by

1 striking “subsection (aa)(5)” and inserting “sub-  
2 section (aa)(7)”.

3 (c) RECOGNITION UNDER MEDICAID.—

4 (1) COVERAGE.—Section 1905(a)(2) of the So-  
5 cial Security Act (42 U.S.C. 1396d(a)(2)) is  
6 amended—

7 (A) by striking “and (C)” and inserting “,  
8 (C)”;

9 (B) by inserting “, and

10 “(D) integrated health center services (as  
11 defined in subsection (1)(3)(A)) and any other  
12 ambulatory services offered by the integrated  
13 health center and which are otherwise included  
14 in the plan.” after “included in the plan” the  
15 second place it appears.

16 (2) DEFINITIONS.—Section 1905(l) of such Act  
17 (42 U.S.C. 1396d(l)) is amended by adding at the  
18 end the following:

19 “(3)(A) The term ‘integrated health center services’  
20 means services of the type described in subparagraphs (A)  
21 through (C) of section 1861(aa) when furnished to an in-  
22 dividual as a patient of an integrated health center and,  
23 for this purpose, any reference to a rural health clinic or  
24 a physician described in section 1861(aa)(2)(B) is deemed

1 a reference to an integrated health center or a physician  
2 at the center, respectively.

3 “(B) The term ‘integrated health center’ means a  
4 center that is operated by a qualified integrated health  
5 care system that—

6 “(i) is receiving a grant under section 340H of  
7 the Public Health Service Act; or

8 “(ii) is determined by the Secretary, based on  
9 the recommendations of the Administrator of the  
10 Centers for Medicare & Medicaid Services, to meet  
11 the requirements for receiving such a grant.”.

12 (3) PAYMENT.—Section 1902(a) of such Act  
13 (42 U.S.C. 1396a(a)) is amended—

14 (A) in paragraph (15), by inserting “and  
15 for services described in clause (D) of section  
16 1905(a)(2) in accordance with the provisions of  
17 subsection (cc)” after “subsection (bb)”; and

18 (B) by adding at the end the following:

19 “(cc) PAYMENT FOR SERVICES PROVIDED BY INTE-  
20 GRATED HEALTH CENTERS.—

21 “(1) IN GENERAL.—Beginning with fiscal year  
22 2006 with respect to services furnished on or after  
23 January 1, 2006, and each succeeding fiscal year,  
24 the State plan shall provide for payment for services  
25 described in section 1905(a)(2)(D) furnished by an

1 integrated health center in accordance with the pro-  
2 visions of this subsection.

3 “(2) FISCAL YEAR 2006.—Subject to paragraph  
4 (4), for services furnished on and after January 1,  
5 2006, during fiscal year 2006, the State plan shall  
6 provide for payment for such services in an amount  
7 (calculated on a per visit basis) that is equal to 100  
8 percent of the average of the costs of the center of  
9 furnishing such services during fiscal years 2004  
10 and 2005 which are reasonable and related to the  
11 cost of furnishing such services, or based on such  
12 other tests of reasonableness as the Secretary pre-  
13 scribes in regulations under section 1833(a)(3), or,  
14 in the case of services to which such regulations do  
15 not apply, the same methodology used under section  
16 1833(a)(3), adjusted to take into account any in-  
17 crease or decrease in the scope of such services fur-  
18 nished by the center during fiscal years 2004 and  
19 2005.

20 “(3) FISCAL YEAR 2007 AND SUCCEEDING FIS-  
21 CAL YEARS.—Subject to paragraph (4), for services  
22 furnished during fiscal year 2007 or a succeeding  
23 fiscal year, the State plan shall provide for payment  
24 for such services in an amount (calculated on a per  
25 visit basis) that is equal to the amount calculated for

1       such services under this subsection for the preceding  
2       fiscal year—

3               “(A) increased by the percentage increase  
4               in the MEI (as defined in section 1842(i)(3))  
5               for that fiscal year; and

6               “(B) adjusted to take into account any in-  
7               crease or decrease in the scope of such services  
8               furnished by the center during that fiscal year.

9               “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
10       MENT AMOUNT FOR NEW CENTERS.—In any case in  
11       which an entity first qualifies as an integrated  
12       health center after fiscal year 2006, the State plan  
13       shall provide for payment for services described in  
14       section 1905(a)(2)(D) furnished by the center in the  
15       first fiscal year in which the center so qualifies in  
16       an amount (calculated on a per visit basis) that is  
17       equal to 100 percent of the costs of furnishing such  
18       services during such fiscal year based on the rates  
19       established under this subsection for the fiscal year  
20       for other such centers located in the same or adja-  
21       cent area with a similar case load or, in the absence  
22       of such a center, in accordance with the regulations  
23       and methodology referred to in paragraph (2) or  
24       based on such other tests of reasonableness as the  
25       Secretary may specify. For each fiscal year following

1 the fiscal year in which the entity first qualifies as  
2 an integrated health center, the State plan shall pro-  
3 vide for the payment amount to be calculated in ac-  
4 cordance with paragraph (3).

5 “(5) ADMINISTRATION IN THE CASE OF MAN-  
6 AGED CARE.—

7 “(A) IN GENERAL.—In the case of services  
8 furnished by an integrated health center pursu-  
9 ant to a contract between the center and a  
10 managed care entity (as defined in section  
11 1932(a)(1)(B)), the State plan shall provide for  
12 payment to the center by the State of a supple-  
13 mental payment equal to the amount (if any) by  
14 which the amount determined under paragraphs  
15 (2), (3), and (4) exceeds the amount of the pay-  
16 ments provided under the contract.

17 “(B) PAYMENT SCHEDULE.—The supple-  
18 mental payment required under subparagraph  
19 (A) shall be made pursuant to a payment  
20 schedule agreed to by the State and the inte-  
21 grated health center, but in no case less fre-  
22 quently than every 4 months.

23 “(6) ALTERNATIVE PAYMENT METHODOLO-  
24 GIES.—Notwithstanding any other provision of this  
25 section, the State plan may provide for payment in

1 any fiscal year to an integrated health center for  
2 services described in section 1905(a)(2)(D) in an  
3 amount which is determined under an alternative  
4 payment methodology that—

5 “(A) is agreed to by the State and the cen-  
6 ter; and

7 “(B) results in payment to the center of an  
8 amount which is at least equal to the amount  
9 otherwise required to be paid to the center  
10 under this section.”.

11 (4) WAIVER PROHIBITED.—Section 1915(b) of  
12 the Social Security Act (42 U.S.C.1396n(b)) is  
13 amended in the matter preceding paragraph (1), by  
14 inserting “1902(cc),” after “1902(bb),”.

15 (d) PROTECTION AGAINST LIABILITY.—Section  
16 224(g) of the Public Health Service Act (42 U.S.C.  
17 233(g)) is amended—

18 (1) In paragraph (4), by striking “An entity”  
19 and inserting “Subject to paragraph (6), an entity”;  
20 and

21 (2) by adding at the end the following:

22 “(6) For purposes of this section—

23 “(A) a qualified integrated health care system  
24 receiving a grant under section 340H and any inte-  
25 grated health center operated by such system shall



1 be considered to be an entity described in paragraph  
2 (4); and

3 “(B) the provisions of this section shall apply to  
4 such system and centers in the same manner as such  
5 provisions apply to an entity described in such para-  
6 graph (4), except that—

7 “(i) notwithstanding paragraph (1)(B), the  
8 deeming of any system or center, or of an offi-  
9 cer, governing board member, employee, or con-  
10 tractor of such system or center, to be an em-  
11 ployee of the Public Health Service for purposes  
12 of this section shall apply only with respect to  
13 items and services that are furnished to a mem-  
14 ber of the underserved population served by the  
15 entity;

16 “(ii) notwithstanding paragraph (3), this  
17 paragraph shall apply only with respect to  
18 causes of action arising from acts or omissions  
19 that occur on or after January 1, 2006; and

20 “(iii) the Secretary shall make separate es-  
21 timates under subsection (k)(1) with respect to  
22 such systems and centers and entities described  
23 in paragraph (4) (other than such systems and  
24 centers), establish separate funds under sub-  
25 section (k)(2) with respect to such groups of

1 entities, and any appropriations under this sub-  
2 section for such systems and centers shall be  
3 separate from the amounts authorized by sub-  
4 section (k)(2).”.

5 (e) EFFECTIVE DATE.—The amendments made sub-  
6 sections (b) and (c) shall apply to items and services fur-  
7 nished on or after October 1, 2005.

8 **Subtitle C—Miscellaneous**  
9 **Provisions**

10 **SEC. 331. COMMUNITY HEALTH CENTER COLLABORATIVE**  
11 **ACCESS EXPANSION.**

12 Section 330 of the Public Health Service Act (42  
13 U.S.C. 254b) is amended by adding at the end the fol-  
14 lowing:

15 “(s) MISCELLANEOUS PROVISIONS.—

16 “(1) RULE OF CONSTRUCTION WITH RESPECT  
17 TO RURAL HEALTH CLINICS.—

18 “(A) IN GENERAL.—Nothing in this sec-  
19 tion shall be construed to prevent a community  
20 health center from contracting with a federally  
21 certified rural health clinic (as defined by sec-  
22 tion 1861(aa)(2) of the Social Security Act) for  
23 the delivery of primary health care services that  
24 are available at the rural health clinic to indi-  
25 viduals who would otherwise be eligible for free

1 or reduced cost care if that individual were able  
2 to obtain that care at the community health  
3 center. Such services may be limited in scope to  
4 those primary health care services available in  
5 that rural health clinic.

6 “(B) ASSURANCES.—In order for a rural  
7 health clinic to receive funds under this section  
8 through a contract with a community health  
9 center under paragraph (1), such rural health  
10 clinic shall establish policies to ensure—

11 “(i) nondiscrimination based upon the  
12 ability of a patient to pay; and

13 “(ii) the establishment of a sliding fee  
14 scale for low-income patients.”.

15 **SEC. 332. IMPROVEMENTS TO SECTION 340B PROGRAM.**

16 (a) ELIMINATION OF GROUP PURCHASING PROHIBI-  
17 TION FOR CERTAIN HOSPITALS.—Section 340B(a)(4)(L)  
18 of the Public Health Service Act (42 U.S.C.  
19 256b(a)(4)(L)) is amended—

20 (1) in clause (i), by adding “and” at the end;

21 (2) in clause (ii), by striking “; and” and in-  
22 serting a period; and

23 (3) by striking clause (iii).

24 (b) PERMITTING USE OF MULTIPLE CONTRACT  
25 PHARMACIES.—Section 340B f the Public Health Service

1 Act (42 U.S.C. 256b) is amended by adding at the end  
2 the following:

3 “(e) PERMITTING USE OF MULTIPLE CONTRACT  
4 PHARMACIES.—Nothing in this section shall be construed  
5 as prohibiting a covered entity from entering into con-  
6 tracts with more than one pharmacy for the provision of  
7 covered drugs, including a contract that—

8 “(1) supplements the use of an in-house phar-  
9 macy arrangement; or

10 “(2) requires the approval of the Secretary.”.

11 (c) IMPROVEMENTS IN PROGRAM ADMINISTRA-  
12 TION.—Section 340B of the Public Health Service Act (42  
13 U.S.C. 256b), as amended by subsection (b), is further  
14 amended by adding at the end the following:

15 “(f) IMPROVEMENTS IN PROGRAM ADMINISTRA-  
16 TION.—

17 “(1) IN GENERAL.—The Secretary shall pro-  
18 vide, from funds appropriated under paragraph (2),  
19 for improvements in the integrity and administration  
20 of the program under this section in order to pre-  
21 vent abuse and misuse of discounted prices made  
22 available under this section. Such improvements  
23 shall include the following:

24 “(A) The development of a system to verify  
25 the accuracy of information regarding covered

1 entities that is listed on the Internet website of  
2 the Department of Health and Human Services  
3 relating to this section.

4 “(B) The establishment of a third-party  
5 auditing system by which covered entities and  
6 manufacturers are regularly audited to ensure  
7 compliance with the requirements of this sec-  
8 tion.

9 “(C) The conduct of such audits under  
10 subsection (a)(5)(C) that supplement the audits  
11 conducted under subparagraph (B) as the Sec-  
12 retary determines appropriate and the imple-  
13 mentation of dispute resolution guidelines and  
14 other compliance programs.

15 “(D) The development of more detailed  
16 guidance regarding the definition of section  
17 340B patients and describing options for billing  
18 under the medicaid program under title XIX of  
19 the Social Security Act in order to avoid dupli-  
20 cative discounts.

21 “(E) The issuance of advisory opinions  
22 within defined time periods in response to ques-  
23 tions from manufacturers or covered entities re-  
24 garding the application of the requirements of  
25 this section in specific factual circumstances.

1           “(F) Insofar as the Secretary determines  
2           feasible, providing access through the Internet  
3           website of the Department of Health and  
4           Human Services on the prices for covered drugs  
5           made available under this section, but only in a  
6           manner (such as through the use of password  
7           protection) that limits such access to covered  
8           entities.

9           “(G) The improved dissemination of edu-  
10          cational materials regarding the program under  
11          this section to covered entities that are not cur-  
12          rently participating in such programs including  
13          regional educational sessions.

14          “(2) AUTHORIZATION OF APPROPRIATIONS.—  
15          There are authorized to be appropriated to carry out  
16          this subsection, such sums as may be necessary for  
17          fiscal year 2006 and each succeeding fiscal year.”.

18   **SEC. 333. FORBEARANCE FOR STUDENT LOANS FOR PHYSI-**  
19                   **CIANS PROVIDING SERVICES IN FREE CLIN-**  
20                   **ICS.**

21          (a) IN GENERAL.—Section 428(c)(3)(A) of the High-  
22          er Education Act of 1965 (20 U.S.C. 1078(c)(3)(A)) is  
23          amended—

24                  (1) in clause (i)—

1 (A) in subclause (III), by striking “or” at  
2 the end;

3 (B) in subclause (V), by adding “or” at  
4 the end; and

5 (C) by adding at the end the following:

6 “(V) is volunteering without pay  
7 for at least 80 hours per month at a  
8 free clinic as defined under section  
9 224 of the Public Health Service  
10 Act;”; and

11 (2) in clause (ii)(III), by inserting “or (i)(V)”  
12 after “clause (i)(III)”.

13 (b) PERKINS PROGRAM.—Section 464(e) of the High-  
14 er Education Act of 1965 (20 U.S.C. 1087dd(e)) is  
15 amended—

16 (1) in paragraph (1), by striking “or” at the  
17 end;

18 (2) in paragraph (2), by striking the period and  
19 inserting “; or”; and

20 (3) by adding at the end the following:

21 “(3) the borrower is volunteering without pay  
22 for at least 80 hours per month at a free clinic as  
23 defined under section 224 of the Public Health Serv-  
24 ice Act.”.

1   **SEC. 334. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

2                   **ACT RELATING TO LIABILITY.**

3           Section 224 of the Public Health Service Act (42  
4   U.S.C. 233) is amended—

5                   (1) in subsection (g)(1)—

6                           (A) in subparagraph (A)—

7                                   (i) in the first sentence, by striking  
8                                   “or employee” and inserting “employee, or  
9                                   (subject to subsection (k)(4)) volunteer  
10                                  practitioner”; and

11                                  (ii) in the second sentence, by insert-  
12                                  ing “and subsection (k)(4)” after “subject  
13                                  to paragraph (5)”; and

14                           (B) by adding at the end the following:

15                   “(I) For purposes of this subsection, the term ‘em-  
16   ployee’ shall include a health professional who volunteers  
17   to provide health-related services for an entity described  
18   in paragraph (4).”;

19                           (2) in subsection (k), by adding at the end the  
20                           following:

21                   “(4)(A) Subsections (g) through (m) apply with re-  
22   spect to volunteer practitioners beginning with the first  
23   fiscal year for which an appropriations Act provides that  
24   amounts in the fund under paragraph (2) are available  
25   with respect to such practitioners.



1       “(B) For purposes of subsections (g) through (m),  
2 the term ‘volunteer practitioner’ means a practitioner who,  
3 with respect to an entity described in subsection (g)(4),  
4 meets the following conditions:

5           “(i) The practitioner is a licensed physician or  
6 a licensed clinical psychologist.

7           “(ii) At the request of such entity, the practi-  
8 tioner provides services to patients of the entity, at  
9 a site at which the entity operates or at a site des-  
10 ignated by the entity. The weekly number of hours  
11 of services provided to the patients by the practi-  
12 tioner is not a factor with respect to meeting condi-  
13 tions under this subparagraph.

14           “(iii) The practitioner does not for the provision  
15 of such services receive any compensation from such  
16 patients, from the entity, or from third-party payors  
17 (including reimbursement under any insurance pol-  
18 icy or health plan, or under any Federal or State  
19 health benefits program).”;

20           (3) in subsection (o)(2)—

21           (A) in subparagraph (D), by striking  
22 clause (i) and inserting the following:

23           “(i) The health care practitioner may pro-  
24 vide the services involved as an employee of the  
25 free clinic, or may receive repayment from the

1 free clinic only for reasonable expenses incurred  
2 by the health care practitioner in the provision  
3 of the services to the individual.”; and

4 (B) by adding at the end the following:

5 “(G) The health care practitioner is providing  
6 the services involved as a paid employee of the free  
7 clinic.”; and

8 (4) in each of subsections (g), (i), (j), (k), (l),  
9 and (m), by striking “employee, or contractor” each  
10 place such term appears and inserting “employee,  
11 volunteer practitioner, or contractor”;

12 **SEC. 335. SENSE OF THE SENATE CONCERNING HEALTH**  
13 **DISPARITIES.**

14 It is the sense of the Senate that additional measures  
15 are needed to reduce or eliminate disparities in health care  
16 related to race, ethnicity, socioeconomic status, and geog-  
17 raphy that affect access to quality health care.