110TH CONGRESS
1ST SESSION

S. _____

To provide affordable, guaranteed private health coverage that will make Americans healthier and can never be taken away.

IN THE SENATE OF THE UNITED STATES

Mr. WYDEN introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To provide affordable, guaranteed private health coverage that will make Americans healthier and can never be taken away.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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(b) TABLE OF CONTENTS.—

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SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Americans want affordable, guaranteed private health coverage that makes them healthier and can never be taken away.

(2) American health care provides primarily ''sick care'' and does not do enough to prevent chronic illnesses like heart disease, stroke, and diabetes. This results in significantly higher health costs for all Americans.

(3) Staying as healthy as possible often requires an individual to change behavior and assume more personal responsibility for his or her health.

(4) Personal responsibility for one's health should include purchasing one's own private health care coverage.

(5) To accompany this new focus on staying healthy and personal responsibility, our government must guarantee that all Americans receive private affordable health coverage that can never be taken away.

(6) Financing this guarantee should be a shared responsibility between individuals, the Government, and employers.

(7) The $2,200,000,000,000 spent annually on American health care must be spent more effectively in order to meet this guarantee.

(8) This guarantee must include easier access to understandable information about the quality, cost, and effectiveness of health care providers, products, and services.

(9) The fact that businesses in the United States compete globally against businesses whose governments pay for health care, coupled with the aging of the American population and the explosive growth of preventable health problems, makes the status quo in American health care unacceptable.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADULT INDIVIDUAL.—The term ''adult individual'' means an individual who—

(A) is—

(i) age 19 or older;

(ii) a resident of a State;

(iii)(I) a United States citizen; or

(II) an alien with permanent residence;

(iv) not a dependent child; and

(v) not an alien unlawfully present in the United States; and

(B) in the case of an incarcerated individual, such an individual who is incarcerated for less than 1 month.

(2) ALIEN WITH PERMANENT RESIDENCE.—The term ''alien with permanent residence'' has the meaning given the term ''qualified alien'' in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641).

(3) COVERED INDIVIDUAL.—The term ''covered individual'' means an individual who is enrolled in a HAPI plan.

(4) DEPENDENT CHILD.—The term ''dependent child'' has the meaning given the term ''qualifying child'' in section 152(c) of the Internal Revenue Code of 1986.

(5) HAPI PLAN.—The term ''HAPI plan'' means a Healthy Americans Private Insurance plan described under subtitle B of title I.

(6) HHA.—The term ''HHA'' means the Health Help Agency of a State as described under title V.

(7) HEALTH INSURANCE ISSUER.—The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as de-

fined in paragraph (7)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(8) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(9) PERSONAL RESPONSIBILITY CONTRIBUTION.—The term ''personal responsibility contribution'' means a payment made by a covered individual to a health care provider or a health insurance issuer with respect to the provision of health care services under a HAPI plan, not including any health insurance premium payment.

(10) QUALIFIED COLLECTIVE BARGAINING AGREEMENT.—

(A) IN GENERAL.—The term ''qualified collective bargaining agreement'' means an agreement between a qualified collective bargaining employer and an employee organization that represents the employees of such employer that is in effect until the date that is the earlier of—

(i) January 1 of the first year which is more than 7 years after the date of enactment of this Act, or

(ii) the date the collective bargaining agreement expires.

(B) QUALIFIED COLLECTIVE BARGAINING EMPLOYER.—The term ''qualified collective bargaining employer'' means an employer who provides health insurance to employees under the terms of a collective bargaining agreement which is entered into before the date of the enactment of this Act.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(12) STATE.—The term ''State'' means each of the several States of the United States, the District

of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and other territories of the United States.

(13) STATE OF RESIDENCE.—The term ''State of residence'', with respect to an individual, means the State in which the individual has primary residence.

TITLE I—HEALTHY AMERICANS PRIVATE INSURANCE PLANS

Subtitle A—Guaranteed Private Coverage

SEC. 101. GUARANTEE OF HEALTHY AMERICANS PRIVATE INSURANCE COVERAGE.

Not later than the date that is 2 years after the date of enactment of this Act, each adult individual shall have the opportunity to purchase a Healthy Americans Private Insurance plan that meets the requirements of subtitle B, (referred to in this Act as ''HAPI plan'') for such individual and the dependent children of such individual.

SEC. 102. INDIVIDUAL RESPONSIBILITY TO ENROLL IN A HEALTHY AMERICANS PRIVATE INSURANCE PLAN.

(a) INDIVIDUAL RESPONSIBILITY.—

(1) ADULT INDIVIDUALS.—Each adult individual shall have the responsibility to enroll in a HAPI plan offered through the HHA of the adult individual's State of residence, unless the adult individual—

(A) provides evidence of receipt of coverage under, or enrollment in a health plan offered through—

(i) the Medicare program under title XVIII of the Social Security Act;

(ii) a health insurance plan offered by the Department of Defense;

(iii) an employee benefit plan through a former employer;

(iv) a qualified collective bargaining agreement;

(v) the Department of Veterans Affairs; or

(vi) the Indian Health Service; or

(B) is opposed to health plan coverage for religious reasons, including an individual who declines health plan coverage due to a reliance on healing using spiritual means through prayer alone.

(2) DEPENDENT CHILDREN.—Each adult individual shall have the responsibility to enroll each dependent child of the adult individual in a HAPI plan offered through the HHA of the adult individual's State of residence, unless the adult individual—

(A) provides evidence that the dependent child is enrolled in a health plan offered through a program described in paragraph (1)(A); or

(B) is described in paragraph (1)(B).

(3) VERIFICATION OF RELIGIOUS EXCEPTION.—Each State shall develop guidelines for determining and verifying the individuals who qualify for the exception under paragraph (1)(B).

(b) PENALTY FOR FAILURE TO PURCHASE COVERAGE.—

(1) PENALTY.—

(A) IN GENERAL.—In the case of an individual described in subparagraph (B), such individual shall be subject to a late enrollment penalty in an amount determined under subparagraph (C).

(B) INDIVIDUALS SUBJECT TO PENALTY.—An individual described in this subparagraph is an adult individual for whom there is a contin-

uous period of 63 days or longer, beginning on the applicable date (as defined in subparagraph (E)) and ending on the date of enrollment in a HAPI plan, during all of which the individual—

(i) was not covered under a HAPI plan or a health plan offered through a program described in paragraph (1)(A) of section 102(a); and

(ii) was not described in paragraph (1)(B) of such section.

(C) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The amount determined under this subparagraph for an individual is an amount equal to the sum of—

(I) the number of uncovered months multiplied by the weighted average of the monthly premium for HAPI plans of the same class of coverage as the individual's in the applicable coverage area (determined without regard to any subsidy under section 121); and

(II) 15 percent of the amount determined under subclause (I).

(ii) UNCOVERED MONTH DEFINED.—For purposes of this subsection, the term ''uncovered month'' means, with respect to an individual, any month beginning on or after the applicable date (as defined in subparagraph (E)) unless the individual can demonstrate that the individual—

(I) was covered under a HAPI plan or a health plan offered through a program described in paragraph (1)(A) of section 102(a) for any portion of such month; or

(II) was described in paragraph (1)(B) of such section for any portion of such month.

A month shall not be treated as an uncovered month if the individual has already paid a late enrollment penalty under this subsection for such month or if the individual was incarcerated for the entire month.

(D) PAYMENT.—Payment of any late enrollment penalty by an individual under this subsection shall be made to the HHA of the in-

dividual's State of residence under procedures established by the State.

(E) APPLICABLE DATE.—In this paragraph, the term ''applicable date'' means the earlier of—

(i) the day after the end of the State's first open enrollment period for HAPI plans (during which all adult individuals are eligible to enroll); and

(ii) the day after the end of the first enrollment period for a fallback HAPI plan in the State.

(2) WAIVER.—An HHA of a State may reduce or waive the amount of any late enrollment penalty applicable to an individual under this subsection if payment of such penalty would constitute a hardship (determined under procedures established by the State).

(3) ENFORCEMENT.—Each State shall determine appropriate mechanisms, which may not include revocation or ineligibility for coverage under a HAPI plan, to enforce the responsibility of each adult individual to purchase HAPI plan coverage for such individual and any dependent children of such individual under subsection (a).

(c) OTHER INSURANCE COVERAGE.—Nothing in this Act shall be construed to prohibit an individual from enrolling in a health insurance plan that is not a HAPI plan.

Subtitle B—Standards for Healthy Americans Private Insurance Coverage

SEC. 111. HEALTHY AMERICANS PRIVATE INSURANCE PLANS.

(a) OPTIONS.—A State HHA—

(1) shall require that at least 2 HAPI plans that comply with the requirements of subsection (b), be offered through the HHA to each individual in the State;

(2) may require the offering of 1 or more HAPI plans that include coverage for benefits, items, or services required by the State in addition to the standardized benefits, items, or services required under subsection (b) for HAPI plans if—

(A) such additional benefits, items, and services build upon the standardized benefits package;

(B) a list of such additional benefits, items, or services, and the prices applicable to such additional benefits, items, and services, is displayed in a manner that is separate from the

description of the standardized benefits, items, or services required under the plan under this section (and consistent with the manner in which such items are displayed by medigap policies) and that enables a consumer to identify such additional benefits, items, and services and the cost associated with such; and

(C) no premium subsidies are available under subtitle C for any portion of the premiums for a HAPI plan that are attributable to such additional benefits, items, or services; and

(3) may permit the offering of 1 or more actuarially equivalent HAPI plans through the HHA as provided for in subsection (c).

(b) STANDARDIZED COVERAGE REQUIREMENTS FOR HAPI PLANS.—

(1) IN GENERAL.—Each HAPI plan offered through an HHA shall—

(A) provide benefits for health care items and services that are actuarially equivalent or greater in value than the benefits offered as of January 1, 2007, under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, in-

cluding coverage of an initial primary care assessment and annual physical examinations;

(B) provide benefits for wellness programs and incentives to promote the use of such programs;

(C) provide coverage for catastrophic medical events that result in out-of-pocket costs for an individual or family if lifetime limits are exhausted;

(D) designate a health care provider, such as a primary care physician, nurse practitioner, or other qualified health provider, to monitor the health and health care of a covered individuals (such provider shall be known as the ''health home'' of the covered individual);

(E) ensure that, as part of the first visit with a primary care physician or the health home of a covered individual, such provider and individual determine a care plan to maximize the health of the individual through wellness and prevention activities;

(F) provide benefits for comprehensive disease prevention, early detection, disease management, and chronic condition management

that meets minimum standards developed by the Secretary;

(G) provide for the application of personal responsibility contribution requirements with respect to covered benefits in a manner that may be similar to the cost sharing requirements applied as of January 1, 2007, under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, except that no contributions shall be required for—

(i) preventive items or services; and

(ii) early detection, disease management, or chronic pain treatment items or services; and

(H) comply with the requirements of section 112.

(2) DETERMINATION OF BENEFITS BY SECRETARY.—Not later than 1 year after the date of enactment of this Act, the Secretary shall promulgate guidelines concerning the benefits, items, and services that are covered under paragraph (1).

(3) COVERAGE FOR FAMILY PLANNING.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a health insurance issuer shall make available supplemental coverage for abortion services that may be purchased in conjunction with enrollment in a HAPI plan or an actuarially equivalent healthy American plan.

(B) RELIGIOUS AND MORAL EXCEPTION.—Nothing in this paragraph shall be construed to require a health insurance issuer affiliated with a religious institution to provide the coverage described in subparagraph (A).

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit a HAPI plan from providing coverage for benefits, items, and services in addition to the coverage required under this subsection. No premium subsidies shall be available under subtitle C for any portion of the premiums for a HAPI plan that are attributable to such additional benefits, items, or services.

(c) ACTUARIALLY EQUIVALENT HEALTHY AMERICAN PLANS.—Each actuarially equivalent healthy American plan offered through an HHA shall—

(1) cover all treatments, items, services, and providers at least to the same extent as those covered under a HAPI plan that—

(A) shall include coverage for—

(i) preventive items and services (including well baby care and well child care and appropriate immunizations) and disease management services;

(ii) inpatient and outpatient hospital services;

(iii) physicians' surgical and medical services; and

(iv) laboratory and x-ray services; and

(B) may include additional supplemental benefits to the extent approved by the State and provided for in advance in the plan contract; and

(2) ensure that no personal responsibility contribution requirements are applied for prevention and chronic disease management benefits, items, or services.

(d) PREMIUMS AND RATING REQUIREMENTS.—

(1) CLASSES OF COVERAGE.—With respect to a HAPI plan, a health insurance issuer shall provide for the following classes of coverage:

(A) Coverage of an individual.

(B) Coverage of a married couple or domestic partnership (as determined by a State) without dependent children.

(C) Coverage of an adult individual with 1 or more dependent children.

(D) Coverage of a married couple or domestic partnership (as determined by a State) with 1 or more dependent children.

(2) DETERMINATIONS OF PREMIUMS.—With respect to each class of coverage described in paragraph (1), a health insurance issuer shall determine the premium amount for a HAPI plan using adjusted community rating principals, as described in paragraphs (3) and (4) established by the State. States may permit premium variations based only on geography, tobacco use, and family size. A State may determine to have no variation.

(3) REWARDS.—A State shall permit a health insurance issuer to provide premium discounts and other incentives to enrollees based on the participation of such enrollees in wellness, chronic disease management, and other programs designed to improve the health of the enrollees.

(4) LIMITATION.—A health insurance issuer shall not consider age, gender, industry, health sta-

tus, or claims experience in determining premiums under this subsection.

(e) APPLICATION OF STATE MANDATE LAWS.—State benefit mandate laws that would otherwise be applicable to HAPI plans shall be preempted.

SEC. 112. SPECIFIC COVERAGE REQUIREMENTS.

(a) IN GENERAL.—Each HAPI plan offered through a HHA shall—

(1) provide for increased portability through limitations on the application of preexisting condition exclusions, in a manner similar to that provided for under section 2701 of the Public Health Service Act (42 U.S.C. 300gg), as such section existed on the day before the date of enactment of this Act, except that the State shall develop procedures to ensure that preexisting exclusion limitations do not apply to new enrollees who had no applicable creditable coverage immediately prior to the first enrollment period;

(2) provide for the guaranteed availability of coverage to prospective enrollees in a manner similar to that provided for under section 2711 of the Public Health Service Act (42 U.S.C. 300gg–11), as such section existed on the day before the date of enactment of this Act;

(3) provide for the guaranteed renewability of coverage in a manner similar to that provided for under section 2712 of the Public Health Service Act (42 U.S.C. 300gg–12), as such section existed on the day before the date of enactment of this Act, except that the prohibition on market reentry provided for under such section shall be deemed to be 2 years;

(4) prohibit discrimination against individual enrollees and prospective enrollees based on health status in a manner similar to that provided for under section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1), as such section existed on the day before the date of enactment of this Act;

(5) provide coverage protections for enrollees who are mothers and newborns in a manner similar to that provided for under section 2704 of the Public Health Service Act (42 U.S.C. 300gg–3), as such section existed on the day before the date of enactment of this Act;

(6) provide for full parity in the application of certain limits to mental health benefits in a manner similar to that provided for under section 2705 of the Public Health Service Act (42 U.S.C. 300gg–4), as such section existed on the day before the date of enactment of this Act;

(7) provide coverage for reconstructive surgery following a mastectomy in a manner similar to that provided for under section 2706 of the Public Health Service Act (42 U.S.C. 300gg–5), as such section existed on the day before the date of enactment of this Act; and

(8) prohibit discrimination on the basis of genetic information, as provided for under subsection (b).

(b) GENETIC NONDISCRIMINATION.—

(1) PROHIBITION ON GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A HAPI plan shall not establish rules for the eligibility (including continued eligibility) of any individual to enroll in coverage under the plan based on genetic information (including information about a request for or receipt of genetic services by an individual or family member of such individual).

(2) PROHIBITION ON GENETIC INFORMATION IN SETTING PREMIUM RATES.—A HAPI plan shall not adjust premium or personal responsibility contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual (including information

about a request for or receipt of genetic services by an individual or family member of such individual).

(3) GENETIC TESTING.—

(A) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A HAPI plan shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

(i) limit the authority of a health care professional who is providing health care services with respect to an individual to request that such individual or a family member of such individual undergo a genetic test;

(ii) limit the authority of a health care professional who is employed by or affiliated with a HAPI plan and who is providing health care services to an individual as part of a bona fide wellness program to notify such individual of the availability of a genetic test or to provide information to such individual regarding such genetic test; or

(iii) authorize or permit a health care professional to require that an individual undergo a genetic test.

(c) GUIDELINES.—Not later than 1 year after the date of enactment of this Act, the Secretary shall develop guidelines for the application of the requirements of this section.

SEC. 113. UPDATING HEALTHY AMERICANS PRIVATE INSURANCE PLAN REQUIREMENTS.

(a) IN GENERAL.—The Secretary shall establish the Healthy America Advisory Committee (referred to in this section as the ''Advisory Committee'') to provide annual recommendations to the Secretary and Congress concerning modifications to the benefits, items, and services required under section 111(a)(1).

(b) COMPOSITION.—

(1) IN GENERAL.—The Advisory Committee shall be composed of 15 members to be appointed by the Comptroller General, of which—

(A) at least 1 such member shall be a health economist;

(B) at least 1 such member shall be an ethicist;

(C) at least 1 such member shall be a representative of health care providers, including nurses and other nonphysician providers;

(D) at least 1 such member shall be a representative of health insurance issuers;

(E) at least 1 such member shall be a health care consumer;

(F) at least 1 such member shall be a representative of the United States Preventive Services Task Force; and

(G) at least 1 such member shall be an actuary.

(2) GEOGRAPHIC BALANCE.—The Comptroller General shall ensure the geographic diversity of the members appointed under paragraph (1).

(c) TERMS, VACANCIES.—Members of the Advisory Committee shall be appointed for a term of 3 years and may be reappointed for 1 additional term. In appointing members, the Comptroller General shall stagger the terms of the initial members so that the terms of one-third of the members expire each year. Vacancies in the membership of the Advisory Committee shall not affect the Committee's ability to carry out its functions. The Comptroller General shall appoint an individual to fill the remaining

term of a vacant member within 2 months of being notified of such vacancy.

(d) COMPENSATION AND EXPENSES.—Each member of the Advisory Committee who is not otherwise employed by the United States Government shall receive compensation at a rate equal to the daily rate prescribed for GS-18 under the General Schedule under section 5332 of title 5, United States Code, for each day, including travel time, such member is engaged in the actual performance of duties as a member of the Committee. A member of the Advisory Committee who is an officer or employee of the United States Government shall serve without additional compensation. All members of the Advisory Committee shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties.

(e) ACTION BY SECRETARY.—Not later than December 31 of the second full calendar year following the date of enactment of this Act, and each December 31 thereafter, the Advisory Committee shall provide to Congress and the Secretary a report that—

(1) describes any recommendations for modifications to the benefits, items, and services that are required to be covered under a HAPI plan; and

(2) includes any recommendations to modify HAPI plans to improve the quality of life for United States citizens and to ensure that benefits in such plans are medically- and cost-effective.

(f) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Advisory Committee, except that section 14 of such Act shall not apply.

Subtitle C—Eligibility for Premium and Personal Responsibility Contribution Subsidies

SEC. 121. ELIGIBILITY FOR PREMIUM SUBSIDIES.

(a) INDIVIDUALS AND FAMILIES AT OR BELOW THE POVERTY LINE.—For any calendar year, in the case of a covered individual who is determined to have a modified adjusted gross income that is at or below 100 percent of the poverty line, as applicable to a family of the size involved, the covered individual is entitled under this section to an income-related premium subsidy equal to the basic premium subsidy amount.

(b) PARTIAL SUBSIDY FOR OTHER INDIVIDUALS AND FAMILIES.—

(1) IN GENERAL.—For any calendar year, in the case of a covered individual who is determined to have a modified adjusted gross income that is

greater than 100 percent of the poverty line, as applicable to a family of the size involved, but below the applicable percentage of the poverty line, as applicable to a family of the size involved, the covered individual is entitled under this section to an income-related premium subsidy equal to the basic premium subsidy amount reduced by the amount determined under paragraph (2).

(2) AMOUNT OF REDUCTION.—The amount of the reduction determined under this paragraph is the amount that bears the same ratio to the basic premium subsidy amount as—

(A) the excess of—

(i) such individual's modified adjusted gross income, over

(ii) an amount equal to 100 percent of the poverty line as applicable to a family of the size involved, bears to

(B) the excess of—

(i) an amount equal to the applicable percentage of the poverty line as applicable to a family of the size involved, over

(ii) an amount equal to 100 percent of the poverty line as applicable to a family of the size involved.

(3) APPLICABLE PERCENTAGE.—For purposes of this subsection, the applicable percentage is 400 percent.

(c) BASIC PREMIUM SUBSIDY AMOUNT.—For purposes of this section, the term ''basic premium subsidy amount'' means, with respect to any individual, the lesser of—

(1) the annual premium for the HAPI plan under which the individual is a covered individual; or

(2) the weighted average of the premium for HAPI plans of the same class of coverage (as described in section 111(d)(1)) as the individual's in the applicable coverage area.

(d) CHANGE IN STATUS NOTIFICATION.—

(1) IN GENERAL.—If an individual's modified adjusted income changes such that the individual becomes eligible or ineligible for a subsidy under this section, the individual shall report that change to the HHA of the individual's State of residence not more than 60 days after the change takes effect. If an individual reports the change within 60 days under the preceding sentence, the individual's HAPI plan coverage shall be deemed credible coverage for the purposes of maintaining coverage for preexisting conditions.

(2) ADJUSTMENT.—The HHA shall adjust the premium subsidy of such individual to take effect on the first month after the date of the notification under paragraph (1) for which the next premium payment would be due from the individual.

(e) CATASTROPHIC EVENT.—A State may develop mechanisms to ensure that covered individuals do not have a break in coverage due to a catastrophic financial event.

SEC. 122. ELIGIBILITY FOR PERSONAL RESPONSIBILITY CONTRIBUTION SUBSIDIES.

(a) FULL SUBSIDY.—To meet the eligibility requirements under subtitle B for an HHA, for any taxable year, in the case of a covered individual who is determined to have a modified adjusted gross income that is below 100 percent of the poverty line as applicable to a family of the size involved, an HHA shall provide to such an individual a subsidy equal to the full amount of any personal responsibility contributions applicable to such individual.

(b) PARTIAL SUBSIDY.—To meet the eligibility requirements under subtitle B for an HHA, for any taxable year, in the case of a covered individual who is determined to have a modified adjusted gross income that is at or above 100 percent of the poverty line as applicable to a family of the size involved, an HHA may provide to such an individual a subsidy equal to the part of the amount

of any personal responsibility contributions applicable to such individual.

SEC. 123. DEFINITIONS AND SPECIAL RULES.

(a) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—

(1) IN GENERAL.—In this subtitle, the term ''modified adjusted gross income'' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

(A) determined without regard to sections 86, 135, 137, 199, 221, 222, 911, 931, and 933 of such Code; and

(B) increased by—

(i) the amount of interest received or accrued during the taxable year which is exempt from tax under such Code; and

(ii) the amount of any social security benefits (as defined in section 86(d) of such Code) received or accrued during the taxable year.

(2) TAXABLE YEAR TO BE USED TO DETERMINE MODIFIED ADJUSTED GROSS INCOME.—In applying this subtitle to determine an individual's annual premiums, the covered individual's modified adjusted gross income shall be such income determined

using the individual's most recent income tax return or other information furnished to the Secretary by such individual, as the Secretary may require.

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

(c) OTHER PROCEDURES TO DETERMINE SUBSIDIES.—The Secretary shall promulgate regulations to be used by HHAs to calculate the premium subsidies under section 121 and personal responsibility subsidies under section 122 for individuals whose modified adjusted gross income described in subsection (a)(2) is significantly lower than the modified adjusted gross income of the year involved.

(d) SPECIAL RULE FOR UNLAWFULLY PRESENT ALIENS.—A health insurance issuer shall remit to the Federal Government any funding, including any subsidy payments, received by such issuer from the Federal Government on behalf of any adult alien who is unlawfully present in the United States.

(e) SPECIAL RULE FOR ALIENS.—The Secretary of Homeland Security may not extend or renew an alien's

eligibility for status in the United States or adjust the status of an alien in the United States if the alien owes—

(1) a premium payment for a HAPI plan that is past due; or

(2) a penalty incurred for failing to pay such a premium.

(f) NO DISCHARGE IN BANKRUPTCY.—In the case of any bankruptcy filed by or on behalf of any person after the date that is 2 years after the date of enactment of this Act, under title 11, United States Code, any penalty imposed with respect to such person for failure to pay a HAPI plan premium shall not be subject to discharge under such title.

Subtitle D—Wellness Programs

SEC. 131. REQUIREMENTS FOR WELLNESS PROGRAMS.

(a) DEFINITION.—In this Act, the term ''wellness program'' means a program that consists of a combination of activities that are designed to increase awareness, assess risks, educate, and promote voluntary behavior change to improve the health of an individual, modify his or her consumer health behavior, enhance his or her personal well-being and productivity, and prevent illness and injury.

(b) DISCOUNTS.—

(1) ELIGIBILITY.—With respect to a HAPI plan that is offered in a State that permits premium discounts for enrollees who participate in a wellness program, to be eligible to receive such a discount, the administrator of the wellness program, on behalf of the enrollee, shall certify in writing to the plan that—

(A)(i) the enrollee is participating in an approved wellness program; or

(ii) the dependent child of the enrollee is participating in an approved wellness program; and

(B) the wellness program meets the requirements of this subsection.

(2) REQUIREMENTS.—A wellness program meets the requirements of this paragraph if such program—

(A) is reasonably designed (as determined by the HAPI plan) to promote good health and prevent disease for program participants;

(B) has been approved by the HAPI plan for purposes of applying participation discounts;

(C) is offered to all enrollees in a HAPI plan regardless of health status;

(D) permits any enrollee for whom it is unreasonably difficult to meet the initial program standard for participation due to a medical condition (or for whom it is medically inadvisable to attempt) an opportunity to meet a reasonable alternative participation standard—

(i)(I) that is developed prior to enrollment of the enrollee; or

(II) that is developed in consultation with the enrollee after enrollment of the enrollee, after a determination has been made that the enrollee cannot safely meet the program participation standard; and

(ii) the availability of which is disclosed in the original documents relating to participation in the program;

(E) applies procedures for determining whether an enrollee is participating in a meaningful manner in the program, including procedures to determine if such participation is resulting in lifestyle changes that are indicative of an improved health outcome or outcomes; and

(F) meets any other requirements imposed by the HAPI plan.

(3) RELATION TO HEALTH STATUS.—Participation in a wellness program may not be used by a HAPI plan to make rate or discount determinations with respect to the health status of an enrollee.

(4) AVAILABILITY OF DISCOUNTS.—

(A) OFFERING OF ENROLLMENT.—A HAPI plan shall provide enrollees with the opportunity to participate in a wellness program (for purposes of qualifying for premium discounts) at least once each year.

(B) DETERMINATIONS.—Determinations with respect to the successful participation by an enrollee in a wellness program for purposes of qualifying for discounts shall be made by the HAPI plan based on a retrospective review of the scope of activities of the enrollee under the program. The HAPI plan may require a minimum level of successful participation in such a program prior to applying any premium discount.

(C) PARTICIPATION IN MULTIPLE PROGRAMS.—An enrollee may participate in multiple wellness programs to reach the maximum premium discount permitted by the HAPI plan under applicable State law.

(5) PERSONAL RESPONSIBILITY CONTRIBUTION DISCOUNT.—A HAPI plan may elect to provide discounts in the amount of the personal responsibility contribution that is required of an enrollee if the enrollee participates in an approved wellness program.

(c) EMPLOYER INCENTIVE FOR WELLNESS PROGRAMS.—For provisions relating to employers deducting the costs of offering wellness programs or worksite health centers see section 162(l) of the Internal Revenue Code of 1986.

TITLE II—HEALTHY START FOR CHILDREN

Subtitle A—Benefits and Eligibility

SEC. 201. GENERAL GOAL AND AUTHORIZATION OF APPROPRIATIONS FOR HAPI PLAN COVERAGE FOR CHILDREN.

(a) GENERAL GOAL.—It is the general goal of this Act to provide essential, good quality, affordable, and prevention-oriented health care coverage for all children in the United States.

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each fiscal year to enable the Secretary to provide assistance to States to enable such States to ensure that each child who is a member of a family with a modi-

fied adjusted gross income that is below 300 percent of the poverty line as applicable to a family of the size involved, who is not otherwise eligible for coverage as a dependent under a HAPI plan maintained by his or her parents, is covered under a HAPI plan provided through the State HHA.

(c) POLICIES AND PROCEDURES.—The Secretary shall develop policies and procedures to be applied by the States to identify children described in subsection (a) and to provide such children with coverage under a HAPI plan. States shall determine, in consultation with health insurance issuers, a separate class of coverage to assure affordable child coverage.

(d) DEFINITION.—In this title, the term ''child'' means an individual who is under the age of 19 years or, in the case of an individual in foster care, under the age of 21 years.

SEC. 202. COORDINATION OF SUPPLEMENTAL COVERAGE UNDER THE MEDICAID PROGRAM TO HAPI PLAN COVERAGE FOR CHILDREN.

(a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—The Secretary shall provide guidance to States and health insurance issuers that ensures that, after December 31 of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins, any child

covered under a HAPI plan provided through the State HHA continues to receive medical assistance under State Medicaid plans in a manner that—

(1) is provided in coordination with, and as a supplement to, the coverage provided the child under the HAPI plan in which the child is enrolled;

(2) does not supplant the child's coverage under a HAPI plan; and

(3) ensures that the child receives any items or services that are not available under the HAPI plan in which they are enrolled but that the child would have received under the Medicaid program of the State in which the child resides if the Healthy Americans Act had not been enacted, including items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) and provided in accordance with the requirements of section 1902(a)(43)).

(b) DEFINITION.—In this section, the term ''child'', in addition to the meaning given that term under section 201(d), includes any individual who would be considered a child under the Medicaid program of the State in which the individual resides.

Subtitle B—Service Providers

SEC. 211. INCLUSION OF PROVIDERS UNDER HAPI PLANS.

(a) IN GENERAL.—To ensure that children have access to health care in their communities, and that such care is provided to such children for no cost or on a reimbursable basis, a HAPI plan shall ensure that health care items and services may be obtained by such children from, at a minimum, the providers described in subsection (b) if available in the area involved.

(b) PROVIDERS DESCRIBED.—The providers described in this subsection include the following:

(1) A school-based health center (in accordance with section 212).

(2) A health center funded under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(3) A federally qualified health center.

(4) A rural health clinic under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(5) An Indian health service facility.

SEC. 212. USE OF, AND GRANTS FOR, SCHOOL-BASED HEALTH CENTERS.

(a) DEFINITION.—In this section, the term ''school-based health center'' means a health center that—

(1) is located within an elementary or secondary school facility;

(2) is operated in collaboration with the school in which such center is located;

(3) is administered by a community-based organization including a hospital, public health department, community health center, or nonprofit health care agency;

(4) at a minimum, provides to school-aged children—

(A) primary health care services, including comprehensive health assessments, and diagnosis and treatment of minor, acute, and chronic medical conditions and Healthy Start benefits;

(B) mental health services, including crisis intervention, counseling, and emergency psychiatric care at the school or by referral;

(C) the availability of services at the school when the school is open and 24-hour coverage through an on-call system with other providers to ensure access when the school or health center is closed;

(D) services through the use of a qualified and appropriately credentialed individual, including a nurse practitioner or physician assist-

ant, a mental health professional, a physician, and a health assistant; and

(E) by not later than January 1, 2010, an electronic medical record relating to the individual; and

(5) may provide optional preventive dental services, consistent with State licensure law, through the use of dental hygienists or dental assistants that provide preventive services such as basic oral exams, cleanings, and sealants.

(b) ACCESS TO SCHOOL-BASED HEALTH CENTERS.—

(1) IN GENERAL.—A school-based health center may provide services to students in more than 1 school if the school district or other supervising State entity determined that capacity and geographic location make such provision of services appropriate.

(2) ENROLLMENT.—Upon the enrollment of a student in a school with a school-based health center, the center will provide the student with the opportunity to enroll, after parental consent, to receive health care from the center.

(3) REIMBURSEMENT FOR SERVICES.—

(A) IN GENERAL.—A school-based health center may seek reimbursement from a third party payer if available, including a HAPI plan, if a child receives health care items or services through the center.

(B) USE OF FUNDS.—Amounts received from a third party payer under subparagraph (A) shall be allocated to the school-based health center that provided the care for which the reimbursement was provided for use by that center for providing additional health care items and services.

(c) DEVELOPMENTAL GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants to local school districts and communities for the establishment and operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a local school district or local community shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) SELECTION CRITERIA.—In awarding grants under this subsection, the Secretary shall give priority to—

(A) an applicant that will use amounts under the grant to establish a school-based health center in a medically underserved area, or an area for which there are extended distances between the school involved and appropriate providers of care for school-aged children in the geographic area involved;

(B) an applicant that will use amounts under the grant to establish a school-based health center in a school that serves students with the highest incidence of unmet medical and psycho-social needs; and

(C) an applicant that can demonstrate that State, local, or community partners, or any combination of such entities, have provided at least 50 percent of the funding for the school-based health center involved to ensure the ongoing operation of the center.

(4) USE OF FUNDS.—A grantee shall use amounts received under a grant under this subsection to establish and operate a school-based health center. Not less than 50 percent of the amounts received under the grant shall be used for the ongoing operations of the center.

(d) COVERAGE BY FEDERAL TORT CLAIMS ACT.—In providing health care items and services to students through a school-based health care center, a health care provider shall be deemed to be an employee of the government for purposes of the application of chapter 171 of title 28, United States Code (the Federal Tort Claims Act) if such provider was acting within the scope of his or her license.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each fiscal year to carry out this section.

TITLE III—BETTER HEALTH FOR OLDER AND DISABLED AMERICANS

Subtitle A—Assurance of Supplemental Medicaid Coverage

SEC. 301. COORDINATION OF SUPPLEMENTAL COVERAGE UNDER THE MEDICAID PROGRAM FOR ELDERLY AND DISABLED INDIVIDUALS.

(a) COORDINATION OF CARE.—The Secretary shall provide guidance to States and insurers that—

(1) takes into account the special health care needs of elderly and disabled individuals who are eligible for medical assistance under State Medicaid programs, particularly with respect to institutional-

ized care or home and community-based services; and

(2) ensures that, after December 31 of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins, each such individual continues to receive medical assistance under State Medicaid programs in a manner that—

(A) is provided in coordination with, and as a supplement to, the coverage provided the individual under the HAPI plans in which the individual is enrolled;

(B) does not supplant the individual's coverage under a HAPI plan; and

(C) ensures that the individual receives any items or services that are not available under the HAPI plan in which the individual is enrolled but that the individual would have received under the Medicaid program of the State in which the individual resides if the Healthy Americans Act had not been enacted.

(b) DEFINITIONS.—In this section—

(1) the term ''institutionalized care'' means the health care provided under the Medicaid plan of the State of residence of an elderly or disabled individual

who is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases (as such terms are defined for purposes of such plan); and

(2) the term ''home and community-based services'' means any services which may be offered under the Medicaid plan of the State of residence of an elderly or disabled individual under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or under subsection (c), (d), or (i) of section 1915 of such Act (42 U.S.C. 1396n).

Subtitle B—Empowering Individuals and States to Improve Long-Term Care Choices

SEC. 311. NEW, AUTOMATIC MEDICAID OPTION FOR STATE CHOICES FOR LONG-TERM CARE PROGRAM.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by adding at the end the following new section:

''STATE CHOICES FOR LONG-TERM CARE PROGRAM

''SEC. 1940. (a) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall permit a State to establish and operate under the State plan under this title (including such a plan operating under a state-

wide waiver under section 1115) a State Choices for Long-Term Care Program in accordance with this section.

''(b) PROGRAM REQUIREMENTS.—A program established under the authority of this section shall satisfy the following requirements:

''(1) INDIVIDUALIZED BENEFIT PACKAGE.—Each individual enrolled in the program shall be provided with long-term care coverage consisting of medical assistance for long-term care services that are provided according to the specific needs of the individual and that best reflect the individual's needs and preferences, based on a clinical assessment of the individual.

''(2) PERSONAL CASE MANAGERS.—Each individual enrolled in the program shall be provided with a personal case manager who shall assist the individual in—

''(A) determining the individual's needs and preferences for the long-term care services that are contained within the individual's benefit package, including the selection of the service providers for such services;

''(B) identifying community resources that are available to provide support for the individual; and

''(C) addressing issues related to ensuring the safety and quality of the long-term care services provided to the individual.

''(3) INFORMED CHOICE.—The program shall have procedures to ensure that each individual that is likely to satisfy the eligibility criteria established for the program under paragraph (6) who is discharged from a hospital or who resides in a nursing facility, intermediate care facility for the mentally retarded, or institution for mental diseases and who requires long-term care services is informed of the options available to the individual under the program for obtaining such services.

''(4) SELF-DIRECTED OPTION.—The program shall provide an individual enrolled in the program with the option to elect to plan and purchase the long-term care services that are contained in the individual's benefit package under the direction and control of the individual (or the individual's authorized representative), subject to an individualized budget developed for, and with the involvement of, the individual (or the individual's authorized representative).

''(5) EQUAL ACCESS TO INSTITUTIONAL CARE AND HOME AND COMMUNITY-BASED SERVICES.—The

program shall provide an individual enrolled in the program who, because of the individual's mental or physical condition, requires a level of care for long term care services that is above a level of care for such services that can appropriately be provided solely through home and community-based providers (as defined by the State and approved by the Secretary), with equal access to long-term care services provided through institutional facilities and long-term care services provided through home and community-based providers.

''(6) ELIGIBILITY; PRIORITIZATION OF NEED.—The program shall apply eligibility criteria for individuals desiring to enroll in the program that is established by the State and approved by the Secretary. The eligibility criteria established by the State shall—

''(A) require that an individual enrolled in the program—

''(i) be eligible for medical assistance under the State plan (or under a statewide waiver of such plan) for nursing facility services, services in an intermediate care facility for the mentally retarded, services in an institution for mental diseases, or

services provided under a home and community-based waiver approved for the State; and

''(ii) satisfy such other criteria as the State shall establish; and

''(B) be based on a strategy for prioritizing and allocating expenditures so that those individuals with the highest level of need for long-term care services are assured of receiving such services through an institutional facility or through a home and community-based provider, based on the individual's needs and preferences.

''(c) ADDITIONAL REQUIREMENTS.—A State may not establish and operate a program under this section unless it satisfies the following requirements:

''(1) AGREEMENT TO LIMIT FEDERAL EXPENDITURES .—

''(A) IN GENERAL.—The State agrees to an aggregate limit for a 5-year period for Federal payments under section 1903(a) for expenditures for medical assistance for long-term care services under the State plan and administrative expenditures related to the provision of such assistance.

"(B) CALCULATION OF AGGREGATE LIMIT.—The 5-year aggregate limit applicable to a State under subparagraph (A) shall be determined by the State and the Secretary based on the following:

"(i) HISTORICAL AND PROJECTED CASELOADS.—The historical and projected State caseloads (determined for a 5-year period, respectively) of individuals receiving nursing facility services, services in an intermediate care facility for the mentally retarded, services in an institution for mental diseases, or services provided under a home and community-based waiver approved for the State under the State plan, based on data from the Secretary, the Bureau of the Census, the Commissioner of Social Security, and such other sources as the Secretary may approve.

"(ii) HISTORICAL AND PROJECTED EXPENDITURES.—The historical and projected expenditures (determined for a 5-year period, respectively) for the services identified in clause (i). Projected expenditures shall be determined without regard to

the program established under this section and shall take into account the percentage change (if any) in the medical care component of the consumer price index for all urban consumers (U.S. city average) for each year of the period.

''(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the requirement for a State to incur State expenditures for medical assistance for long-term care services in order to be paid the Federal medical assistance percentage determined for the State for such expenditures (not to exceed the aggregate 5-year limit on Federal payments for such expenditures applicable under subparagraph (A)).

''(2) PLAN FOR CAPACITY BUILDING AND SKILLS ENHANCEMENT.—The State establishes a plan for building the capacity of the long-term care services system within the State, particularly with respect to the delivery of home and community-based services, and for enhancing the skill levels of the caregivers for individuals eligible for medical assistance for such services under the State plan.

''(3) DEDICATION OF PROGRAM SAVINGS FOR PREVENTION OR EARLY INTERVENTION SERVICES.—The State agrees that for each fiscal year in which the program is operated, the State will expend an amount equal to the State share of the expenditures that the State would have made under the State plan for providing medical assistance for long-term care services for individuals enrolled in the program but for the operation of such program, for the provision of prevention or early intervention services for nonenrolled individuals residing in the State who require a level of long-term care services that is below the level that individuals enrolled in the program require (regardless of whether such nonenrolled individuals are eligible for medical assistance under the State plan).

''(d) OPTION TO OPERATE PROGRAM THOUGH A MANAGED CARE PLAN.—A State may operate a program under this section through an arrangement on a capitated basis with a medicaid managed care organization (as defined in section 1903(m)(1)(A)).

''(e) INDEPENDENT EVALUATION AND REPORT.—

''(1) IN GENERAL.—The Secretary shall contract with a nongovernmental organization or aca-

demic institution to conduct an ongoing independent evaluation of the program that assesses—

''(A) the quality of the long-term care services provided under the program;

''(B) the cost-effectiveness of such services;

''(C) consumer satisfaction; and

''(D) the consistency and accuracy with which the prioritization of need criteria required under subsection (b)(6)(B) is applied.

''(2) BIENNIAL REPORTS.—The organization or institution conducting the evaluation required under this subsection shall submit biennial reports to the Secretary regarding the results of the evaluation.

''(f) DEFINITION OF LONG-TERM CARE SERVICES.—For purposes of this section, the term 'long-term care services' has the meaning given such term by a State establishing and operating a program under this section, subject to approval by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of enactment of this Act.

SEC. 312. SIMPLER AND MORE AFFORDABLE LONG-TERM CARE INSURANCE COVERAGE.

(a) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT MUST SATISFY QUALIFIED LONG-TERM CARE

PLAN REQUIREMENTS.—Section 7702B(b)(1)(A) (defining qualified long-term care insurance contract) is amended by inserting ''through a qualified long-term care plan'' after ''qualified long-term care services''.

(b) QUALIFIED LONG-TERM CARE PLAN.—Section 7702B is amended by adding at the end the following new subsection:

''(h) QUALIFIED LONG-TERM CARE PLAN.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care plan' means an insurance plan that meets the standards and requirements set forth in paragraph (2) (including the 2009 NAIC Model Regulation or 2009 Federal Regulation (as the case may be)) on or after the date specified in paragraph (5).

''(2) DEVELOPMENT OF STANDARDS AND REQUIREMENTS FOR QUALIFIED LONG-TERM CARE PLANS.—

''(A) IN GENERAL.—If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') adopts a model regulation (in this section referred to as the '2009 NAIC Model Regulation') to incorporate—

"(i) limitations on the groups or packages of benefits that may be offered under a long-term care insurance policy consistent with paragraphs (3) and (4),

"(ii) uniform language and definitions to be used with respect to such benefits,

"(iii) uniform format to be used in the policy with respect to such benefits, and

"(iv) other standards required by the Secretary of Health and Human Services

paragraph (1) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (5).

"(B) SECRETARIAL RESPONSIBILITY.—If the Association does not adopt the 2009 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation (in this section referred to as the '2009 Federal Regulation') and paragraph (1) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (5).

''(C) CONSULTATION.—In promulgating standards and requirements under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of long-term care insurance policies, consumer groups, long-term care insurance beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to insure balanced representation among the interested groups.

''(3) LIMITATIONS OF GROUPS OR PACKAGES OF BENEFITS.—The benefits under the 2009 NAIC Model Regulation or 2009 Federal Regulation shall provide—

''(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (4) and the requirements of the succeeding subparagraphs,

''(B) for identification of a core group of basic benefits common to all policies, and

''(C) that the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that

may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

''(4) SPECIFIC CONSIDERATIONS.—The benefits under paragraph (3) shall, to the extent possible—

''(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of November 5, 2008, and

''(B) balance the objectives of—

''(i) simplifying the market to facilitate comparisons among policies,

''(ii) avoiding adverse selection,

''(iii) providing consumer choice,

''(iv) providing market stability, and

''(v) promoting competition.

''(5) EFFECTIVE DATE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph shall be the date the State adopts the 2009 NAIC Model Regulation or 2009 Federal Regulation or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

''(B) REQUIRED STATE LEGISLATION.—In the case of a State which the Secretary identifies, in consultation with the Association, as—

''(i) requiring State legislation (other than legislation appropriating funds) in order for long-term care insurance policies to meet the 2009 NAIC Model Regulation or 2009 Federal Regulation, but

''(ii) having a legislature which is not scheduled to meet in 2009 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 2010. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.''.

(c) ADDITIONAL CONSUMER PROTECTIONS.—

(1) IN GENERAL.—Section 7702B(g)(1) (relating to consumer protection provisions) is amended—

(A) by striking subparagraph (A) and inserting the following new paragraph:

''(1) the requirements of the 1993 NAIC model regulation and model Act described in paragraph (2) and the 2000 NAIC model regulation and model Act described in paragraph (5),'',

(B) by striking ''and'' at the end of subparagraph (B),

(C) by striking the period at the end of subparagraph (C) and inserting '', and'', and

(D) by adding at the end the following new subparagraph:

''(D) the requirements relating to mandatory offer and information under paragraph (6).''.

(2) NAIC MODEL REGULATION AND ACT.—Section 7702B(g) is amended—

(A) by inserting ''1993 NAIC'' after ''REQUIREMENTS OF'' in the heading for paragraph (2),

(B) by redesignating paragraph (5) as paragraph (7), and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) REQUIREMENTS OF 2000 NAIC MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 6A (other than paragraph (5) thereof) and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (other than paragraph (7) thereof).

''(III) Sections 6C, 6D, 6E, and 7.

''(IV) Section 8 (other than sections 8F, 8G, 8H, and 8I thereof).

''(V) Sections 9, 11, 12, 14, 15, and 22.

''(VI) Section 23, including inaccurate completion of medical histories (other than paragraphs (1), (6), and (9) of section 23C).

''(VII) Sections 24 and 25.

''(VIII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(IX) Sections 29 and 30.

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Sections 6C and 6D.

''(II) The provisions of section 8 relating to contingent nonforfeiture benefits.

''(III) Sections 6F, 6G, 6H, 6J, 6K, and 7.

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.''.

(d) MANDATORY OFFER AND INFORMATION.—Section 7702B(g), as amended by subsection (c), is amended by inserting after paragraph (5) the following new paragraph:

''(6) MANDATORY OFFER AND INFORMATION.—The requirements of this paragraph are met if—

''(A) MANDATORY OFFER.—Any person who sells a long-term care insurance policy to an individual shall make available for sale to the individual a long-term care insurance policy with only the core group of basic benefits (described in subsection (h)(3)(B)).

''(B) INFORMATION.—Any person who sells a long-term care insurance policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 2009 NAIC Model Regulation or 2009 Federal Regulation.''.

(e) STATE REGULATION OF OUT-OF-STATE CONTRACTS.—Section 7702B is amended by adding at the end the following new subsection:

''(i) STATE REGULATION OF OUT-OF-STATE CONTRACTS.—Nothing in this section shall be construed so as to affect the right of any State to regulate long-term care insurance policies which, under the provisions of this section, are considered to be issued in another State.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts issued after December 31, 2008.

TITLE IV—HEALTHIER MEDICARE

Subtitle A—Authority to Adjust Amount of Part B Premium to Reward Positive Health Behavior

SEC. 401. AUTHORITY TO ADJUST AMOUNT OF MEDICARE PART B PREMIUM TO REWARD POSITIVE HEALTH BEHAVIOR.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j)(1) With respect to the monthly premium amount for months after December 2008, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designating a health home, and other behaviors determined appropriate by the Secretary.

''(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premiums to be paid under this part for the month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.''.

Subtitle B—Promoting Primary Care for Medicare Beneficiaries

SEC. 411. PRIMARY CARE SERVICES MANAGEMENT PAYMENT.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1807 the following new section:

''SEC. 1807A. PRIMARY CARE MANAGEMENT PAYMENT FOR COORDINATING CARE.

''(a) PAYMENT.—

''(1) IN GENERAL.—Not later than January 1, 2008, the Secretary, subject to paragraph (2), shall establish procedures for providing primary care and participating providers with a management fee (as determined appropriate by the Secretary, in consultation with the Medicare Payment Advisory Commission established under section 1805) that reflects the amount of time spent with a Medicare bene-

ficiary, and the family of such beneficiary, providing chronic care disease management services or other services in assisting in coordinating care.

''(2) REQUIREMENT FOR DESIGNATION AS HEALTH HOME.—The management fee under paragraph (1) shall not be provided to a primary care provider with respect to a Medicare beneficiary unless the provider has been designated (under procedures established by the Secretary) as the health home by the beneficiary.

''(b) DEFINITIONS.—In this section:

''(1) HEALTH HOME.—The term 'health home' means a health care provider that a Medicare beneficiary has designated to monitor the health and health care of the beneficiary.

''(2) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A, enrolled under part B, or both.

''(3) PRIMARY CARE PROVIDER.—

''(A) IN GENERAL.—The term 'primary care provider' means a primary care physician (as defined in subparagraph (B), a nurse practitioner (as defined in section 1861aa(5)(A)), or a physician assistant (as so defined).

''(B) PRIMARY CARE PHYSICIAN.—In subparagraph (A), the term 'primary care physician' means a physician, such as a family practitioner or internist, who is chosen by an individual to provide continuous medical care, who is able to give a wide range of care, including prevention and treatment, and who can refer the individual to a specialist.''.

Subtitle C—Chronic Care Disease Management

SEC. 421. CHRONIC CARE DISEASE MANAGEMENT.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 411, is amended by inserting after section 1807A the following new section:

''SEC. 1807B. CHRONIC CARE DISEASE MANAGEMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2008, the Secretary shall develop and implement a chronic care disease management program (in this section referred to as the 'program'). The program shall be designed to provide chronic care disease management to all Medicare beneficiaries with respect to at least the 5 most prevalent diseases within

the population of such beneficiaries (as determined by the Secretary).

''(2) DEVELOPMENT.—In developing and implementing the program under paragraph (1), the Secretary shall—

''(A) take into consideration—

''(i) the results of chronic care improvement programs conducted under section 1807, including the independent evaluations of such programs conducted under section 1807(b)(5) and any outcomes reports submitted under section 1807(e)(4)(A); and

''(ii) the results of the payments to primary care providers under section 1807A; and

''(B) consult individuals with expertise in chronic care disease management.

''(b) IDENTIFICATION AND ENROLLMENT.—The Secretary shall establish procedures for identifying and enrolling Medicare beneficiaries who may benefit from participation in the program.

''(c) CHRONIC CARE DISEASE MANAGEMENT PAYMENT FOR NON-PRIMARY CARE PHYSICIANS.—

''(1) IN GENERAL.—Under the program, a non-primary care physician shall receive a chronic care disease management payment if the physician serves the Medicare beneficiary by assuring the beneficiary receives appropriate and comprehensive care, including referral of the individual to specialists, and assuring the beneficiary receives preventive services.

''(2) AMOUNT OF PAYMENT.—The amount of the management payment under the program shall be an amount determined appropriate by the Secretary, in consultation with the Medicare Payment Advisory Commission established under section 1805. Such amount shall reflect the amount of time spent with a Medicare beneficiary, and the family of such beneficiary, providing chronic care disease management services.

''(d) DEFINITIONS.—In this section:

''(1) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A, enrolled under part B, or both.

''(2) NON-PRIMARY CARE PHYSICIAN.—The term 'non-primary care physician' means a physician who—

"(A) is not a primary care physician (as defined in section 1807A (b)(3)(B)); and

"(B) provides chronic care disease management services to a Medicare beneficiary under the program.".

SEC. 422. CHRONIC CARE EDUCATION CENTERS.

(a) ESTABLISHMENT.—The Secretary shall establish Chronic Care Education Centers.

(b) PURPOSE.—The Chronic Care Education Centers established under subsection (a) shall serve as clearinghouses for information on health care providers who have expertise in the management of chronic disease.

(c) USE OF CERTAIN INFORMATION.—In developing the information described in subsection (b), the Secretary shall utilize—

(1) information on the performance of providers in chronic disease demonstration projects and pay for performance efforts; and

(2) additional information determined appropriate by the Secretary.

Subtitle D—Part D Improvements

SEC. 431. NEGOTIATING FAIR PRICES FOR MEDICARE PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by strik-

ing subsection (i) (relating to noninterference) and by inserting the following:

''(i) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—

''(1) IN GENERAL.—Subject to paragraph (4), in order to ensure that beneficiaries enrolled under prescription drug plans and MA–PD plans pay the lowest possible price, the Secretary shall have authority similar to that of other Federal entities that purchase prescription drugs in bulk to negotiate contracts with manufacturers of covered part D drugs, consistent with the requirements and in furtherance of the goals of providing quality care and containing costs under this part.

''(2) MANDATORY RESPONSIBILITIES.—The Secretary shall be required to—

''(A) negotiate contracts with manufacturers of covered part D drugs for each fallback prescription drug plan under subsection (g); and

''(B) participate in negotiation of contracts of any covered part D drug upon request of an approved prescription drug plan or MA–PD plan.

''(3) RULE OF CONSTRUCTION.—Nothing in paragraph (2) shall be construed to limit the authority of the Secretary under paragraph (1) to the mandatory responsibilities under paragraph (2).

''(4) NO PARTICULAR FORMULARY OR PRICE STRUCTURE.—In order to promote competition under this part and in carrying out this part, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

''(5) USE OF SAVINGS TO REDUCE COVERAGE GAP.—The Secretary shall establish a process for using the savings to the Medicare Prescription Drug Account through the use of the authority provided under this subsection (including the mandatory responsibilities under paragraph (2)) to reduce the coverage gap under section 1860D–2.''.

(b) CONFORMING AMENDMENT.—Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended in the matter preceding paragraph (1) by striking ''For purposes'' and inserting ''Subject to section 1860D–11(i)(5), for purposes''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 432. PROCESS FOR INDIVIDUALS ENTERING THE MEDICARE COVERAGE GAP TO SWITCH TO A PLAN THAT PROVIDES COVERAGE IN THE GAP.

(a) PROCESS.—Notwithstanding any other provision of law, by not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a process under which an applicable individual may terminate enrollment in the prescription drug plan or the MA–PD plan in which they are enrolled and enroll in any prescription drug plan or MA–PD plan—

(1) that provides some coverage of covered part D drugs (as defined in subsection (e) of section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102)) after the individual has reached the initial coverage limit under the plan but has not reached the annual out-of-pocket threshold under subsection (b)(4)(B) of such section; and

(2) subject to subsection (b), that serves the area in which the individual resides.

(b) SPECIAL RULE PERMITTING APPLICABLE INDIVIDUALS TO ENROLL IN A PRESCRIPTION DRUG PLAN OUTSIDE OF THE REGION IN WHICH THE INDIVIDUAL RESIDES.—In the case of an applicable individual who resides in a PDP region under section 1860D–11(a)(2) of

the Social Security Act (42 U.S.C. 1395w–111(a)(2)) in which there is no prescription drug plan available that provides some coverage of brand name covered part D drugs (as so defined) after the individual has reached the initial coverage limit under the plan but before the individual has reached such annual out-of-pocket threshold, the Secretary shall ensure that the process established under subsection (a) permits the individual to enroll in a prescription drug plan that provides such coverage but is in another PDP region. The Secretary shall determine the PDP region in which the individual may enroll in such a prescription drug plan.

(c) NOTIFICATION OF APPLICABLE INDIVIDUALS.—Under the process established under subsection (a), the Secretary shall notify, or require sponsors of prescription drug plans and organizations offering MA–PD plans to notify, applicable individuals of the option to change plans under such process. Such notice shall be provided to an applicable individual within 30 days of meeting the definition of such an individual.

(d) PROCESS IN EFFECT THROUGH 2012.—The process established under subsection (a) shall remain in effect through December 31, 2012.

(e) DEFINITIONS.—In this section:

(1) APPLICABLE INDIVIDUAL.—The term ''applicable individual'' means a part D eligible individual (as defined in section 1860D–1(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–101(a)(3)(A)) who, with respect to a year—

(A) is enrolled in a prescription drug plan or an MA–PD plan that does not provide any coverage of covered part D drugs (as so defined) after the individual has reached the initial coverage limit under the plan but has not reached such annual out-of-pocket threshold; and

(B) has reached such initial coverage limit or is within $750 of reaching such limit.

(2) PRESCRIPTION DRUG PLAN; MA–PD PLAN.—The terms ''prescription drug plan'' and ''MA–PD plan'' have the meanings given those terms in section 1860D–41(a)(14) of the Social Security Act (42 U.S.C. 1395w–151(a)(14)) and section 1860D–1(a)(3)(C) of such Act (42 U.S.C. 1395w–101(a)(3)(C)), respectively.

Subtitle E—Improving Quality in Hospitals for All Patients

SEC. 441. IMPROVING QUALITY IN HOSPITALS FOR ALL PATIENTS.

(a) IMPROVING HEALTHCARE QUALITY FOR ALL PATIENTS.—

(1) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (V) the following new subparagraph:

''(W) in the case of hospitals, to demonstrate to accrediting bodies measurable improvement in quality control with respect to all patients and to have in place quality control programs that are directed at care for all patients and that include—

''(i) rapid response teams that can assist patients with unstable vital signs;

''(ii) heart attack treatments with proven reliability;

''(iii) procedures that reduce medication errors;

''(iv) aggressive infection prevention, with special focus on surgeries and infections with the highest death rates;

''(v) procedures that reduce the threat of pneumonia, with special focus on the incidence of ventilator-related illness; and

''(vi) such other elements as the Secretary determines appropriate.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to hospitals as of the date that is 2 years after the date of enactment of this Act.

(b) PANEL OF INDEPENDENT EXPERTS.—Beginning not later than the date that is 2 years after the date of enactment of this Act, in order to ensure that hospitals practice state-of-the-art quality control, the Secretary shall convene a panel of independent experts to update the measures of quality control and the types of quality control programs, including the elements of such programs, required under section 1866(a)(1)(W) of the Social Security Act, as added by subsection (a), not less frequently than on an annual basis.

Subtitle F—End-of-Life Care Improvements

SEC. 451. PATIENT EMPOWERMENT AND FOLLOWING A PATIENT'S HEALTH CARE WISHES.

(a) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 441(a), is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by striking the period at the end and inserting '', and''; and

(3) by inserting after subparagraph (W) the following new subparagraph:

''(X) to provide each patient with a document designed to promote patient autonomy by documenting the patient's treatment preferences (and coordinating these preferences with physician orders) that at a minimum—

''(i) transfers with the patient from one setting to another;

''(ii) provides a summary of treatment preferences in multiple scenarios by the patient or the patient's guardian and a physician or other practitioner's order for care;

''(iii) is easy to read in an emergency situation;

''(iv) reduces repetitive activities in complying with the Patient Self Determination Act;

''(v) ensures that the use of the document is voluntary by the patient or the patient's guardian;

''(vi) is easily accessible in a patient's medical chart; and

''(vii) does not supplant State health care proxy, living wills, or other end-of-life care forms.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to entities as of the date that is 2 years after the date of enactment of this Act.

SEC. 452. PERMITTING HOSPICE BENEFICIARIES TO RECEIVE CURATIVE CARE.

(a) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(4), by striking ''in lieu of certain other benefits,''; and

(2) in subsection (d)—

(A) in paragraph (1), by striking ''instead of certain other benefits under this title''; and

(B) in paragraph (2)(A), by striking ''to be—'' and all that follows before the period and inserting ''to be equivalent to (or duplicative of) hospice care''.

(b) CONFORMING AMENDMENT.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of enactment of this Act.

SEC. 453. PROVIDING BENEFICIARIES WITH INFORMATION REGARDING END-OF-LIFE CARE CLEARINGHOUSE.

Section 1804 of the Social Security Act (42 U.S.C. 1395b–2) is amended—

(1) in the heading, by inserting ''; END-OF-LIFE CARE INFORMATION'' after ''INFORMATION''; and

(2) by adding at the end the following new subsection:

''(d) Not later than 1 year after the date of enactment of the Healthy Americans Act, the Secretary shall establish procedures to ensure that each individual, at the time the individual applies for benefits under part A or enrolls under part B, is provided with contact information

for the clearinghouse described in section 454 of such Act.''.

SEC. 454. CLEARINGHOUSE.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall provide for the establishment of a national, toll-free, information clearinghouse that the public may access to find out about State-specific information regarding advance directive and end-of-life care decisions. If the Secretary determines that such a clearinghouse exists and is administered by a not-for-profit organization and meets standards developed by the Secretary to assure the easy access of the public to State-specific information and forms concerning advance directives and end-of-life care decisions through the Internet and a national toll free information line, the Secretary shall support such clearinghouse.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for fiscal year 2007 and each subsequent fiscal year to carry out this section.

Subtitle G—Additional Provisions

SEC. 461. ADDITIONAL COST INFORMATION.

(a) IN GENERAL.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) ADDITIONAL COST INFORMATION.—A contract under this section shall require a Medicare Advantage Organization to aggregate claims information into episodes of care and to provide such information to the Secretary so that costs for specific hospitals and physicians may be measured and compared. The Secretary shall make such information public on an annual basis.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contracts entered into on or after the date of enactment of this Act.

SEC. 462. REDUCING MEDICARE PAPERWORK AND REGULATORY BURDENS.

Not later than 18 months after the date of enactment of this Act, the Secretary shall provide to Congress a plan for reducing regulations and paperwork in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such plan shall focus initially on regulations that do not directly enhance the quality of patient care provided under such program.

TITLE V—STATE HEALTH HELP AGENCIES

SEC. 501. ESTABLISHMENT.

As a condition of receiving payment under section 503, a State shall, not later than the date that is 2 years

after the date of enactment of this Act, establish or designate a State agency, to be known as the State ''Health Help Agency'' (referred to in this Act as a ''HHA'') to—

(1) carry out the administration of HAPI plans to individuals in such State; and

(2) carry out the functions described in section 502.

SEC. 502. RESPONSIBILITIES AND AUTHORITIES.

(a) PROMOTION OF PREVENTION AND WELLNESS.—Each HHA shall promote prevention and wellness for all State residents, including through the implementation of programs that—

(1) educate residents about responsibility for individual health and the health of children;

(2) upon request, distribute information to covered individuals regarding the availability of wellness programs;

(3) make available to the public, with respect to each health insurance issuer and each HAPI plan, the number of covered individuals who have designated a health home described in section 111(b); and

(4) promote the use and understanding of health information technology.

(b) ENROLLMENT OVERSIGHT.—Each HHA shall oversee enrollment in HAPI plans by—

(1) providing standardized, unbiased information on HAPI plans and supplemental health insurance options;

(2) not less than once per year, administering open enrollment periods for individuals;

(3) allowing a covered individual to make enrollment changes during a 30-day period following marriage, divorce, birth, adoption or placement for adoption, and other circumstances;

(4) establish procedures for health insurance issuers to report to the HHA of each State in which the issuer offers a HAPI plan, the health insurance status of State residents in order for the HHA to report annual on the number of uninsured and other relevant data;

(5) establish procedures for default enrollment of uninsured individuals into low-cost HAPI plans for individuals or families who do not enroll, are not covered under a health plan offered through a program described in paragraphs (1)(A) of section 102(a), and are not described in paragraph (1)(B) of such section;

(6) establish procedures for hospitals and other providers to report to the HHA if an individual seeks care and is uninsured or does not know his or her health insurance status;

(7) ensure that the enrollment of all individuals into HAPI plans, including those individuals assisted by an employer, insurance agent, or other person, is administered by the HHA;

(8) develop standardized language for HAPI plan terms and conditions and require participating health insurance issuers to use such language in plan information documents;

(9) provide prospective enrollees with a comparative document that describes all the HAPI plans in which the individual may enroll; and

(10) to assist consumers in choosing a HAPI plan, publish information that includes loss ratios, outcome data regarding wellness programs, disease detection and chronic care management programs categorized by health insurance issuer, and other data as the HHA determines appropriate.

(c) DETERMINATION AND ADMINISTRATION OF HAPI PLAN SUBSIDIES.—Each HHA shall oversee the determination and administration of HAPI plan subsidies by—

(1) informing State residents about how subsidy eligibility determinations are made;

(2) obtaining necessary information about income from individuals and Federal and State agencies;

(3) making eligibility determinations on an individual basis and informing individuals of such determinations;

(4) establishing a process by which an individual may appeal an eligibility determination;

(5) collecting from health insurance issuers an administrative fee for joining the HHA system and offering a HAPI plan in a State;

(6) collecting premium payments made by, or on behalf of, covered individuals, and remitting such payments to the HAPI plans; and

(7) collecting Federal premium subsidies for covered individuals and remitting such subsidies to HAPI plans.

(d) PREMIUM RATING RULES.—Each HHA shall ensure that the premium payments for each HAPI plan are determined in accordance with the rating rules described in section 111(d).

(e) EMPOWERMENT OF INDIVIDUALS TO MAKE HEALTH CARE DECISIONS.—Each HHA shall, upon en-

rollment of an individual in a HAPI plan, provide such individual with information regarding—

(1) the right of individuals to refuse treatment and to make end-of-life care decisions;

(2) State laws relating to end-of-life care, including applicable State law with respect to health care proxies, advanced directives, living wills, and other documentation by which individuals may make their care decisions known;

(3) contact information for any State end-of-life care advocates; and

(4) applicable State forms on health proxies, advanced directives, living wills, and other such documentation.

(f) DETERMINATION OF PLAN COVERAGE AREAS.—Each HHA shall establish, and may revise, HAPI plan coverage areas for the State in which the HHA is located. The service area of a HAPI plan shall consist of an entire coverage area established under the preceding sentence.

(g) COOPERATION AMONG STATES.—States that share 1 or more metropolitan statistical area may enter into agreements to share administrative responsibilities described under this section.

(h) TRANSITION FROM MEDICAID AND SCHIP; COORDINATION OF SUPPLEMENTAL MEDICAL ASSISTANCE

FOR ELDERLY AND DISABLED MEDICAID ELIGIBLES.—Each HHA shall work with the Secretary to ensure that the requirements of section 301 of this Act, section 1941 of the Social Security Act (as added by section 673(a) of this Act), and subsections (a) and (b) of section 1940 of the Social Security Act (as added by section 311 of this Act) are met.

SEC. 503. APPROPRIATIONS FOR TRANSITION TO STATE HEALTH HELP AGENCIES.

(a) APPROPRIATION.—There is authorized to be appropriated and there is appropriated, for each of the 2 full fiscal years immediately following the date of enactment of this Act, such sums as may be necessary for the purpose of enabling each State to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States that have submitted, and had approved by the Secretary, an HHA plan under this section.

(b) SUBMISSION OF STATE HHA PLAN.—Each HHA plan submitted by a State shall provide for—

(1) the establishment of an HHA within such State by the date that is 2 years after the date of enactment of this Act;

(2) the administration by with State of such HHA in accordance with the requirements described under this Act; and

(3) the compliance by the State of the requirements described under section 631.

(c) PAYMENT TO STATES.—From the sums appropriated under subsection (a), the Secretary shall pay to each State that has an HHA plan approved under this section, an amount necessary for the State to implement such plan for the applicable fiscal year.

TITLE VI—SHARED RESPONSIBILITIES

Subtitle A—Individual Responsibilities

SEC. 601. INDIVIDUAL RESPONSIBILITY TO ENSURE HAPI PLAN COVERAGE.

(a) OPEN SEASON.—An adult individual, on behalf of such individual and the dependent children of such individual, shall—

(1) enroll in a HAPI plan through the HHA of the individual's State of residence during an open enrollment period; and

(2) submit necessary documentation to the applicable HHA so that such HHA may determine in-

dividual eligibility for premium and personal responsibility contribution subsidies.

An adult individual may carry out the activities described under paragraphs (1) and (2) on behalf of the spouse of such adult individual.

(b) DURING PLAN YEAR.—A covered individual shall—

(1) submit any required monthly premium payments;

(2) submit any personal responsibility contributions as required; and

(3) inform such HHA of any changes in the family status or residence of such individual.

Subtitle B—Employer Responsibilities

SEC. 611. HEALTH CARE RESPONSIBILITY PAYMENTS.

(a) PAYMENT REQUIREMENTS.—

(1) IN GENERAL.—Subtitle C of the Internal Revenue Code of 1986 is amended by inserting after chapter 24 the following new chapter:

"CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS

"SUBCHAPTER A—EMPLOYER SHARED RESPONSIBILITY PAYMENTS

"SUBCHAPTER B—INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS

"SUBCHAPTER C—GENERAL PROVISIONS

"Subchapter A—Employer Shared Responsibility Payments

"Sec. 3411. Payment requirement.
"Sec. 3412. Instrumentalities of the United States.

"SEC. 3411. PAYMENT REQUIREMENT.

"(a) EMPLOYER SHARED RESPONSIBILITY PAYMENTS.—Every employer shall pay an employer shared responsibility payment for each calendar year in an amount equal to the product of—

"(1) the number of full-time equivalent employees employed by the employer during the preceding calendar year, multiplied by

"(2) the applicable percentage of the average HAPI plan premium amount for such calendar year.

"(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)(2)—

"(1) IN GENERAL.—The applicable percentage shall be determined as follows:

Revenue per employee national percentile of the taxpayer for the preceding calendar year:	Large employer:	Small employer:
0-20th percentile	17%	2%
21st-40th percentile	19%	4%
41st-60th percentile	21%	6%
61st-80th percentile	23%	8%
81st-99th percentile	25%	10%.

"(2) APPLICABLE PERCENTAGE FOR CERTAIN NON-REVENUE PRODUCING ENTITIES.—In the case

of an employer which is a nonprofit entity, a State or local government, or any other type of entity for which the Secretary determines that calculating revenue per employee is not appropriate, the applicable percentage shall be—

"(A) in the case of a large employer, 17 percent, and

"(B) in the case of a small employer, 2 percent.

"(3) ADDITIONAL RATE FOR CERTAIN SMALL EMPLOYERS.—

"(A) IN GENERAL.—In the case of a small employer, the applicable percentage determined under paragraph (1) shall be increased by 0.1 percent for each full-time equivalent employee employed by the employer during the preceding calendar year in excess of 50.

"(B) MAXIMUM ADDITIONAL RATE.—The increase in the applicable percentage determined under this paragraph shall not exceed 15 percent.

"(4) REVENUE PER EMPLOYEE NATIONAL PERCENTILE RANK.—At the beginning of each calendar year, the Secretary, in consultation with the Secretary of Labor, shall publish a table, based on sam-

pling of employers, to be used in determining the national percentile for revenue per employee amounts for the preceding calendar year.

''(c) TRANSITION RATES.—

''(1) TRANSITION RATE FOR EMPLOYERS PREVIOUSLY PROVIDING HEALTH INSURANCE.—

''(A) IN GENERAL.—In the case of the first and second calendar years to which this section applies, in the case of any employer who provided health insurance coverage for employees on the day before the date of enactment of the Healthy Americans Act, the employer shared responsibility payment shall be, in lieu of the amount determined under subsection (a), an amount equal to—

''(i) 100 percent of the designated employee health insurance premium amount of such employer, minus

''(ii) the employee salary investment amount.

''(B) EMPLOYEE SALARY INVESTMENT AMOUNT.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'employee salary investment amount' means the lesser of—

''(I) the excess of the amount of average yearly wages paid to all employees for such year over the amount of average yearly wages paid to such employee for the year before the first year this section applies, or

''(II) the designated employee health insurance premium amount of such employer.

''(ii) NONDISCRIMINATION RULES.—No amount paid by an employer shall be treated as an employee salary investment amount unless such amount is distributed to all employees on a basis that is proportional to the amount of wages paid to such employee before such distribution.

''(iii) NOTICE REQUIREMENT.—No amount paid by an employer shall be treated as an employee salary investment amount unless the employer gives each employee notice of the amount of the designated employee health insurance premium amount paid by the employer with respect to the employee.

''(C) EMPLOYER SHARED RESPONSIBILITY CREDIT.—The Secretary may provide a credit to private employers who provided health insurance benefits greater than the 80th percentile of the national average in the 2 years prior to enactment of this Act, can demonstrate the benefits provided encouraged prevention and wellness activities as defined in this Act, and continue to provide wellness programs

''(D) SPECIAL RULE FOR SELF-INSURED EMPLOYERS.—In the case of any employer who provided health care coverage for employees through self-insurance, 'average HAPI plan premium amount for the first year this section applies' shall be substituted for 'designated employee health insurance premium amount of such employer' in subparagraphs (A)(i) and (B)(i)(II).

''(E) REGULATIONS.—The Secretary may establish such rules and regulations as necessary to carry out the purposes of this paragraph.

''(2) TRANSITION RATE FOR OTHER EMPLOYERS.—In the case of any employer who did not provide health insurance to employees on the day before

the date of enactment of the Healthy Americans Act—

''(A) the employer shared responsibility payment for the first year this section applies shall be an amount equal ⅓ of the amount otherwise required under this section (determined without regard to this subsection), and

''(B) the employer shared responsibility payment for the second year this section applies shall be an amount equal ⅔ of the amount otherwise required under this section (determined without regard to this subsection).

''SEC. 3412. INSTRUMENTALITIES OF THE UNITED STATES.

''Notwithstanding any other provision of law (whether enacted before or after the enactment of this section) which grants to any instrumentality of the United States an exemption from taxation, such instrumentality shall not be exempt from the payment required by section 3411 unless such provision of law grants a specific exemption, by reference to section 3111 from the payment required by such section.

''Subchapter B—Individual Shared Responsibility Payments

''Sec. 3421. Amount of payment.
''Sec. 3422. Deduction of tax from wages.

"SEC. 3421. AMOUNT OF PAYMENT.

"(a) IN GENERAL.—Every individual shall pay an individual shared responsibility payment in an amount equal to the HAPI plan premium amount of such individual.

"(b) EXCEPTION.—This section shall not apply to any individual—

"(1) who is covered under a HAPI plan of another individual, or

"(2) who provides such documentation as required by the Secretary demonstrating that such individual has paid such HAPI plan premium amount, but only for the period with respect to which such amount is shown to be paid.

"SEC. 3422. DEDUCTION OF INDIVIDUAL SHARED RESPONSIBILITY PAYMENT FROM WAGES.

"(a) IN GENERAL.—The individual shared responsibility payment imposed by section 3421 shall be collected by the employer by deducting the amount of the payment from the wages as and when paid.

"(b) NONDEDUCTIBILITY BY EMPLOYER.—The individual shared responsibility payment deducted and withheld by the employer under subsection (a) shall not be allowed as a deduction to the employer in computing taxable income under subtitle A.

"(c) INDEMNIFICATION OF EMPLOYER; SPECIAL RULE FOR TIPS.—Rules similar to the rules of subsections

(b) and (c) of section 3102 shall apply for purposes of this section.

"Subchapter C—General Provisions

''Sec. 3431. Definitions and special rules.
''Sec. 3432. Labor contracts.

"SEC. 3431. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this chapter—

''(1) AVERAGE HAPI PLAN PREMIUM AMOUNT.—The term 'average HAPI plan premium amount' means the national average yearly premium for HAPI plans with standard coverage (as determined under section 103(b) of the Healthy Americans Act), determined without regard to differing classes of coverage.

''(2) DESIGNATED EMPLOYEE HEALTH INSURANCE PREMIUM AMOUNT.—The term 'designated employee health insurance premium amount' means the greater of—

''(A) the yearly premium paid by an employer for health insurance coverage for employees for the most recent calendar year ending before the date of enactment of the Healthy Americans Act, or

''(B) the yearly premium paid by an employer for health insurance coverage for employ-

ees for the year before the first year this section applies.

''(3) EMPLOYER.—

''(A) IN GENERAL.—The term 'employer' has the meaning given such term under section 3401(d).

''(B) AGGREGATION RULES.—For purposes of this chapter, all persons treated as a single employer under subsection (a) or (b) of section 52 shall be treated as 1 person.

''(4) EMPLOYMENT.—The term 'employment' has the meaning given such term under section 3121(b).

''(5) FULL-TIME EQUIVALENT EMPLOYEE.—The term 'full-time equivalent employee' means the equivalent number of full-time employees of an employer determined for any year under the following formula:

''(A) The sum of the number of full-time employees employed by the employer for more than 3 months during such year, plus

''(B) The quotient of—

''(i) the sum of the average weekly hours worked during such year for each

employee of the employer (including common law employees) who—

"(I) was employed by such employer during such year for more than 3 months, and

"(II) is not a full-time employee, divided by

"(ii) 40.

"(6) FULL-TIME EMPLOYEE.—The term 'full-time employee' means an employee (including a common law employee) who during an average workweek performs, or can reasonably be expected to perform, at least 40 hours of work. The Secretary may prescribe alternative rules for determining full-time equivalent employees in occupations or industries not using a standard workweek.

"(7) HAPI PLAN.—The term 'HAPI plan' has the meaning given such term under section 3 of the Healthy Americans Act.

"(8) HAPI PLAN PREMIUM AMOUNT.—The term 'HAPI plan premium amount' means, with respect to any individual, the monthly premium for the HAPI plan under which such individual is enrolled, determined after taking into account any subsidy

provided to such individual under section 131 of the Healthy Americans Act.

''(9) LARGE EMPLOYER.—The term 'large employer' means, with respect to any year, an employer who employs an average of over 200 full-time equivalent employees during such year.

''(10) REVENUE PER EMPLOYEE.—The term 'revenue per employee' means, with respect to any employer for any year, the gross receipts of the employer for such year divided by the number of full-time equivalent employees employed by such employer for such year.

''(11) SMALL EMPLOYER.—The term 'small employer' means, with respect to any year, an employer who employs an average of 200 or fewer full-time equivalent employees during such year.

''(12) WAGES.—The term 'wages' has the meaning given such term under section 3401(a).

''(b) SPECIAL RULES.—

''(1) SPECIAL RULE FOR SELF-EMPLOYED INDIVIDUALS.—For purposes of this chapter, a self-employed individual (as defined by section 401(c)(1)(B)) shall be treated as both a full-time equivalent employee and as an employer.

''(2) TREATMENT OF PAYMENTS.—For purposes of this title, the payments required by sections 3411 and 3421 shall be treated as a tax imposed by such sections, respectively.

''(3) OTHER SPECIAL RULES.—For purposes of this chapter, rules similar to rules under the following provisions shall apply:

''(A) Section 3122 (relating to Federal service).

''(B) Section 3123 (relating to deductions as constructive payments).

''(C) Section 3125 (relating to returns in the case of governmental employees in States, Guam, American Samoa, and the District of Columbia).

''(D) Section 3126 (relating to return and payment by government employer).

''(E) Section 3127 (relating to exemption for employers and their employees where both are members of religious faiths opposed to participation in social security act programs).

''SEC. 3432. LABOR CONTRACTS.

''(a) IN GENERAL.—This chapter shall not apply with respect to any qualified collective bargaining employee of

any qualified collective bargaining employer before the earlier of—

''(1) January 1 of the first year which is more than 7 years after the date of the enactment of this chapter, or

''(2) the date the collective bargaining agreement expires.

''(b) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED COLLECTIVE BARGAINING EMPLOYER.—The term 'qualified collective bargaining employer' means an employer who provides health insurance to employees under the terms of a collective bargaining agreement which is entered into before the date of the enactment of this chapter.

''(2) QUALIFIED COLLECTIVE BARGAINING EMPLOYEE.—The term 'qualified collective bargaining employee' means an employee of a qualified collective bargaining employer who is covered by a collective bargaining agreement governing the employee's health insurance.''.

(2) CONFORMING AMENDMENT.—The table of chapters of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 24 the following new item:

''CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS''.

(b) COLLECTION OF INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS THROUGH ESTIMATED TAXES.—Section 6654 of the Internal Revenue Code of 1986 (relating to failure by individual to pay estimated tax) is amended—

(1) in subsection (a), by striking ''and the tax under chapter 2'' and inserting '', the tax under chapter 2, and the individual shared responsibility payment required under subchapter B of chapter 24A'', and

(2) in subsection (f)—

(A) by striking ''minus'' at the end of paragraph (2) and inserting ''plus'',

(B) by redesignating paragraph (3) as paragraph (5), and

(C) by inserting after paragraph (2) the following new paragraphs:

''(3) the individual shared responsibility payment required under subchapter B of chapter 24A, minus

''(4) the amount withheld as an individual shared responsibility payment under section 3422, minus''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning at least 2 years after the date of the enactment of this Act.

SEC. 612. DISTRIBUTION OF INDIVIDUAL RESPONSIBILITY PAYMENTS TO HHAS.

(a) IN GENERAL.—The Secretary of the Treasury shall pay to the HHA in each State an amount equal to the amount of individual shared responsibility payments received under section 3421 of the Internal Revenue Code of 1986 with respect to each individual residing in such State.

(b) TREATMENT OF PAYMENTS.—Any amount paid to a State under subsection (a) shall be treated as an amount paid by the individual as a premium for the HAPI plan in which such individual is enrolled.

Subtitle C—Insurer Responsibilities

SEC. 621. INSURER RESPONSIBILITIES.

(a) IN GENERAL.—To offer a HAPI plan through an HHA, a State shall require that a health insurance issuer meet the requirements of this section.

(b) REQUIREMENTS.—A health insurance issuer offering a HAPI plan in a State shall—

(1) implement and emphasize prevention, early detection and chronic disease management;

(2) ensure that a wellness program as described in section 131 is available to all covered individuals so long as such a wellness program meets the re-

quirements of the health insurance issuers and other relevant requirements;

(3) demonstrate how the provider reimbursement methodology used by such an issuer has been adjusted to reward providers for achieving quality and cost efficiency in prevention, early detection of disease, and chronic care management;

(4) ensure enrollees have the opportunity to designate a health home as described in section 111(b) and make public how many enrollees per policy have designated a health home;

(5) upon enrollment, make available to each covered individual an initial physical and a care plan;

(6) create and implement an electronic medical record for each covered individual, unless the individual submits a notification to the issuer that the individual declines to have such a record;

(7) contribute to the financing of the HHAs by incorporating into the administration component of premiums an additional amount to reimburse HHAs for administrative costs;

(8) comply with loss ratios as established by the Secretary under subsection (e);

(9) use standardized common claims forms and uniform billing practices as provided for under subsection (c);

(10) require that hospitals, as a condition of receiving payment, send bills that are in an amount more than $5,000 to the covered individual (without regard to whether the covered individual is responsible for full or partial payment of the bill) and provide the individual the contact information of a person who can discuss the bill with the individual;

(11) provide incentives such as premium discounts—

(A) for parents, if a covered child participates in wellness activities and the health of such child improves; and

(B) for adults covered by a plan to participate in prevention, wellness and chronic disease management programs;

(12) report to the HHA of the State in which the issuer offers HAPI plans, outcome data regarding wellness program, disease detection and chronic care management, and loss ratio information, so that the HHAs may make such data available to the public in a consumer-friendly format;

(13) work with the Agency for Healthcare Research and Quality, medical experts, and patient groups to make information on high quality affordable health providers available to all Americans within 2 years of the date of enactment of this Act through a website searchable by zip code;

(14) provide to the HHA of each State in which the issuer offers a HAPI plan, detailed information on the HAPI plans offered by such issuer, using standardized language as required by the HHA, so that the HHA may compile a document that compares the HAPI plans for use by prospective enrollees; and

(15) paying to the HHA of each State in which the issuer seeks to offer a HAPI plan the amount of the administrative fee assessed by the HHA under section 502(c)(5) to enter the HHA system of that State.

(c) UNIFORM BILLING PRACTICES.—

(1) IN GENERAL.—A health insurance issuer offering a HAPI plan in a State shall not receive subsidy payments from the applicable State HHA unless such issuer agrees to use standardized common claim forms prescribed by the applicable State HHA.

(2) EXCEPTION.—Paragraph (1) shall not apply to any State worker's compensation system.

(d) CHRONIC CARE PROGRAMS OFFERED BY ISSUERS.—

(1) IN GENERAL.—A health insurance issuer offering a HAPI plan in a State shall provide a chronic care program to provide early identification and management of chronic diseases.

(2) DETERMINATION OF CHRONIC CARE PROGRAM.—Each State HHA shall determine what constitutes a chronic care program under this subsection and whether to collect and report financial information related to chronic care programs.

(3) UNIFORM CLINICAL PERFORMANCE STANDARDS.—Each chronic care program offered by a health insurance issuer shall use a uniform set of clinical performance standards prescribed by the HHA of the State in which the issuer offers a HAPI plan (in consultation with the State Medicare quality improvement organizations and patient and physician organizations) which should include encouragement that the issuers not require personal responsibility contributions for clinically-needed services to treat or manage a covered individual's chronic disease, particularly if the individual is taking an active

management role in working with their provider to manage any such disease.

(4) REPORTING BY ISSUERS.—Five years after the date of enactment of this Act and on an annual basis thereafter, each health insurance issuer shall report to the applicable State Insurance Commissioner, State Secretary of Health or other state entity selected by the State HHA, the chronic care management performance of the issuer as measured by the uniform clinical performance standards described in paragraph (3). The issuer shall make such performance public in a manner accessible to the public.

(e) PRIVATE INSURANCE COMPANY LOSS RATIO.—

(1) IN GENERAL.—The Secretary, in consultation with consumer and patient organizations, the National Association of Insurance Commissioners, and health insurance issuers (including health maintenance organizations) shall establish a loss ratio for issuers of HAPI plans.

(2) DETERMINATION OF LOSS RATIO.—In determining the loss ratio, administrative costs shall be defined as expenses consisting of all actual, allowable, allocable, and reasonable expenses incurred in the adjudication of subscriber benefit claims or in-

curred in the health insurance issuer's overall operation of the business.

(3) ADMINISTRATIVE EXPENSES.—

(A) IN GENERAL.—Unless otherwise determined by an agreement between a State HHA and a health insurance issuer, the administrative expenses of an issuer shall—

(i) include all taxes (excluding premium taxes) reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review when not billed by a health care provider and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments, and bank charges for letters of credit; and

(ii) not include the cost of personnel, equipment, and facilities directly used in the delivery of health care services (benefit costs), payments to HHAs for establishment and administration of HHAs, and the cost of overseeing chronic disease management programs and wellness programs.

Subtitle D—State Responsibilities

SEC. 631. STATE RESPONSIBILITIES.

(a) GENERAL REQUIREMENTS.—As a condition of receiving payment under section 503, each State shall—

(1) designate or create a Health Help Agency as described in title V;

(2) ensure that the HAPI plans offered in the State—

(A) are sold only through the State HHA; and

(B) comply with the requirements of this Act;

(3) ensure that health insurance issuers offering a HAPI plan in such State comply with the requirements described in section 621;

(4) ensure that HAPI plans offer premium discounts and incentives for participation in wellness programs;

(5) implement mechanisms to collect premium payments not otherwise collected under chapter 24A of the Internal Revenue Code of 1986 (as added by this Act);

(6) continue to apply State law with respect to—

(A) solvency and financial standards for health insurance issuers;

(B) fair marketing practices for health insurance issuers;

(C) grievances and appeals for covered individuals; and

(D) patient protection;

(7) eliminate fictitious group prohibitions; and

(8) comply with subsections (b) and (c).

(b) ENSURING MAXIMUM ENROLLMENT.—Each State shall—

(1) collect and exchange data with Federal and other public agencies as necessary to maintain a database containing information on the health insurance enrollment status of all State residents;

(2) implement methods to check enrollment status and enroll individuals in HAPI plans, such as through the Department of Motor Vehicles of the State, the enrollment of children in elementary and secondary schools, the voter registration authority of the State, and other checkpoints determined appropriate by the State;

(3) implement mechanisms, which may not include revocation or ineligibility for coverage under a HAPI plan, to enforce the responsibility of each

adult individual to purchase HAPI plan coverage for such individual and any dependent children of such individual; and

(4) implement a mechanism to automatically enroll individuals in a HAPI plan who present in emergency departments without health insurance.

(c) MAINTENANCE OF EFFORT.—Each State shall submit an annual report to the Secretary that demonstrates that, for each State fiscal year that begins on or after January 1 of the first calendar year in which HAPI coverage begins under this Act, State expenditures for health services (as defined by the Secretary) are not less than the amount equal to—

(1) in the case of the first State fiscal year for which such a report is submitted, 100 percent of the total amount of the State share of expenditures for such services under all public health programs operated in the State that are funded in whole or in part with State expenditures (including the Medicaid program) for the most recent State fiscal year ending before January 1 of the first calendar year in which HAPI coverage begins under this Act ; and

(2) in the case of any subsequent State fiscal year for which such a report is submitted, the amount applicable under this subsection for the pre-

ceding State fiscal year increased by the percentage change, if any, in the consumer price index for all urban consumers over the previous Federal fiscal year.

SEC. 632. EMPOWERING STATES TO INNOVATE THROUGH WAIVERS.

(a) IN GENERAL.—A State that meets the requirements of subsection (b) shall be eligible for a waiver of applicable Federal health-related program requirements.

(b) ELIGIBILITY REQUIREMENTS.—A State shall be eligible to receive a waiver under this section if—

(1) the legislature of such State enacts legislation, or the State through a publically approved ballot measure approves a plan, to provide health care coverage to it's residents that is at least as comprehensive as the coverage required under a HAPI plan; and

(2) the State submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a comprehensive description of the State legislation or plan for implementing the State-based health plan.

(c) DETERMINATIONS BY SECRETARY.—

(1) IN GENERAL.—Not later than 180 days after the receipt of an application from a State under subsection (b)(2), the Secretary shall make a determination with respect to the granting of a waiver under this section to such State.

(2) GRANTING OF WAIVER.—If the Secretary determines that a waiver should be granted under this section, the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(3) REFUSAL TO GRANT WAIVER.—If the Secretary refuses to grant a waiver under this section, the Secretary shall—

(A) notify the State involved of such determination, and the reasons therefore; and

(B) notify the appropriate committees of Congress of such determination and the reasons therefore.

(d) SCOPE OF WAIVERS.—The Secretary shall determine the scope of a waiver granted to a State under this section, including which Federal laws and requirements will not apply to the State under the waiver.

Subtitle E—Federal Fallback Guarantee Responsibility

SEC. 641. FEDERAL GUARANTEE OF ACCESS TO COVERAGE.

(a) FEDERAL GUARANTEE.—

(1) IN GENERAL.—If a State does not establish an HHA in compliance with title V by the date that is 2 years after the date of enactment of this Act, the Secretary shall ensure that each individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 HAPI plans in the coverage area in which the individual resides. In any such case in which such plans are not available, the individual shall be given the opportunity to enroll in a fallback HAPI plan.

(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1) is not satisfied with respect to a coverage area if only 1 entity offers all the HAPI plans in the area.

(b) CONTRACTS.—

(1) IN GENERAL.—The Secretary shall enter into contracts under this subsection with entities for the offering of fallback HAPI plans in coverage areas in which the guarantee under subsection (a) is not met.

(2) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under this subsection.

(c) FALLBACK HAPI PLAN.—For purposes of this section, the term ''fallback HAPI plan'' means a HAPI plan that—

(1) meets the requirements described in section 111(b) and does not provide actuarially equivalent coverage described in section 111(c); and

(2) meets such other requirements as the Secretary may specify.

Subtitle F—Federal Financing Responsibilities

SEC. 651. APPROPRIATION FOR SUBSIDY PAYMENTS.

There is authorized to be appropriated and there is appropriated for each fiscal year such sums as may be necessary to fund the insurance premium subsidies under section 121.

SEC. 652. RECAPTURE OF MEDICARE AND 90 PERCENT OF MEDICAID FEDERAL DSH FUNDS TO STRENGTHEN MEDICARE AND ENSURE CONTINUED SUPPORT FOR PUBLIC HEALTH PROGRAMS.

(a) RECAPTURE OF MEDICARE DSH FUNDS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended by inserting ''and before January 1 of the first calendar year in which coverage under a HAPI plan begins under the Healthy Americans Act,'' after ''May 1, 1986,''.

(2) SAVINGS TO PART A TRUST FUND.—The savings to the Federal Hospital Insurance Trust Fund by reason of the amendment made by paragraph (1) shall be used to strengthen the financial solvency of such Trust Fund.

(b) RECAPTURE OF 90 PERCENT OF MEDICAID DSH FUNDS.—

(1) HEALTHY AMERICANS PUBLIC HEALTH TRUST FUND.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9511. HEALTHY AMERICANS PUBLIC HEALTH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Healthy Americans Public Health Trust Fund', consisting of any amount appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFER TO TRUST FUND OF 90 PERCENT OF MEDICAID DSH FUNDS.—There are hereby appropriated to the Healthy Americans Public Health Trust Fund the following amounts:

"(1) In the case of the second, third, and fourth quarters of the first fiscal year in which coverage under a HAPI plan begins under the Healthy Americans Act, an amount equal to 90 percent of the amount that would otherwise have been appropriated for the purpose of making payments to States under section 1903(a) of the Social Security Act for the Federal share of disproportionate share hospital payments made under section 1923 of such Act for such quarters of that fiscal year but for subsections (c)(2) and (d)(2)(D) of section 1941 of the such Act, as determined by the Secretary of Health and Human Services.

''(2) In the case of each succeeding fiscal year, an amount equal to 90 percent of the amount that would otherwise have been appropriated for the purpose of making payments to States under section 1903(a) of the Social Security Act for the Federal share of disproportionate share hospital payments made under section 1923 of such Act for that fiscal year but for subsections (c)(1) and (d)(2)(D) of section 1941 of such Act, as determined by the Secretary of Health and Human Services, taking into account the percentage change, if any, in the consumer price index for all urban consumers (U.S. city average) for the preceding fiscal year.

''(c) EXPENDITURES FROM TRUST FUND.—With respect to each fiscal year for which transfers are made under subsection (b), amounts in the Healthy Americans Public Health Trust Fund shall be available for that fiscal year for the following purposes:

''(1) PROVIDING PREMIUM AND PERSONAL RESPONSIBILITY CONTRIBUTION SUBSIDIES.—For making appropriations authorized under section 651 of the Healthy Americans Act for providing premium and personal responsibility contribution subsidies in accordance with section 122 of such Act.

''(2) MAKING BONUS PAYMENTS TO STATES FOR IMPLEMENTING MEDICAL MALPRACTICE REFORM.—For making appropriations for bonus payments to States in accordance with section 802 of such Act for implementing a State medical malpractice reform law that complies with subsection (b) of such section.

''(3) REDUCING THE FEDERAL BUDGET DEFICIT.—The Secretary shall transfer any amounts in the Trust Fund that are not expended as of September 30 of a fiscal year for a purpose described in paragraph (1), (2), or (3) to the general revenues account of the Treasury.''.

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter is amended by adding at the end the following new item:

''Sec. 9511. Healthy Americans Public Health Trust Fund.''.

Subtitle G—Tax Treatment of Health Care Coverage Under Healthy Americans Program; Termination of Coverage Under Other Governmental Programs and Transition Rules for Medicaid and Schip

PART I—TAX TREATMENT OF HEALTH CARE COVERAGE UNDER HEALTHY AMERICANS PROGRAM

SEC. 661. LIMITED EMPLOYEE INCOME AND PAYROLL TAX EXCLUSION FOR EMPLOYER SHARED RESPONSIBILITY PAYMENTS, HISTORIC RETIREE HEALTH CONTRIBUTIONS, AND TRANSITIONAL COVERAGE CONTRIBUTIONS.

(a) INCOME TAX EXCLUSION.—

(1) IN GENERAL.—Subsection (a) of section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended to read as follows:

"(a) GENERAL RULE.—Gross income of an individual does not include—

"(1) if such individual is an employee, shared responsibility payments made by an employer under section 3411,

''(2) if such individual is a former employee before the first calendar year beginning 2 years after the date of the enactment of the Healthy Americans Act, employer-provided coverage under an accident or health plan,

''(3) if such individual is a qualified collective bargaining employee under an accident or health plan in effect on January 1 of the first calendar year beginning 2 years after the date of the enactment of the Healthy Americans Act, employer-provided coverage under such plan during any transition period described in section 3432, and

''(4) employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)).''.

(2) CONFORMING AMENDMENTS.—Section 106 of such Code is amended—

(A) by adding at the end of subsection (b) the following new paragraph:

''(8) TERMINATION.—This subsection shall not apply to contributions made in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act.'',

(B) by inserting ''and before the first calendar year beginning 2 years after the date of

the enactment of the Healthy Americans Act,'' after ''January 1, 1997,'' in subsection (c)(1), and

(C) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan'' in subsection (d)(1) and inserting ''shall not be included in such employee's gross income''.

(b) PAYROLL TAXES.—

(1) IN GENERAL.—Section 3121(a) (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act, paragraphs (2) and (3) shall apply to payments on account of sickness only if such payments are described in section 106(a).''.

(2) RAILROAD RETIREMENT.—Section 3231(e)(1) (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act, this paragraph shall apply to payments on account of sickness only if such payments are described in section 106(a).''.

(3) UNEMPLOYMENT.—Section 3306(b) (defining wages) is amended by adding at the end the following new sentence: ''In the case of any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act, paragraphs (2) and (4) shall apply to payments on account of sickness only if such payments are described in section 106(a).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning at least 2 years after the date of the enactment of the Healthy Americans Act.

SEC. 662. EXCLUSION FOR LIMITED EMPLOYER-PROVIDED HEALTH CARE FRINGE BENEFITS.

(a) IN GENERAL.—Section 132(a) of the Internal Revenue Code of 1986 (relating to certain fringe benefits) is amended by striking ''or'' at the end of paragraph (7), by striking the period at the end of paragraph (8) and inserting '', or'', and by adding at the end the following new paragraph:

''(9) qualified health care fringe.''.

(b) QUALIFIED HEALTH CARE FRINGE.—

(1) IN GENERAL.—Section 132 of the Internal Revenue Code of 1986 is amended by redesignating

subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) QUALIFIED HEALTH CARE FRINGE.—For purposes of this section, the term 'qualified health care fringe' means—

''(1) any wellness program described in section 131 of the Healthy Americans Act, and

''(2) any on-site first aid coverage for employees.''.

(2) NONDISCRIMINATORY TREATMENT.—Section 132(j)(1) of such Code (relating to exclusions under subsection (a)(1) and (2) apply to highly compensated employees only if no discrimination) is amended—

(A) by striking ''Paragraphs (1) and (2) of subsection (a)'' and inserting ''Paragraphs (1), (2), and (9) of subsection (a)'', and

(B) by striking ''SUBSECTION (a)(1) AND (2)'' in the heading and inserting ''SUBSECTIONS (a)(1), (2), AND (9)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning at least 2 years after the date of the enactment of the Healthy Americans Act.

SEC. 663. LIMITED EMPLOYER DEDUCTION FOR EMPLOYER SHARED RESPONSIBILITY PAYMENTS, HISTORIC RETIREE HEALTH CONTRIBUTIONS, AND OTHER HEALTH CARE EXPENSES.

(a) IN GENERAL.—Subsection (l) of section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended to read as follows:

''(l) LIMITATION ON DEDUCTIBLE EMPLOYER HEALTH CARE EXPENDITURES.—No deduction shall be allowed under this chapter for any employer contribution to an accident or health plan other than—

''(1) any shared responsibility payment made under section 3411,

''(2) any accident or health plan coverage for individuals who are former employees before the first calendar year beginning 2 years after the date of the enactment of the Healthy Americans Act,

''(3) any accident or health plan in effect on January 1 of the first calendar year beginning 2 years after the date of the enactment of the Healthy Americans Act with respect to coverage for qualified collective bargaining employees during a transition period described in section 3432,

''(4) any accident or health plan which qualifies as a wellness program described in section 131 of such Act,

''(5) any accident or health plan which constitutes on-site first aid coverage for employees, and

''(6) any accident or health plan which is a qualified long-term care insurance contract.''.

(b) CONFORMING AMENDMENT.—Section 162 of the Internal Revenue Code of 1986 is amended by striking subsection (n).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning at least 2 years after the date of the enactment of the Healthy Americans Act.

SEC. 664. HEALTH CARE STANDARD DEDUCTION.

(a) IN GENERAL.—Section 62(a) of the Internal Revenue Code of 1986 (defining adjusted gross income) is amended by inserting after paragraph (20) the following new paragraph:

''(21) INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS.—

''(A) IN GENERAL.—In the case of a taxpayer with gross income for the taxable year exceeding 100 percent of the poverty line (adjusted for the size of the family involved) for the calendar year in which such taxable year begins and who is enrolled in a HAPI plan under the Healthy Americans Act, the deduc-

tion allowable under section 213 by reason of subsection (d)(1)(D) thereof (determined without regard to any income limitation under subsection (a) thereof) in an amount equal to the lesser of—

"(i) the amount paid under section 3421 with respect to such plan by such taxpayer for such taxable year, or

"(ii) the applicable fraction times, in the case of—

"(I) coverage of an individual, $6,025,

"(II) coverage of a married couple or domestic partnership (as determined by a State) without dependent children, $12,050,

"(III) coverage of an unmarried individual with 1 or more dependent children, $8,610, plus $2,000 for each dependent child, and

"(IV) coverage of a married couple or domestic partnership (as determined by a State) with 1 or more dependent children, $15,210, plus $2,000 for each dependent child.

"(B) APPLICABLE FRACTION.—For purposes of subparagraph (A)(ii), the applicable fraction is the fraction (not to exceed 1)—

"(i) the numerator of which is the gross income of the taxpayer for the taxable year expressed as a percentage of the poverty line (adjusted for the size of the family involved) minus such poverty line for the calendar year in which such taxable year begins, and

"(ii) the denominator of which is 400 percent of the poverty line (adjusted for the size of the family involved) minus such poverty line.

"(C) PHASEOUT OF DEDUCTION AMOUNT.—

"(i) IN GENERAL.—The amount otherwise determined under subparagraph (A) for any taxable year shall be reduced by the amount determined under clause (ii).

"(ii) AMOUNT OF REDUCTION.—The amount determined under this clause shall be the amount which bears the same ratio to the amount determined under subparagraph (A) as—

"(I) the excess of the taxpayer's modified adjusted gross income for such taxable year, over $62,500 ($125,000 in the case of a joint return), bears to

"(II) $62,500 ($125,000 in the case of a joint return).

Any amount determined under this clause which is not a multiple of $1,000 shall be rounded to the next lowest $1,000.

"(D) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2009, each dollar amount contained in subparagraph (A)(ii) and subparagraph (C)(ii)(I) shall be increased by an amount equal to such dollar amount, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof. Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50 ($1,000 in the case of the dollar amount contained in subparagraph (C)(ii)(I)).

"(E) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'modified adjusted gross income' means adjusted gross income—

"(ii) determined without regard to this section and sections 86, 135, 137, 199, 221, 222, 911, 931, and 933, and

"(iii) increased by—

"(I) the amount of interest received or accrued during the taxable year which is exempt from tax under this title, and

"(II) the amount of any social security benefits (as defined in section 86(d)) received or accrued during the taxable year.

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

(b) CONFORMING AMENDMENT.—Section 213(d)(1)(D) of the Internal Revenue Code of 1986 is amended by inserting ''amounts paid under section 3421 and'' after ''including''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made in calendar years beginning at least 2 years after the date of the enactment of this Act.

SEC. 665. MODIFICATION OF OTHER TAX INCENTIVES TO COMPLEMENT HEALTHY AMERICANS PROGRAM.

(a) TERMINATION OF CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35 of the Internal Revenue Code of 1986 (relating to health insurance costs of eligible individuals) is amended by adding at the end the following new subsection:

''(h) TERMINATION.—This section shall not apply to payments made in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act.''.

(b) TERMINATION OF HEALTH CARE EXPENSE REIMBURSEMENT UNDER CAFETERIA PLANS.—

(1) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsection (h) as sub-

section (i) and by inserting after subsection (g) the following new subsection:

''(h) TERMINATION.—This section shall not apply to health benefits coverage in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act.''.

(2) LONG-TERM CARE ALLOWED UNDER CAFETERIA PLANS.—

(A) IN GENERAL.—Section 125(f) of such Code (defining qualified benefits) is amended by striking the last sentence.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to contracts issued with respect to any calendar year beginning at least 2 years after the date of the enactment of this Act.

(c) TERMINATION OF ARCHER MSA CONTRIBUTIONS.—Section 220 of the Internal Revenue Code of 1986 (relating to Archer MSAs) is amended—

(1) by inserting ''and made before the first calendar year beginning 2 years after the date of the enactment of the Healthy Americans Act'' after ''in cash'' in subsection (d)(1)(A)(i), and

(2) by adding at the end the following new subsection:

''(k) TERMINATION.—This section shall not apply to contributions made in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act.''.

(d) HEALTH SAVINGS ACCOUNTS ALLOWED IN CONJUNCTION WITH HIGH DEDUCTIBLE HAPI PLANS.—

(1) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986 (relating to health savings accounts) is amended—

(A) by inserting ''qualified'' before ''high deductible health plan'' each place it appears in the text (other than subsection (c)(2)(A)),

(B) by striking ''The term 'high deductible health plan' means a health plan'' in subsection (c)(2)(A) and inserting ''The term 'qualified high deductible health plan' means a HAPI plan under the Healthy Americans Act'',

(C) by striking subparagraphs (B) and (C) of subsection (c)(2) and by redesignating subparagraph (D) of subsection (c)(2) as subparagraph (B), and

(D) by striking ''HIGH'' in the heading for paragraph (2) of subsection (c) and inserting ''QUALIFIED HIGH''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made in calendar years beginning at least 2 years after the date of the enactment of this Act.

SEC. 666. TERMINATION OF CERTAIN EMPLOYER INCENTIVES WHEN REPLACED BY LOWER HEALTH CARE COSTS.

(a) IN GENERAL.—Subchapter C of chapter 90 of the Internal Revenue Code of 1986 (relating to provisions affecting more than one subtitle) is amended by adding at the end the following new section:

"SEC. 7875. TERMINATION OF CERTAIN PROVISIONS.

''The following provisions shall not apply to taxable years beginning (or transactions in the case of sections referred to in paragraph (3)) in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act:

''(1) Section 199 (relating to income attributable to domestic production activities).

''(2) Section 501(c)(9) (relating to tax-exempt status of voluntary employees' beneficiary associations).

''(3) Sections 861(a)(6), 862(a)(6), 863(b)(2), 863(b)(3), and 865(b) (relating to inventory property sales source rule exception).''.

(b) DEFERRAL OF ACTIVE INCOME OF CONTROLLED FOREIGN CORPORATIONS.—Section 952 of the Internal Revenue Code of 1986 (relating to subpart F income defined) is amended by adding at the end the following new subsection:

''(e) SPECIAL APPLICATION OF SUBPART.—

''(1) IN GENERAL.—For taxable years beginning in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act, notwithstanding any other provision of this subpart, the term 'subpart F income' means, in the case of any controlled foreign corporation, the income of such corporation derived from any foreign country.

''(2) APPLICABLE RULES.—Rules similar to the rules under the last sentence of subsection (a) and subsection (d) shall apply to this subsection.''.

(c) CONFORMING AMENDMENT.—The table of sections for subchapter C of chapter 90 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 7875. Termination of certain provisions.''.

PART II—TERMINATION OF COVERAGE UNDER OTHER GOVERNMENTAL PROGRAMS AND TRANSITION RULES FOR MEDICAID AND SCHIP

SEC. 671. GROUP AND INDIVIDUAL HEALTH PLAN REQUIREMENTS NOT APPLICABLE TO HAPI PLANS.

(a) ERISA.—Section 3(1) of Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)) is amended by adding at the end the following new sentence: ''Such terms shall not include the provision of medical, surgical, or hospital care or benefits through HAPI plans under the Healthy Americans Act.''.

(b) INTERNAL REVENUE CODE OF 1986.—Section 5000 of the Internal Revenue Code of 1986 (relating to certain group health plans) is amended by adding at the end the following new subsection:

''(e) HAPI PLANS.—For purposes of this section, the terms 'group health plan' and 'large group health plan' shall not include any HAPI plan under the Healthy Americans Act.''.

(c) PUBLIC HEALTH SERVICE ACT.—Section 2791(b)(5) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(5)) is amended by adding at the end the following new sentence: ''Such term shall not include health insurance coverage offered to individuals through a HAPI plan under the Healthy Americans Act.''.

SEC. 672. FEDERAL EMPLOYEES HEALTH BENEFITS PLAN.

(a) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by adding at the end the following new section:

"§ 8915. Termination

''No contract shall be entered into under this chapter or chapters 89A and 89B with respect to any coverage period occurring in any calendar year beginning at least 2 years after the date of the enactment of the Healthy Americans Act.''.

(b) CONFORMING AMENDMENT.—The table of sections for such chapter 89 is amended by adding at the end the following new item:

''8915. Termination.''.

SEC. 673. MEDICAID AND SCHIP.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 311, is amended by adding at the end the following new section:

''TRANSITION TO COVERAGE UNDER HAPI PLANS; REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE; TERMINATION OF UNNECESSARY PROVISIONS

''SEC. 1941. (a) TRANSITION AND SUPPLEMENTAL COVERAGE REQUIREMENTS.—The Secretary shall provide technical assistance to States and health insurance issuers of HAPI plans to ensure that individuals receiving medical assistance under State Medicaid plans under this title or

child health assistance under child health plans under title XXI are—

''(1) informed of—

''(A) the guarantee of private coverage for essential services for all Americans established by the Healthy Americans Act; and

''(B) each individual's personal responsibility—

''(i) for health care prevention;

''(ii) to enroll (or to be enrolled on their behalf) in a HAPI plan through the applicable State HHA during an open enrollment period; and

''(iii) to submit necessary documentation to their State HHA so that the HHA may determine the individual's eligibility for premium and personal responsibility contribution subsidies;

''(2) provided with appropriate assistance in transitioning from receiving medical assistance under State Medicaid plans or child health assistance under child health plans for their primary health coverage to obtaining such coverage through enrollment in HAPI plans in a manner that ensures continuation of coverage for such individuals;

''(3) notwithstanding any other provision of this title, after December 31 of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins in accordance with the Healthy Americans Act, provided with medical assistance that consists of supplemental coverage that meets the requirements of sections 202 and 301 of such Act; and

''(4) if the State elects to establish a State Choices for Long-Term Care Program under section 1940 and the individual is likely to be eligible for the program, informed of the coverage available under the program and how to enroll.

''(b) MAINTENANCE OF MEDICARE COST-SHARING.—For each month beginning after the last month of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins in accordance with the Healthy Americans Act—

''(1) a State shall continue to provide medical assistance for medicare cost-sharing to individuals described in section 1902(a)(10)(E) as if the Healthy Americans Act had not been enacted; and

''(2) the Secretary shall continue to reimburse the State for the provision of such medical assistance.

''(c) CONTINUED SUPPORT FOR DSH EXPENDITURES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, with respect to each fiscal year that begins after the first calendar year in which coverage under a HAPI plan begins in accordance with the Healthy Americans Act, the DSH allotment for each State otherwise applicable under section 1923(f) for that fiscal year shall be reduced by 90 percent and no payment shall be made under section 1903(a) to a State with respect to any payment adjustment made under section 1923 for hospitals in the State for quarters in the fiscal year in excess of the reduced DSH allotment for the State applicable for such year.

''(2) SPECIAL RULE FOR LAST 3 QUARTERS OF FIRST FISCAL YEAR IN WHICH COVERAGE UNDER A HAPI PLAN BEGINS.—With respect to the first fiscal year in which coverage under a HAPI plan begins in accordance with the Healthy Americans Act, the Secretary shall reduce the DSH allotment for each State that is otherwise applicable under section 1923(f) for that fiscal year so that each such DSH allotment reflects a 90 percent reduction in the allot-

ment for the second, third, and fourth quarters of that fiscal year.

''(d) TERMINATION OF ALL FEDERAL PAYMENTS UNDER THIS TITLE OTHER THAN FOR MEDICARE COST-SHARING, SUPPLEMENTAL MEDICAL ASSISTANCE, OR A STATE CHOICES FOR LONG-TERM CARE PROGRAM.—Notwithstanding any other provision of this title:

''(1) no individual other than an individual to which section 202, 301, or 311 of the Healthy Americans Act applies is entitled to medical assistance under a State plan approved under this title for any item or service furnished after December 31 of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins in accordance with such Act;

''(2) no payment shall be made to a State under section 1903(a) for any item or service furnished after that date or for any other sums expended by a State for which a payment would have been made under such section, other than for the Federal medical assistance percentage of the total amount expended by a State for each fiscal year quarter beginning after that date for providing—

''(A) medical assistance for the maintenance of medicare cost-sharing in accordance with subsection (b);

''(B) medical assistance for individuals who are eligible for supplemental medical assistance under this title after such date in accordance with section 202 or 301 of the Healthy Americans Act;

''(C) payments for expenditures for establishing and operating a State Choices for Long-Term Care Program under section 1940 (subject to the aggregate 5-year limit established under subsection (c)(1) of such section); and

''(D) payment adjustments under section 1923 for hospitals in the State that do not exceed the reduced DSH allotment for the State determined under subsection (c)''.

(b) APPLICATION TO SCHIP.—

(1) APPLICATION OF TRANSITION REQUIREMENTS.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following:

''(E) Section 1941(a) (relating to transition to coverage under HAPI plans and, in the case of paragraph (3) of such section, the re-

quirement to provide supplemental medical assistance for targeted low-income children who are provided child health assistance as optional targeted low-income children under title XIX).''.

(2) TERMINATION.—Title XXI of the Social Security Act is amended by adding at the end the following new section:

''TERMINATION

''SEC. 2111. Notwithstanding any other provision of this title, no payment shall be made to a State under section 2105(a) with respect to child health assistance for any item or service furnished after December 31 of the last calendar year ending before the first calendar year in which coverage under a HAPI plan begins in accordance with the Healthy Americans Act.''.

TITLE VII—PURCHASING HEALTH SERVICES AND PRODUCTS THAT ARE MOST EFFECTIVE

Subtitle A—Effective Health Services and Products

SEC. 701. ONE TIME DISALLOWANCE OF DEDUCTION FOR ADVERTISING AND PROMOTIONAL EXPENSES FOR CERTAIN PRESCRIPTION PHARMACEUTICALS.

(a) IN GENERAL.—Part IX of subchapter B of chapter 1 of subtitle A of the Internal Revenue Code of 1986 (relating to items not deductible) is amended by adding at the end the following new section:

"SEC. 280I. ONE TIME DISALLOWANCE OF DEDUCTION FOR CERTAIN PRESCRIPTION PHARMACEUTICALS ADVERTISING AND PROMOTIONAL EXPENSES.

''(a) IN GENERAL.—No deduction shall be allowed under this chapter for expenses relating to advertising or promoting the sale and use of prescription pharmaceuticals other than drugs for rare diseases or conditions (within the meaning of section 45C) for any taxable year which includes any portion of—

''(1) the 3-year period which begins on the date of a new drug application approval with respect to such a pharmaceutical, unless the manufacturer of such pharmaceutical demonstrates to the satisfaction of the Secretary that such pharmaceutical is subject to a comparison effectiveness study, including over-the-counter medication (if appropriate), or

''(2) the 1-year period which ends with the availability of a generic drug substitute, unless such advertising or promotion includes a statement that a lower cost alternative may soon be available and includes the chemical name of such alternative.

''(b) ADVERTISING OR PROMOTING.—For purposes of this section, the term 'advertising or promoting' includes direct-to-consumer advertising and any activity designed to promote the use of a prescription pharmaceutical directed to providers or others who may make decisions about the use of prescription pharmaceuticals (including the provision of product samples, free trials, and starter kits).''.

(b) CONFORMING AMENDMENT.—The table of sections for such part IX is amended by adding after the item relating to section 280H the following new item:

''Sec. 280I. One time disallowance of deduction for certain prescription pharmaceuticals advertising and promotional expenses.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning with or within calendar years beginning at least 2 years after the date of the enactment of this Act.

SEC. 702. ENHANCED NEW DRUG AND DEVICE APPROVAL.

(a) IN GENERAL.—

(1) NEW DRUGS.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by adding at the end the following:

''(o)(1) The sponsor of a new drug application under subsection (b) may include as part of such application a full report of an investigation which has been made to show, with respect to the new drug that is the subject of the application—

''(A) the population for whom the drug is appropriate; and

''(B) the effectiveness of the drug when compared to the effectiveness of drugs on the market as of the date that the application is submitted.

''(2) If a sponsor of a new drug application under subsection (b) includes in such application the report described under paragraph (1) then, notwithstanding any other provision of law, the Secretary shall apply section 505A(b) to the drug that is the subject of such application in the same manner as the Secretary applies such section

to a new drug in the pediatric population that is the subject of a study described in such section.

''(3) If a sponsor of a new drug application under subsection (b) does not include in such application the report described under paragraph (1) then, notwithstanding any other provision of law, the Secretary shall require that—

''(A) all promotional material with respect to such drug include the following disclosure: 'This drug has not been proven to be more effective than other drugs on the market for any condition or illness mentioned in this advertisement.'; and

''(B) such disclosure—

''(i) appears at the beginning and end of any audio and visual promotional material;

''(ii) constitutes not less than 20 percent of the time of any audio and visual promotional material; and

''(iii)(I) in any promotional material, includes a clear and conspicuous printed statement that is larger than other print used in such promotional material; and

''(II) in any audio and visual promotional material, includes such statement in audio as well as visual format.''.

(2) NEW DEVICES.—Section 515(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360e) is amended by adding at the end the following:

''(5)(A) A person that files a report seeking premarket approval under this subsection may include as part of such report a full description of an investigation which has been made to show, with respect to the device that is the subject of the report—

''(i) the population for whom the device is appropriate; and

''(ii) the effectiveness of the device when compared to the effectiveness of devices on the market as of the date that the report is submitted.

''(B) If a person that files a report seeking premarket approval under this subsection includes in such report the description referred to under subparagraph (A), then the Secretary shall certify to the Director of the United States Patent and Trademark Office that such person included such description in such report so that the Director may extend the patent with respect to such device under section 702(b) of the Healthy Americans Act.

''(C) If a person that files a report seeking premarket approval under this subsection does not include in such report the description referred to under subparagraph (A)

then, notwithstanding any other provision of law, the Secretary shall require that—

''(i) all promotional material with respect to such device include the following disclosure: 'This device has not been proven to be more effective than other devices on the market for any condition or illness mentioned in this advertisement.'; and

''(ii) such disclosure—

''(I) appears at the beginning and end of any audio and visual promotional material;

''(II) constitutes not less than 20 percent of the time of any audio and visual promotional material; and

''(III)(aa) in any promotional material, includes a clear and conspicuous printed statement that is larger than other print used in such promotional material; and

''(bb) in any audio and visual promotional material, includes such statement in audio as well as visual format.''.

(b) EXTENSION OF DEVICE PATENTS.—If the Director of the United States Patent and Trademark Office receives a certification from the Secretary pursuant to section 515(c)(5) of the Federal Food, Drug, and Cosmetic Act (as added under subsection (a)), the Director shall

extend, for a period of 2 years, the patent in effect with respect to such device under title 35 of the United States Code.

(c) EFFECTIVE DATE.—This section shall apply to new drug applications filed under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) and to applications for premarket approval of devices under section 515 of such Act (21 U.S.C. 350e) 180 days after the date of enactment of this Act.

SEC. 703. MEDICAL SCHOOLS AND FINDING WHAT WORKS IN HEALTH CARE.

Part B of title IX of the Public Health Service Act (42 U.S.C. 299b et seq.) is amended by adding at the end the following:

"SEC. 918. MEDICAL SCHOOLS AND FINDING WHAT WORKS IN HEALTH CARE.

''(a) ESTABLISHMENT OF WEBSITE.—Not later than 1 year after the date of enactment of the Healthy Americans Act, the Agency shall establish an Internet website—

''(1) on which researchers at medical schools and other institutions may post the results of their research concerning evidence-informed best practices for improving the quality and efficiency of care; and

''(2) that—

"(A) includes a description on how to implement such best practices; and

"(B) clearly identifies the funding source for the research.

"(b) PILOT PROGRAM.—

"(1) ESTABLISHMENT.—Using the information about evidence-informed best practices from the website under subsection (a) and other sources, the Agency, through the National Research Training Program and in consultation with medical schools, shall develop a pilot program to establish methods by which medical school curricula and training may be updated regularly to reflect best practices to improve quality and efficiency in medical practice.

"(2) APPLICATION TO PARTICIPATE.—To participate in the pilot program, an entity shall—

"(A) be an accredited medical school; and

"(B) submit an application at such time, in such manner, and containing such information as the Secretary may require.

"(3) PARTICIPANTS.—The Secretary shall ensure that not less than 28 medical schools shall be included in the pilot program.

"(4) DURATION; PUBLICATION OF RESULTS.—The Agency shall—

''(A) operate the pilot program for 3 years; and

''(B) not later than 180 days after the date of the completion of the pilot program, publish and make public the results of the pilot program; and

''(C) include, as part of the published results under subparagraph (B), recommendations on how to assure that all medical school curricula is updated on a regular basis to reflect best practices to improve quality and efficiency in medical practice.''.

SEC. 704. FINDING AFFORDABLE HEALTH CARE PROVIDERS NEARBY.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary, in consultation with each HHA and health insurance issuers that offer a HAPI plan, shall establish an Internet website to assist covered individuals with locating health care providers in their State of residence who provide affordable, high-quality health care services.

(b) QUALITY OF CARE STANDARD.—To develop the information displayed on the website with respect to the quality of care of a health care provider, the Secretary shall—

(1) on the date of establishment of the website, use information on the performance of providers in quality initiatives under the Medicare program, including demonstration projects, reporting initiatives, and pay for performance efforts; and

(2) not later than 3 years after the date of establishment of the website, in addition to the information used under paragraph (1), use quality of care standards developed in consultation with, and similar to standards used by, Medicare quality improvement organizations of each State.

(c) AFFORDABILITY STANDARD.—Not later than 2 years after the date of enactment of this Act, the Secretary shall, in consultation with health insurance issuers that offer a HAPI plan, develop guidelines by which each health care provider reports to the Secretary with respect to the affordability of services by such provider. The Secretary shall ensure that such guidelines—

(1) on the date of establishment of such guidelines, provide for the reporting of affordability of primary care services; and

(2) by a date that is no later than 3 years after the date of enactment of this Act, provide for the reporting of other services.

Subtitle B—Other Provisions to Improve Health Care Services and Quality

SEC. 711. INDIVIDUAL MEDICAL RECORDS.

The Secretary shall establish procedures to ensure that an individual's medical record is considered the property of such individual.

SEC. 712. BONUS PAYMENT FOR MEDICAL MALPRACTICE REFORM.

(a) IN GENERAL.—Effective 3 years after the date of enactment of this Act, a State shall be eligible for bonus payments under this Act if the State has enacted and is implementing a State medical malpractice reform law that complies with subsection (b).

(b) REQUIREMENTS FOR STATE REFORM LAW.—A State medical malpractice reform law complies with this subsection if such law—

(1) requires that an individual who files a medical malpractice action in State court have the facts of such individual's case reviewed prior to such filing by a panel that consists of—

(A) not less than 1 qualified medical expert, chosen in consultation with the State Medicare quality improvement organizations or

physician speciality society, whose expertise is appropriate for case;

(B) not less than 1 legal expert; and

(C) not less than 1 community representative to verify that there is reasonable cause to believe that a malpractice claim exists;

(2) permits an individual to engage in voluntary non-binding mediation with respect to the malpractice claim involved prior to filing an action in State court;

(3) imposes sanctions against plaintiffs and attorneys who file frivolous medical malpractice claims in State courts;

(4) prohibits attorneys who file 3 frivolous medical malpractice actions in State courts from filing any another medical malpractice action in such courts for a period of 10 years; and

(5) provides for the application of a presumption of reasonableness with respect to a medical malpractice action if the defendant establishes that the defendant provided the items or services involved in accordance with accepted clinical practice guidelines established by the specialty of which the defendant is board certified or listed in the National Guideline

Clearinghouse, unless such presumption is rebutted by a preponderance of the evidence.

(c) USE OF BONUS PAYMENTS.—A State shall use bonus payments received under this section to carry out activities related to disease and illness prevention and for the provision of enhanced health care services for children.

(d) PROCEDURES.—The Secretary, in consultation with the Attorney General, shall by regulation establish guidelines for the implementation of this section.

TITLE VIII—CONTAINING MEDICAL COSTS AND GETTING MORE VALUE FOR THE HEALTH CARE DOLLAR

SEC. 801. COST-CONTAINMENT RESULTS OF THE HEALTHY AMERICANS ACT.

Congress finds that the Healthy Americans Act will result in the following:

(1) Private insurance companies will be forced to hold down costs and will slow the rate of growth because they are required to offer standardized Healthy American Private Insurance plans.

(2) Administrative savings will be derived from decoupling employers from the health care infrastructure and reducing employers' and insurers' administrative costs.

(3) Private insurance companies will implement uniform billing and common claims forms.

(4) Congress will reclaim Medicare and Medicaid disproportionate share hospital (DSH) payments because previously uninsured persons will go to providers on an outpatient basis instead of an emergency department.

(5) State and local governments will save money on programs they operated for the uninsured before enactment of this Act.

(6) The Federal Government will save money on Federal tax subsidies that reward inefficient care and are regressive.

(7) The Federal Government and the private sector will save money if the Food and Drug Administration determines whether products provide new value.

(8) Reducing medical errors will save the government and the private sector money.

(9) Requiring hospitals to send large bills to patients for their review will reduce errors in medical billing and force major providers to be more cost conscious.

(10) Requiring insurers to reimburse for quality and cost effective services will hold down private sector costs.

(11) Reduction of Medicare's restriction on bargaining power for prescription drugs will reduce costs for sole source drugs and other medications.

(12) Establishment of electronic medical records by insurers will create savings.

(13) Publication of cost and quality data will enable people to look up by zip code affordable high-quality providers.