

111TH CONGRESS
1ST SESSION

H. R. 2520

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

IN THE HOUSE OF REPRESENTATIVES

MAY 20, 2009

Mr. RYAN of Wisconsin (for himself and Mr. NUNES) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—INVESTING IN PREVENTION

- Sec. 101. Strategic approach to outcome-based prevention.
- Sec. 102. State grants for outcome-based prevention effort.
- Sec. 103. Focusing the food stamp program on nutrition.
- Sec. 104. Immunizations.

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

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

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

- Sec. 300. Reference.

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

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

Subtitle B—Health Savings Accounts

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

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

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

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

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

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

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

Subtitle B—Reducing Fraud and Abuse

- Sec. 511. Requiring the Secretary of Health and Human Services to change the Medicare beneficiary identifier used to identify Medicare beneficiaries under the Medicare program.
- Sec. 512. Use of technology for real-time data review.
- Sec. 513. Detection of medicare fraud and abuse.
- Sec. 514. Edits on 855S Medicare enrollment application and exemption of pharmacists from surety bond requirement.
- Sec. 515. GAO study and report on effectiveness of surety bond requirements for suppliers of durable medical equipment in combating fraud.

TITLE VI—ENDING LAWSUIT ABUSE

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

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

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

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

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

TITLE VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

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

Subtitle B—Forum for Quality and Effectiveness in Health Care

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

Subtitle C—General Provisions

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

Subtitle D—Terminations and Transition

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

Sec. 832. Transition.

Subtitle E—Independent Health Record Trust

Sec. 841. Short title.

Sec. 842. Purpose.

Sec. 843. Definitions.

Sec. 844. Establishment, certification, and membership of Independent Health Record Trusts.

Sec. 845. Duties of IHRT to IHRT participants.

Sec. 846. Availability and use of information from records in IHRT consistent with privacy protections and agreements.

Sec. 847. Voluntary nature of trust participation and information sharing.

Sec. 848. Financing of activities.

Sec. 849. Regulatory oversight.

TITLE IX—MISCELLANEOUS

Sec. 901. Health care choice for veterans.

Sec. 902. Health care choice for Indians.

Sec. 903. Termination of Federal Coordinating Council for Comparative Effectiveness Research.

Sec. 904. HHS and GAO joint study and report on costs of the 5 medical conditions that have the greatest impact.

**TITLE I—INVESTING IN
PREVENTION**

1

2

3

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

4

5

(a) INTERAGENCY COORDINATING COMMITTEE.—

6

(1) IN GENERAL.—The Secretary of Health and

7

Human Services (referred to in this title as the

8

“Secretary”) shall convene an interagency coordi-

9

nating committee to develop a national strategic

10

plan for prevention. The Secretary shall serve as the

11

chairperson of the committee.

12

(2) COMPOSITION.—In carrying out paragraph

13

(1), the Secretary shall include the participation

14

of—

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

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

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

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

10 (E) the Administrator of the Health Re-
11 sources and Services Administration;

12 (F) the Secretary of Agriculture;

13 (G) the Director of the Centers for Medi-
14 care & Medicaid Services;

15 (H) the Administrator of the Environ-
16 mental Protection Agency;

17 (I) the Director of the Indian Health Serv-
18 ice;

19 (J) the Administrator of the Administra-
20 tion on Aging;

21 (K) the Secretary of Veterans Affairs;

22 (L) the Secretary of Defense;

23 (M) the Secretary of Education; and

24 (N) the Secretary of Labor.

1 (3) REPORT AND PLAN.—Not later than 1 year
2 after the date of enactment of this Act, the Sec-
3 retary, acting through the coordinating committee
4 convened under paragraph (1), shall submit to Con-
5 gress a report concerning the recommendation of the
6 committee for health promotion and disease preven-
7 tion activities. Such report shall include a specific
8 strategic plan that shall include—

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

15 (B) specific science-based initiatives to
16 achieve the measurable goals of Healthy People
17 2010 regarding nutrition, exercise, and smoking
18 cessation, and targeting the 5 leading disease
19 killers in the United States;

20 (C) specific plans for consolidating Federal
21 health programs and Centers that exist to pro-
22 mote healthy behavior and reduce disease risk
23 (including eliminating programs and offices de-
24 termined to be ineffective in meeting the pri-
25 ority goals of Healthy People 2010), that in-

1 clude transferring the nutrition guideline devel-
2 opment responsibility from the Secretary of Ag-
3 riculture to the Director of the Centers for Dis-
4 ease Control and Prevention;

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

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

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

20 (4) ANNUAL REQUEST TO GIVE TESTIMONY.—

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

1 and effectiveness of Federal programs related to this
2 goal.

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

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

12 (1) MEDIA CAMPAIGNS.—

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

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

23 (i) shall be designed to address proper
24 nutrition, regular exercise, smoking ces-
25 sation, obesity reduction, the 5 leading dis-

1 ease killers in the United States, and sec-
2 ondary prevention through disease screen-
3 ing promotion;

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

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

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

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

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

1 (2) WEBSITE.—The Secretary, in consultation
2 with private-sector experts, shall maintain or enter
3 into a contract to maintain an Internet website to
4 provide science-based information on guidelines for
5 nutrition, regular exercise, obesity reduction, smok-
6 ing cessation, and specific chronic disease preven-
7 tion. Such website shall be designed to provide infor-
8 mation to health care providers and consumers.

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

23 (4) PERSONALIZED PREVENTION PLANS.—

24 (A) CONTRACT.—The Secretary, acting
25 through the Director of the Centers for Disease

1 Control and Prevention, shall enter into a con-
2 tract with a qualified entity for the development
3 and operation of a Federal Internet website
4 personalized prevention plan tool.

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

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

20 (6) PRIORITY FUNDING.—Funding for the ac-
21 tivities authorized under this section shall take pri-
22 ority over funding from the Centers for Disease Con-
23 trol and Prevention provided for grants to States
24 and other entities for similar purposes and goals as
25 provided for in this section. Not to exceed

1 \$500,000,000 shall be expended on the campaigns
2 and activities required under this Act.

3 **SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVEN-**
4 **TION EFFORT.**

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

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

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

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

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

24 (4) contain a set of process outcomes and mile-
25 stones, based on the process outcomes and mile-

1 stones developed by the Secretary, for measuring the
2 effectiveness of activities carried out under the grant
3 in the State; and

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

10 (c) PROCESS OUTCOMES AND MILESTONES.—

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

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

24 (3) CONTINUED FAILURE TO MEET OBJEC-
25 TIVES.—If after the expiration of the 2-year period

1 described in paragraph (2), the Secretary determines
2 that the State is failing to make adequate progress
3 in meeting the outcomes and milestones contained in
4 the State plan under subsection (b)(4) over a 5-year
5 period, the Secretary shall terminate all funding to
6 the State under a grant under this section.

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

11 (e) TARGETED ACTIVITIES.—A State may use grant
12 funds to target specific populations within the State to
13 achieve specific outcomes described in Healthy People
14 2010.

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

20 (g) WELLNESS BONUSES.—

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

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

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

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

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

13 (4) FUNDING.—Out of funds appropriated to
14 the Director of the Centers for Disease Control and
15 Prevention for each fiscal year beginning with fiscal
16 year 2010, the Director shall give priority to using
17 \$50,000,000 of such funds to make bonus payments
18 under this subsection.

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

22 (i) STATE.—In this section, the term “State” means
23 the 50 States, the District of Columbia, the Common-
24 wealth of Puerto Rico, Guam, Samoa, the United States

1 Virgin Islands, and the Commonwealth of the Northern
2 Mariana Islands.

3 (j) AUTHORIZATION OF APPROPRIATIONS.—Funding
4 for the activities authorized under this section shall take
5 priority over funding from the Centers for Disease Control
6 and Prevention provided for grants to States and other
7 entities for similar purposes and goals as provided for in
8 this section, not to exceed \$300,000,000 for each fiscal
9 year.

10 **SEC. 103. FOCUSING THE FOOD STAMP PROGRAM ON NU-**
11 **TRITION.**

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

18 (b) LIMITATIONS ON FOOD STAMP PURCHASES.—

19 (1) IN GENERAL.—Not later than 6 months
20 after the date of enactment of this Act, the Sec-
21 retary of Agriculture shall, based on scientific, peer-
22 reviewed recommendations provided by a Commis-
23 sion that includes public health, medical, and nutri-
24 tion experts and the Director of the Centers for Dis-
25 ease Control and Prevention, develop lists of foods

1 that do not meet science-based standards for proper
2 nutrition and that may not be purchased under the
3 food stamp program. Such list shall be updated on
4 an annual basis to ensure the most current science-
5 based recommendations are applied to the food
6 stamp program.

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

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

16 **SEC. 104. IMMUNIZATIONS.**

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

22 (b) TECHNICAL ASSISTANCE AND REDUCTION IN
23 FUNDING.—If a State does not achieve a benchmark of
24 80 percent coverage within the State for Centers for Dis-
25 ease Control and Prevention-recommended vaccines, the

1 Director of the Centers shall provide technical assistance
 2 to the State for a period of 2 years. If after the expiration
 3 of such 2-year period the State continues to fail to achieve
 4 such benchmark, the Secretary shall reduce funding pro-
 5 vided under section 317 of the Public Health Service Act
 6 to such State by 5 percent.

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

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

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

20 **TITLE II—STATE-BASED HEALTH** 21 **CARE EXCHANGES**

22 **SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.**

23 (a) IN GENERAL.—The Secretary of Health and
 24 Human Services (referred to in this title as the “Sec-
 25 retary”) shall establish a process for the review of applica-

1 tions submitted by States for the establishment and imple-
2 mentation of State-based health care Exchanges (referred
3 to in this title as a “State Exchange”) and for the certifi-
4 cation of such Exchanges. The Secretary shall certify a
5 State Exchange if the Secretary determines that such Ex-
6 change meets the requirements of this title.

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

11 **SEC. 202. REQUIREMENTS.**

12 (a) GENERAL REQUIREMENTS FOR CERTIFI-
13 CATION.—An application for certification under section
14 201(a) shall demonstrate compliance with the following:

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

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

1 (3) PLAN PARTICIPATION.—A State shall not
2 restrict or otherwise limit the ability of a health in-
3 surance plan to participate in, and offer health in-
4 surance coverage through, the State Exchange, so
5 long as the health insurance issuers involved are
6 duly licensed under State insurance laws applicable
7 to all health insurance issuers in the State and oth-
8 erwise comply with the requirements of this title.

9 (4) PREMIUMS.—

10 (A) AMOUNT.—A State shall not determine
11 premium or cost sharing amounts for health in-
12 surance coverage offered through the State Ex-
13 change.

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

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

1 (c) FACILITATING UNIVERSAL COVERAGE FOR
2 AMERICANS.—

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

14 (2) OTHER ENROLLMENT OPPORTUNITIES.—

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

21 (B) ANNUAL OPEN ENROLLMENT PERI-
22 ODS.—The State Exchange shall ensure that
23 health insurance coverage offered through the
24 Exchange permits eligible individuals to annu-
25 ally change enrollment among the coverage of-

1 ferred through the Exchange, subject to sub-
2 paragraph (A).

3 (C) INCENTIVES FOR CONTINUOUS AN-
4 NUAL COVERAGE.—The State Exchange shall
5 include an incentive for eligible individuals to
6 remain insured from plan year to plan year,
7 and may include incentives such as State tax
8 incentives or premium-based incentives.

9 (3) GUARANTEED ACCESS FOR INDIVIDUALS.—
10 The State Exchange shall ensure that, with respect
11 to health insurance coverage offered through the Ex-
12 change, all eligible individuals are able to enroll in
13 the coverage of their choice provided that such indi-
14 viduals agree to make applicable premium and cost
15 sharing payments.

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

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

25 (d) LIMITATION ON EXORBITANT PREMIUMS.—

1 (1) ESTABLISHMENT OF MECHANISM.—With
2 respect to health insurance coverage offered through
3 the State Exchange, the Exchange shall establish a
4 mechanisms to protect enrollees from the imposition
5 of excessive premiums, to reduce adverse selection,
6 and to share risk.

7 (2) MECHANISM OPTIONS.—The mechanisms
8 referred to in paragraph (1) may include the fol-
9 lowing:

10 (A) INDEPENDENT RISK ADJUSTMENT.—

11 The implementation of risk-adjustment among
12 health insurance coverage offered through the
13 State Exchange through a contract entered into
14 with a private, independent board. Such board
15 shall include representation of health insurance
16 issuers and State officials but shall be inde-
17 pendently controlled. The State Exchange shall
18 ensure that risk-adjustment implemented under
19 this subparagraph shall be based on a blend of
20 patient diagnoses and estimated costs.

21 (B) HEALTH SECURITY POOLS.—The es-
22 tablishment (or continued operation under sec-
23 tion 2745 of the Public Health Service Act) of
24 a health security pool to guarantee high-risk in-

1 dividuals access to affordable, quality health
2 care.

3 (C) REINSURANCE.—The implementation
4 of a successful reinsurance mechanisms to guar-
5 antee high-risk individuals access to affordable,
6 quality health care.

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

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

20 (g) REGIONAL OPTIONS.—

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

1 (2) MODEL LEGISLATION.—States adopting
2 model legislation as developed by the National Asso-
3 ciation of Insurance Commissioners shall be eligible
4 to enter into an interstate compact as provided for
5 in this section.

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

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

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

15 (2) a resident of the State involved;

16 (3) not incarcerated; and

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

20 **SEC. 203. STATE EXCHANGE INCENTIVES.**

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

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

13 **TITLE III—FAIR TAX TREAT-**
14 **MENT FOR ALL AMERICANS**
15 **TO AFFORD HEALTH CARE**

16 **SEC. 300. REFERENCE.**

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

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

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

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

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

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

17 “(b) **MONTHLY LIMITATION.**—

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

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

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

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

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

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

16 “(4) APPLICABLE AMOUNT.—

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

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

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

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

1 “(B) COST-OF-LIVING ADJUSTMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 “(g) DESIGNATED ACCOUNTS.—

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

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

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

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

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

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

3 “(B) any health insurance reserve account.

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

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

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

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

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

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

13 “(i) SPECIAL RULES.—

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

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

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

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

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

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

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

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

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

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

7 “(j) COORDINATION WITH ADVANCE PAYMENTS.—

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

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

25 “(A) such excess, plus

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

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

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

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

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

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

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

10 (c) INFORMATION REPORTING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (2) ASSESSABLE PENALTIES.—

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

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

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

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

13 (d) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (2) CONFORMING AMENDMENTS.—

11 (A) Section 106(b)(1) is amended—

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

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

18 (B) Section 106(d)(1) is amended—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

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

20 “(2) MONTHLY LIMITATION.—

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

1 “(i) the greater of—

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

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

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

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

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

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

24 “(II) \$1,000.

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

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

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

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

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

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

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

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

7 “(i) the lesser of—

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

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

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

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

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

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

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

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

22 “(4) COVERAGE.—

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

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

6 (4) CONFORMING AMENDMENTS.—

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

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

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

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

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

13 (ii)(I) and inserting “\$5,800”.

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

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

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

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

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

3 “(g) COST-OF-LIVING ADJUSTMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (g) EFFECTIVE DATES.—

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

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

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

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

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

12 “(b) RULES AND REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

“TABLE OF CONTENTS OF TITLE

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

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

“Sec. 1901. Purpose; Appropriation.

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

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

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

“Sec. 1905. Definitions.

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

“Sec. 1907. Drug rebates.

“Sec. 1908. Managed care.

“Sec. 1909. Annual reports.

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

“Sec. 1911. Purpose.

“Sec. 1912. State plan.

“Sec. 1913. State allotments.

“Sec. 1914. Use of grants.

“Sec. 1915. Administrative provisions.

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

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

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

“Sec. 1919. Annual reports.

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

“Sec. 1931. Authorization of appropriations.

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

“PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

“Sec. 1941. Authorization of appropriations.

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

“PART E—GRANTS TO STATES FOR ADMINISTRATION

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

“Sec. 1952. Cost-sharing protections.

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

“PART F—OTHER PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

20 “(a) ELIGIBLE INDIVIDUALS.—

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

23 “(A) who is—

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

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

1 “(B) who the State determines satisfies—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 “(3) EXCEPTIONS.—

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

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

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

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

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

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

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

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

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

20 “(4) methods of service delivery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 **“SEC. 1905. DEFINITIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(2) OTHER OLD PROVISIONS.—

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

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

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

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

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

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

19 **“SEC. 1907. DRUG REBATES.**

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

23 **“SEC. 1908. MANAGED CARE.**

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

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

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

5 **“SEC. 1909. ANNUAL REPORTS.**

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

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

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

16 **“SEC. 1911. PURPOSE.**

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

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

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

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

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

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

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

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

17 **“SEC. 1912. STATE PLAN.**

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

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

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

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

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

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

17 “(b) MINIMUM ELIGIBILITY STANDARDS.—

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

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

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

3 “(3) OTHER ELIGIBILITY REQUIREMENTS.—

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

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

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

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

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

11 “(c) PAYMENT METHODOLOGIES TO PROVIDERS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 **“SEC. 1913. STATE ALLOTMENTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(c) LIMITATION.—

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

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

3 “(2) EXCEPTION.—

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

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

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

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

1 “(1) IN GENERAL.—If the amount appropriated
 2 for fiscal year 2011 under subsection (a)(1) is less
 3 than the amount necessary to fund each State’s al-
 4 lotment for that fiscal year, the Secretary shall re-
 5 duce the allotment for each State for that fiscal year
 6 based on the applicable percentage determined for
 7 the State under paragraph (2) provide a reduced
 8 percentage basis as follows: Each state shall receive
 9 a percentage of its allotment based on the ratio of
 10 non-institutional spending to total long term care
 11 spending in FY 2009.

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

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

15 “(f) ADMINISTRATIVE EXPENSES.—

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

1 “(2) ASSESSMENT-RELATED COSTS.—Costs at-
2 tributable to providing an individualized needs-based
3 assessment for purposes of identifying the long-term
4 care services and supports to be provided under the
5 State plan to an individual shall be considered a
6 long-term care service and support and shall not be
7 treated as an administrative expense.

8 **“SEC. 1914. USE OF GRANTS.**

9 “(a) IN GENERAL.—A State shall use funds for long-
10 term care services and supports as defined in section
11 1916.

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

15 **“SEC. 1915. ADMINISTRATIVE PROVISIONS.**

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

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

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

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

4 **“SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES**
5 **AND SUPPORTS.**

6 “(a) DEFINITION.—

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

13 “(2) SERVICES AND SUPPORTS DESCRIBED.—
14 For purposes of paragraph (1), the services and sup-
15 ports described in this paragraph include assistive
16 technology, adaptive equipment, remote monitoring
17 equipment, case management for the aged, case
18 management for individuals with disabilities, nursing
19 home services, long-term rehabilitative services nec-
20 essary to restore functional abilities, services pro-
21 vided in intermediate care facilities for people with
22 disabilities, habilitation services (including adult day
23 care programs), community treatment teams for in-
24 dividuals with mental illness, home health services,
25 services provided in an institution for mental dis-

1 ease, a Program of All-Inclusive Care for the Elderly
2 (PACE), personal care (including personal assist-
3 ance services), recovery support including peer coun-
4 seling, supportive employment, training skills nec-
5 essary to assist the individual in achieving or main-
6 taining independence, training of family members in-
7 cluding foster parents in supportive and behavioral
8 modification skills, ongoing and periodic training to
9 maintain life skills, transitional care including room
10 and board not to exceed 60 days within a 12-month
11 period.

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

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

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

23 “(C) Old section 1905(a)(22) (relating to
24 home and community care (to the extent al-

1 lowed and as defined in old section 1929) for
2 functionally disabled elderly individuals).

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

7 “(E) Subject to subsection (e), old section
8 1905(a)(24) but without regard to any restric-
9 tion on furnishing services to patients or resi-
10 dents of facilities or institutions (relating to
11 personal care services).

12 “(F) Old sections 1905(a)(26) and 1934
13 (relating to services furnished under a PACE
14 program under old section 1934 to PACE pro-
15 gram eligible individuals enrolled under the pro-
16 gram under such old section).

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

19 “(4) LIMITATION.—Long-term care services
20 and supports cannot be used for services and admin-
21 istrative costs provided through the foster care (with
22 the exception of training of foster care parents),
23 child welfare, adult protective services, juvenile jus-
24 tice, public guardianship, or correctional systems.

1 “(b) REHABILITATIVE CARE.—For purposes of reha-
2 bilitation due to acute care medical needs, a State may
3 claim rehabilitative services provided in an institutional
4 setting, nursing home, or as part of home health expendi-
5 tures as acute care benefits under the State plan under
6 part A rather than under the State plan under this part
7 for a cumulative period of 30 days within a 12-month pe-
8 riod if such care is directly related to the onset of an acute
9 care need. A State shall demonstrate the services were
10 provided as a direct result of an acute care need.

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

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

21 “(e) EXCLUSION.—No payments shall be made under
22 the State plan under this part with respect to long-term
23 care supports and services provided for any individual who
24 is an inmate of a public institution. Nothing in the pre-
25 ceding sentence shall be construed as precluding the provi-

1 sion of long-term care services and supports under the
2 State plan under this part to an individual who is a pa-
3 tient in an institution for mental diseases.

4 **“SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM**
5 **CARE SERVICES AND SUPPORT, INCLUDING**
6 **OPTION FOR SELF-DIRECTED SERVICES AND**
7 **SUPPORTS.**

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

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

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

1 “(B) CRITERIA FOR INSTITUTIONALIZED
2 VERSUS NON-INSTITUTIONALIZED SERVICES.—
3 In establishing needs-based criteria, the State
4 may establish criteria for determining eligibility
5 for, and receipt of, services and supports pro-
6 vided in a facility or institution that are more
7 stringent than the criteria established for eligi-
8 bility and receipt of services and supports in a
9 non-facility or non-institutionalized setting.

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

16 “(D) CRITERIA BASED ON INDIVIDUAL AS-
17 SESSMENT.—

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

1 nificant assistance to perform such activi-
2 ties, and such other risk factors as the
3 State determines to be appropriate.

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

12 “(I) the State provides at least
13 60 days notice to the Secretary and
14 the public of the proposed modifica-
15 tion;

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

1 ical assistance for such services and
2 supports; and

3 “(III) after the effective date of
4 such modification, the State, at a
5 minimum, applies the criteria for de-
6 termining whether an individual re-
7 quires the level of care provided in a
8 facility or institutionalized setting
9 which applied under the State plan
10 immediately prior to the application of
11 the modified criteria.

12 “(E) INDEPENDENT EVALUATION AND AS-
13 SESSMENT.—

14 “(i) ELIGIBILITY DETERMINATION.—
15 The State uses an independent evaluation
16 for making the determinations described in
17 subparagraph (A).

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

23 “(I) determine a necessary level
24 of services and supports to be pro-

1 vided, consistent with an individual's
2 physical and mental capacity;

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

5 “(III) establish an individualized
6 care plan for the individual in accord-
7 ance with subparagraph (G).

8 “(F) ASSESSMENT.—The independent as-
9 sessment required under subparagraph (E)(ii)
10 shall include the following:

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

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

23 “(iii) Where appropriate, consultation
24 with the individual's family, spouse, guard-
25 ian, or other responsible individual.

1 “(iv) Consultation with appropriate
2 treating and consulting health and support
3 professionals caring for the individual.

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

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

15 “(G) INDIVIDUALIZED CARE PLAN.—

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

23 “(ii) PLAN REQUIREMENTS.—The
24 State ensures that the individualized care
25 plan for an individual—

1 “(I) is developed—

2 “(aa) in consultation with
3 the individual, the individual’s
4 treating physician, health care or
5 support professional, or other ap-
6 propriate individuals, as defined
7 by the State, and, where appro-
8 priate the individual’s family,
9 caregiver, or representative; and

10 “(bb) taking into account
11 the extent of, and need for, any
12 family or other supports for the
13 individual;

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

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

1 “(iii) STATE REQUIREMENT TO OFFER
2 ELECTION FOR SELF-DIRECTED SERVICES
3 AND SUPPORTS.—

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

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

1 State plan consistent with the fol-
2 lowing requirements:

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

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

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

22 “(aa) specifies those services
23 and supports which the individual
24 or the individual’s authorized

1 representative would be respon-
2 sible for directing;

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

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

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

1 and professionals as desired or
2 required by the individual or the
3 individual's authorized represent-
4 ative;

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

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

23 “(IV) BUDGET PROCESS.—With
24 respect to individualized budgets de-

1 scribed in subclause (III)(ff), the
2 State plan amendment—

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

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

12 “(cc) provides a procedure
13 to evaluate expenditures under
14 such budgets.

15 “(H) QUALITY ASSURANCE; CONFLICT OF
16 INTEREST STANDARDS.—

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

22 “(ii) CONFLICT OF INTEREST STAND-
23 ARDS.—The State establishes standards
24 for the conduct of the independent evalua-

1 tion and the independent assessment to
2 safeguard against conflicts of interest.

3 “(I) REDETERMINATIONS AND APPEALS.—

4 The State allows for at least annual redeter-
5 minations of eligibility, and appeals in accord-
6 ance with the frequency of, and manner in
7 which, redeterminations and appeals of eligi-
8 bility are made under the State plan.

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

23 “(2) DEFINITION OF INDIVIDUAL’S REP-
24 RESENTATIVE.—In this section, the term ‘individ-
25 ual’s representative’ means, with respect to an indi-

1 vidual, a parent, a family member, or a guardian of
2 the individual, an advocate for the individual, or any
3 other individual who is authorized to represent the
4 individual.

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

12 **“SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR**
13 **CERTAIN INSTITUTIONALIZED SPOUSES.**

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

18 **“SEC. 1919. ANNUAL REPORTS.**

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

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

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

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

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

10 “(4) Expenditures by service category.

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

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

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

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

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

1 **“SEC. 1932. APPLICATION OF CERTAIN REQUIREMENTS**
2 **UNDER PRE-MODERNIZED MEDICAID.**

3 “The following old provisions shall apply under this
4 part:

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

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

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

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

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

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

19 “(7) Old section 1902(y) (relating to psy-
20 chiatric hospitals).

21 “(8) Paragraphs (2) and (6) of old section
22 1903(g) (relating to the Secretarial requirement to
23 conduct sample onsite surveys of private and public
24 institutions and recertifications for the need for cer-
25 tain services).

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

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

6 “(11) Old section 1911 (relating to Indian
7 Health Service facilities).

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

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

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

13 **INTEGRITY**

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

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

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

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

23 “(b) AVAILABILITY; AUTHORITY FOR USE OF
24 FUNDS.—

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

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

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

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

24 “(i) the total amount of funds ex-
25 pended for each conference conducted

1 under the authority of subsection (b)(4);
2 and

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

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

9 “(1) the use of funds appropriated pursuant to
10 subsection (a); and

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

12 **“SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS**
13 **UNDER PRE-MODERNIZED MEDICAID.**

14 “The following old provisions shall apply under this
15 part:

16 “(1) Old subsections (a)(25) (other than sub-
17 paragraph (E)) and (g) of section 1902 and section
18 1903(o) (relating to third party liability).

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

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

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

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

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

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

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

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

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

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

1 “(12) Old section 1902(a)(68) (relating to re-
2 requirements for certain entities).

3 “(13) Old sections 1902(a)(69) and 1936 (re-
4 lating to the Medicaid Integrity Program) other
5 than paragraphs (1), (2)(A), and (3) of old section
6 1936(e).

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

11 “(15) Old sections 1902(a)(71) and 1940 (re-
12 lating to a required asset verification program).

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

15 “(17) Old section 1902(x) (relating to unique
16 identifiers for physicians).

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

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

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

1 “(21) Old section 1903(v) and the seventh sen-
2 tence of old section 1902(a) (relating to limitations
3 on payments for services furnished to aliens), other
4 than subparagraphs (A) and (B) of paragraph (4).

5 “(22) Old section 1903(x) (relating to citizen-
6 ship documentation).

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

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

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

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

18 **“PART E—GRANTS TO STATES FOR**

19 **ADMINISTRATION**

20 **“SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAY-**
21 **MENTS TO STATES.**

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

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

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

5 “(b) PAYMENTS TO STATES.—

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

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

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

24 “(a) IN GENERAL.—A State may impose cost-sharing
25 for individuals provided acute care medical assistance

1 under a State plan under part A or long-term care services
2 and supports under a State plan under part B consistent
3 with the following:

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

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

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

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

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

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

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

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

1 **“SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS**
2 **UNDER PRE-MODERNIZED MEDICAID.**

3 “The following old provisions shall apply to the State
4 plans under this title:

5 “(1) OLD STATE PLAN REQUIREMENTS.—

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

9 “(B) Old section 1902(a)(2) (relating to
10 State financial participation).

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

13 “(D) Old section 1902(a)(4) (relating to
14 administration).

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

17 “(F) Old section 1902(a)(6) (relating to
18 reporting requirements).

19 “(G) Old section 1902(a)(7) (relating to
20 restrictions on the use or disclosure of informa-
21 tion).

22 “(H) Old section 1902(a)(8) (relating to
23 applications for assistance).

24 “(I) Old section 1902(a)(11) (relating to
25 cooperative agreements with other State agen-
26 cies).

1 “(J) Old section 1902(a)(12) (relating to
2 determinations of blindness).

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

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

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

14 “(N) Old section 1902(a)(22) (relating to
15 certain administrative provisions).

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

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

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

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

1 “(S) Old section 1902(a)(30)(A) (relating
2 to utilization review).

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

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

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

11 “(W) Old section 1902(a)(38) (relating to
12 the provision of information described in section
13 1128(b)(9) by certain entities).

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

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

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

20 “(AA) Old section 1902(a)(42) (relating to
21 certain audit requirements).

22 “(BB) Old section 1902(a)(48) (relating to
23 eligibility cards).

24 “(CC) Old section 1902(a)(55) (relating to
25 the receipt and initial processing of applica-

1 tions, but only to the extent such section is con-
2 sistent with the policy embodied in the State
3 plans under parts A and B).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **“PART F—OTHER PROVISIONS**

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

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

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

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

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

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

8 **SEC. 402. OUTREACH.**

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

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

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

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

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

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

7 **SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVI-**
8 **SIONS.**

9 (a) IN GENERAL.—

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

18 (2) No State that is one of the 50 States or the
19 District of Columbia shall approve any applications
20 for medical assistance or child health assistance
21 under a State plan under title XIX or XXI (as in
22 effect for fiscal year 2010) after December 31,
23 2010.

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

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

6 **Subtitle B—Supplemental Health**
7 **Care Assistance for Low-Income**
8 **Families**

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

11 Part D of title III of the Public Health Service Act
12 (42 U.S.C. 254b et seq.) is amended by adding at the end
13 the following:

14 **“Subpart XI—Health Care Assistance to Low-Income**
15 **Families**

16 **“SEC. 340A-1. FINANCIAL ASSISTANCE TO LOW-INCOME**
17 **FAMILIES.**

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

25 “(b) ELIGIBILITY.—

1 “(1) ELIGIBLE FAMILIES.—To be eligible for fi-
2 nancial assistance under this section—

3 “(A) a family shall—

4 “(i) consist of 2 or more individuals
5 living together who are related by mar-
6 riage, birth, adoption, or guardianship;

7 “(ii) have a gross income that does
8 not exceed 200 percent of the poverty line,
9 as applicable to a family of the size in-
10 volved; and

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

13 “(B) no member of the family shall be cov-
14 ered by private health insurance.

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

22 “(3) LIMITATION ON INDIVIDUAL ELIGIBILITY;
23 ASSISTANCE.—

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

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

3 “(B) ALIENS.—The Secretary shall ensure
4 that financial assistance under this section is
5 not provided for costs associated with health
6 care for any member of an eligible family who
7 is an alien individual who is not a lawful per-
8 manent resident of the United States.

9 “(c) SUPPLEMENTAL DEBIT CARD FOR HEALTH
10 CARE EXPENDITURES.—

11 “(1) IN GENERAL.—The Secretary shall issue
12 to each eligible family that enrolls in the program in
13 accordance with subsection (f) a supplemental debit
14 card with a dollar-amount value, in accordance with
15 subsection (d), that may be used to pay for quali-
16 fying health care expenses.

17 “(2) USE OF THE DEBIT CARD.—

18 “(A) QUALIFYING HEALTH CARE EX-
19 PENSES.—A supplemental debit card issued
20 under this section may be used by members of
21 the eligible family to pay for—

22 “(i) the purchase of health care insur-
23 ance for any member of the family;

24 “(ii) cost sharing expenses related to
25 health care, including deductibles, copay-

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

3 “(iii) the direct purchase of health
4 care services and supplies for any member
5 of the family.

6 “(B) GEOGRAPHIC RANGE.—Each supple-
7 mental debit card may be used to pay for quali-
8 fying health care expenses incurred anywhere in
9 the 50 States or the District of Columbia.

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

13 “(i) incurred prior to the determina-
14 tion of the family’s eligibility for assistance
15 under this section; or

16 “(ii) that is not a health-related ex-
17 pense.

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

22 “(A) to the family’s supplemental debit
23 card for expenditure during the subsequent 12-
24 month period, provided that the family to which
25 the supplemental debit card was issued in the

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

4 “(B) to the family’s health savings account
5 (as defined in section 223(g)(2) of the Internal
6 Revenue Code of 1986).

7 “(4) MONTHLY STATEMENTS.—The Secretary
8 shall issue a monthly statement to each family to
9 which a supplemental debit card has been issued
10 under this section, which shall state each payment
11 made with the family’s supplemental debit card dur-
12 ing the month covered by the statement, the dollar
13 amount of each such payment, and the provider to
14 which each such payment was made.

15 “(d) AMOUNT OF FINANCIAL ASSISTANCE.—

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

20 “(A) Each family whose annual income
21 does not exceed 100 percent of the poverty
22 level, as applicable to a family of the size in-
23 volved, shall receive \$5,000.

24 “(B) Each family whose annual income ex-
25 ceeds 100 percent, but does not exceed 200 per-

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

4 “(i) For families whose annual income
5 exceeds 100 percent but does not exceed
6 120 percent, of the poverty level, \$4,000.

7 “(ii) For families whose annual in-
8 come exceeds 120 percent but does not ex-
9 ceed 140 percent, of the poverty level,
10 \$3,500.

11 “(iii) For families whose annual in-
12 come exceeds 140 percent but does not ex-
13 ceed 160 percent, of the poverty level,
14 \$3,000.

15 “(iv) For families whose annual in-
16 come exceeds 160 percent but does not ex-
17 ceed 180 percent, of the poverty level,
18 \$2,500.

19 “(v) For families whose annual in-
20 come exceeds 180 percent but does not ex-
21 ceed 200 percent, of the poverty level,
22 \$2,000.

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

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

3 “(A) For each pregnancy during which a
4 pregnant woman’s family is eligible for assist-
5 ance under this section, an additional amount
6 of \$1,000 shall be added to the family’s supple-
7 mental debit card, except that no family shall
8 receive such additional \$1,000 for any preg-
9 nancy for which the family received such
10 amount in the previous 12-month period.

11 “(B) For each member of an eligible fam-
12 ily who is less than 1 year old on any day with-
13 in the calendar year in which the family is eligi-
14 ble for assistance, an additional amount of
15 \$500 shall be added to the family’s supple-
16 mental debit card.

17 “(3) COST OF LIVING ADJUSTMENTS.—In the
18 case of any taxable year beginning in a calendar
19 year after 2011, each dollar amount contained in
20 paragraphs (1) and (2) shall be increased in the
21 same manner as the dollar amounts specified in sec-
22 tion 25E(b)(3) of the Internal Revenue Code of
23 1986 are increased by the blended cost-of-living ad-
24 justment determined under subsection (k)(2) of sec-

1 tion 25E of the Internal Revenue Code for the tax-
2 able year involved.

3 “(4) STATE OPTION TO INCREASE AMOUNTS.—

4 At the option of each State, amounts in excess of
5 the annual dollar amounts under paragraphs (1) and
6 (2) may be provided through the supplemental debit
7 card to eligible families in that State, but no Federal
8 funds shall be paid to any State for any amount pro-
9 vided in excess of such annual dollar amount.

10 “(5) RISK ADJUSTMENT.—The Secretary may

11 adjust the amount of financial assistance available to
12 an eligible family for a calendar year under this sec-
13 tion based on age, health indicators, and other fac-
14 tors that represent distinct patterns of health care
15 services utilization and costs.

16 “(e) CONTRIBUTIONS OF STATES.—

17 “(1) IN GENERAL.—As a condition for receiving

18 Federal funds under Part A or Part B of Medicaid,
19 each State shall contribute 50 percent of the total
20 amount expended under the supplemental debit card
21 program by the participating families that reside
22 within the State during the time that the family re-
23 sides in that State. For purposes of this section, the
24 residency of a family is determined by the residency
25 the legally responsible head of the household.

1 “(2) PAYMENTS FROM STATES.—

2 “(A) BILLING NOTIFICATION.—

3 “(i) TIMING.—On June 30th and De-
4 cember 31st of each year, the Secretary
5 shall send written notification to each
6 State of that State’s 50 percent share of
7 expenses, as described in paragraph (1),
8 for the 6-month period ending on the last
9 day of the month previous to such notifica-
10 tion.

11 “(ii) CONTENTS.—Each such notifica-
12 tion to a State shall clearly state—

13 “(I) the payment amount due
14 from the State;

15 “(II) the name of each individual
16 for whom payment was made through
17 the supplemental debit card program;

18 “(III) the health care provider to
19 whom each payment was made;

20 “(IV) the amount of each pay-
21 ment; and

22 “(V) any other information, as
23 the Secretary requires.

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

1 billed, not later than 30 days after the billing
2 notification date, in accordance with subpara-
3 graph (A)(i).

4 “(C) PENALTIES.—If a State fails to pay
5 to the Secretary an amount required under sub-
6 paragraph (B), interest shall accrue on such
7 amount at the rate provided under old section
8 1903(d)(5) of the Social Security Act. The
9 amount so owed and applicable interest shall be
10 immediately offset against amounts otherwise
11 payable to the State under this section, in ac-
12 cordance with the Federal Claims Collection Act
13 of 1996 and applicable regulations.

14 “(f) ENROLLMENT.—

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish procedures and times for enrollment in the sup-
17 plemental debit card program. Open enrollment shall
18 be available not less than 4 times per calendar year.

19 “(2) TRANSITION OF INDIVIDUALS ENROLLED
20 IN MEDICAID OR THE STATE CHILDREN’S HEALTH
21 INSURANCE PROGRAM.—

22 “(A) INFORMATION FROM THE STATES.—

23 Each State shall—

24 “(i) not later than June 30, 2010, in-
25 form all individuals then enrolled in Med-

1 icaid or the State Children’s Health Insur-
2 ance Program (SCHIP), of the changes in
3 effect beginning on January 1, 2011; and

4 “(ii) not later than October 31, 2010,
5 redetermine the eligibility of each indi-
6 vidual enrolled in Medicaid or SCHIP,
7 other than those individuals who qualify
8 for Medicaid or SCHIP as disabled, elder-
9 ly, or a special population, for the supple-
10 mental debit card program, according to
11 the eligibility criteria under subsection (b).

12 “(B) AUTOMATIC ENROLLMENT.—The
13 Secretary shall provide for the automatic enroll-
14 ment in the supplemental debit card program of
15 all individuals who are enrolled in Medicaid or
16 SCHIP and who have been redetermined by a
17 State under subparagraph (A) to be eligible for
18 Medicaid or SCHIP. Any individual who is de-
19 termined by a State not to qualify for the sup-
20 plemental debit card program may retain cov-
21 erage under Medicaid or SCHIP until June 30,
22 2011.

23 “(3) ASSISTANCE WITH QUALIFIED HEALTH IN-
24 SURANCE CREDIT.—Each State shall, to the extent
25 practicable, provide individuals residing within the

1 State with information regarding the qualified health
2 insurance credit described in section 25E of the In-
3 ternal Revenue Code of 1986, including information
4 regarding eligibility for, and how to claim, such
5 credit.

6 “(g) ADMINISTRATION.—

7 “(1) NATIONAL SYSTEM.—The Secretary may
8 enter into contracts or agreements with a State, a
9 consortium of States, or a private entity, including
10 a bank, enrollment broker, or similar entity, to es-
11 tablish and maintain a unified national system to
12 support the processes and transactions necessary to
13 administer this section.

14 “(2) AUTOMATED SYSTEM.—The Secretary
15 shall establish an automated means, such as an elec-
16 tronic benefit transfer system, by which the benefits
17 under this section shall be transferred to eligible
18 families.

19 “(3) VERIFICATION OF APPLICANT INFORMA-
20 TION.—The Secretary may verify information pro-
21 vided by applicants with the appropriate Federal,
22 State, and local agencies, including the Internal Rev-
23 enue Service, the Social Security Administration, the
24 Department of Labor, and child support enforce-
25 ment agencies.

1 “(4) CHOICE COUNSELING.—The Secretary
2 may enter into contracts or agreements with a State,
3 a consortium of a State, or a private entity, includ-
4 ing an enrollment broker or community organization
5 or other organization, to educate eligible families
6 about their options and to assist in their enrollment
7 in the supplemental debit card plan.

8 “(5) APPEALS.—The Secretary shall establish
9 an independent appeals process, to be administered
10 by an entity separate from the entity that makes ini-
11 tial eligibility determinations, which shall be avail-
12 able to individuals who are denied benefits under the
13 supplemental debit card program.

14 “(6) RESOLUTION OF ERRORS.—The Secretary
15 shall provide for a reconciliation process with the
16 States to resolve any errors and adjudicate disputes
17 due to incomplete or false information in a family’s
18 application or in the billing process described in sub-
19 section (e).

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

1 “(h) IMPLEMENTATION PLAN.—Not later than 6
2 months after the date of enactment of this section, the
3 Secretary shall submit to Congress a plan for imple-
4 menting this program during fiscal years 2009–2012.

5 “(i) AUTHORIZATION OF APPROPRIATIONS.—

6 “(1) ADMINISTRATION OF THE SUPPLEMENTAL
7 DEBIT CARD PROGRAM.—To administer the program
8 under this section, there are authorized to be appro-
9 priated—

10 “(A) for fiscal year 2009, \$300,000,000,
11 for the design of a unified, national system of
12 conducting the supplemental debit card pro-
13 gram;

14 “(B) for fiscal year 2010, \$1,000,000,000
15 for start-up costs, including, contracting, hiring
16 and training employees, and testing the pro-
17 gram; and

18 “(C) for fiscal year 2011 and each subse-
19 quent fiscal year, \$3,000,000,000.

20 “(2) AUTHORIZATION OF BENEFITS UNDER
21 THE SUPPLEMENTAL DEBIT CARD PROGRAM.—To
22 provide the supplemental debit card benefits de-
23 scribed in this section, there are authorized to be ap-
24 propriated—

1 “(A) for fiscal year 2011,
 2 \$24,020,000,000;
 3 “(B) for fiscal year 2012,
 4 \$25,220,000,000;
 5 “(C) for fiscal year 2013,
 6 \$26,480,000,000;
 7 “(D) for fiscal year 2014,
 8 \$27,810,000,000; and
 9 “(E) for fiscal year 2015,
 10 \$29,200,000,000.”.

11 **TITLE V—FIXING MEDICARE FOR**
 12 **AMERICAN SENIORS**

13 **Subtitle A—Increasing Pro-**
 14 **grammatic Efficiency, Economy,**
 15 **and Accountability**

16 **SEC. 501. ELIMINATING INEFFICIENCIES AND INCREASING**
 17 **CHOICE IN MEDICARE ADVANTAGE.**

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

20 “MEDICARE ADVANTAGE COMPETITIVE BIDDING

21 “SEC. 1860C–2. (a) COMPETITIVE BIDDING.—

22 “(1) IN GENERAL.—In order to promote com-
 23 petition among Medicare Advantage plans and to in-
 24 crease the quality of care furnished under such
 25 plans, the Secretary shall establish and implement a
 26 competitive bidding mechanism under this part.

1 “(2) MECHANISM TO BEGIN IN 2011.—The
2 mechanism established under paragraph (1) shall
3 apply to all MA organizations and plans beginning
4 in 2011.

5 “(3) NO EFFECT ON PART D BENEFITS.—The
6 mechanism established under paragraph (1) shall
7 not affect the provisions of this part relating to ben-
8 efits under part D, including the bidding mechanism
9 used for benefits under such part.

10 “(b) RULES FOR COMPETITIVE BIDDING MECHA-
11 NISM.—Notwithstanding any other provision of this part,
12 the following rules shall apply under the competitive bid-
13 ding mechanism established under subsection (a).

14 “(1) BENCHMARK.—Benchmark amounts for
15 an area for a year shall be established solely through
16 the competitive bids of MA plans. The benchmark
17 amount for each area for a year shall be the average
18 bid of the plans in that area for that year. In estab-
19 lishing the benchmark for an area for a year under
20 the preceding sentence, the Secretary shall exclude
21 the highest and lowest bid for that area and year.
22 The benchmark amount for an area for a year may
23 not exceed the benchmark amount for that area and
24 year that would have applied if this section had not
25 been enacted.

1 “(2) BIDS.—The MA plan bid shall reflect the
2 per capita payments that the MA plan will accept
3 for providing a benefit package that is actuarially
4 equivalent to 106 percent of the value of the original
5 Medicare fee-for-service program option. MA plan
6 bid submissions shall include data on plan average
7 provider network contract rates compared to the
8 rates under the original Medicare fee-for-service pro-
9 gram option for the top 5 most common claim sub-
10 missions per provider type.

11 “(3) RISK ADJUSTMENT.—The benchmark
12 under paragraph (1) and the MA plan bid shall be
13 risk adjusted using the risk adjustment require-
14 ments under this part.

15 “(4) BENEFICIARY PREMIUMS.—The MA
16 monthly basic beneficiary premium for a beneficiary
17 who enrolls in an MA plan whose plan bid is at or
18 below the benchmark shall be zero and the bene-
19 ficiary shall receive the full difference (if any) be-
20 tween the bid and the benchmark in the form of ad-
21 ditional benefits or as a rebate on their premiums
22 under this title. The MA monthly basic beneficiary
23 premium for a beneficiary who enrolls in an MA
24 plan whose plan bid is above the benchmark shall be

1 equal to the amount by which the bid exceeds the
2 benchmark.

3 “(5) BENCHMARK AMOUNTS FOR RURAL COUN-
4 TIES.—The Secretary may adjust the benchmark
5 amount established under paragraph (1) for any
6 rural county (as identified by the Secretary after
7 consultation with the Secretary of Commerce) to en-
8 courage plan participation in such county.

9 “(6) EXISTING REQUIREMENTS.—Requirements
10 relating to licensure, quality, and beneficiary protec-
11 tions that would otherwise apply under this part
12 shall apply under the competitive bidding mechanism
13 established under subsection (a).

14 “(c) WAIVER.—In order to implement the competitive
15 bidding mechanism under established subsection (a), the
16 Secretary may waive or modify requirements under this
17 part.”.

18 **SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION**

19 **DEMONSTRATION PROGRAM.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—In order to promote innova-
22 tive care coordination and delivery that is cost-effec-
23 tive, the Secretary of Health and Human Services
24 (in this section referred to as the “Secretary”) shall

1 conduct a demonstration program under the Medi-
2 care program under which—

3 (A) groups of providers meeting certain
4 criteria may work together to manage and co-
5 ordinate care for Medicare fee-for-service bene-
6 ficiaries through an Accountable Care Organi-
7 zation (in this section referred to as an
8 “ACO”); and

9 (B) providers in participating ACOs are el-
10 igible for bonuses based on performance.

11 (2) MEDICARE FEE-FOR-SERVICE BENEFICIARY
12 DEFINED.—In this section, the term “Medicare fee-
13 for-service beneficiary” means an individual who is
14 enrolled in the original medicare fee-for-service pro-
15 gram under parts A and B of title XVIII of the So-
16 cial Security Act and not enrolled in an MA plan
17 under part C of such title.

18 (b) ELIGIBLE ACOs.—

19 (1) IN GENERAL.—Subject to paragraph (2),
20 the following provider groups are eligible to partici-
21 pate as ACOs under the demonstration program
22 under this section:

23 (A) Physicians in group practice arrange-
24 ments.

1 (B) Networks of individual physician prac-
2 tices.

3 (C) Partnerships or joint venture arrange-
4 ments between hospitals and physicians.

5 (D) Partnerships or joint ventures, which
6 may include pharmacists providing medication
7 therapy management.

8 (E) Hospitals employing physicians.

9 (F) Integrated delivery systems.

10 (G) Community-based coalitions of pro-
11 viders.

12 (2) REQUIREMENTS.—An ACO shall meet the
13 following requirements:

14 (A) The ACO shall have a formal legal
15 structure that would allow the organization to
16 receive and distribute bonuses to participating
17 providers.

18 (B) The ACO shall include the primary
19 care providers of at least 5,000 Medicare fee-
20 for-service beneficiaries.

21 (C) The ACO shall be willing to become
22 accountable for the overall care of the Medicare
23 fee-for-service beneficiaries.

24 (D) The ACO shall provide the Secretary
25 with a list of primary care and specialist physi-

1 cians participating in the ACO to support the
2 beneficiary assignment, implementation of per-
3 formance measures, and the determination of
4 bonus payments under the demonstration pro-
5 gram.

6 (E) The ACO shall have in place contracts
7 with a core group of key specialist physicians,
8 a leadership and management structure, and
9 processes to promote evidence-based medicine
10 and to coordinate care.

11 (c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE
12 BENEFICIARIES.—

13 (1) IN GENERAL.—Under the demonstration
14 program under this section, each Medicare fee-for-
15 service Medicare beneficiary shall be automatically
16 assigned to a primary care provider. Such assign-
17 ment shall be based on the physician from whom the
18 beneficiary received the most primary care in the
19 preceding year.

20 (2) BENEFICIARIES MAY CONTINUE TO SEE
21 PROVIDERS OUTSIDE OF THE ACO.—Under the dem-
22 onstration program under this section, a Medicare
23 fee-for-service Medicare beneficiary may continue to
24 see providers in and outside of the ACO to which
25 they have been assigned.

1 (d) BONUS PAYMENTS.—

2 (1) IN GENERAL.—Under the demonstration
3 program, Medicare payments shall continue to be
4 made to providers under the original Medicare fee-
5 for-service program in the same manner as they
6 would otherwise be made except that a participating
7 ACO is eligible for bonuses if—

8 (A) it meets certain quality performance
9 measures; and

10 (B) spending for their Medicare fee-for-
11 service beneficiaries meets the requirement
12 under paragraph (3).

13 (2) QUALITY.—Under the demonstration pro-
14 gram under this section, providers meet the require-
15 ment under paragraph (1)(A) if they generally follow
16 consensus-based guidelines established by non-gov-
17 ernment professional medical societies. Patient satis-
18 faction and risk-adjusted outcomes shall be deter-
19 mined through an independent entity with medical
20 expertise.

21 (3) REQUIREMENT RELATING TO SPENDING.—

22 (A) IN GENERAL.—An ACO shall only be
23 eligible to receive a bonus payment if the aver-
24 age Medicare expenditures under the ACO for
25 Medicare fee-for-service beneficiaries over a

1 two-year period is at least 2 percent below the
2 average benchmark for the corresponding two-
3 year period. The benchmark for each ACO shall
4 be set using the most recent three years of total
5 per-beneficiary spending for Medicare fee-for-
6 service beneficiaries assigned to the ACO. Such
7 benchmark shall be updated by the projected
8 rate of growth in national per capita spending
9 for the original medicare fee-for-service pro-
10 gram, as projected (using the most recent three
11 years of data) by the Chief Actuary of the Cen-
12 ters for Medicare & Medicaid Services.

13 (4) AMOUNT OF BONUS PAYMENTS.—The
14 amount of the bonus payment to a participating
15 ACO shall be one-half of the percentage point dif-
16 ference between the two-year average of their pa-
17 tients' Medicare expenditures and 98 percent of the
18 two-year average benchmark. The bonus amount, in
19 dollars, shall be equal to the bonus share multiplied
20 by the benchmark for the most recent year.

21 (5) LIMITATION.—Bonus payments may only be
22 made to an ACO if the primary care provider to
23 which the Medicare fee-for-service beneficiary has
24 been assigned under subsection (c) elects to partici-
25 pate in such ACO.

1 (e) WAIVER AUTHORITY.—The Secretary may waive
2 such requirements of titles XI and XVIII of the Social
3 Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as
4 may be appropriate for the purpose of carrying out the
5 demonstration program under this section.

6 (f) REPORT.—Upon completion of the demonstration
7 program under this section, the Secretary shall submit to
8 Congress a report on the program together with such rec-
9 ommendations as the Secretary determines appropriate.

10 **SEC. 503. REDUCING GOVERNMENT HANDOUTS TO**
11 **WEALTHIER SENIORS.**

12 (a) ELIMINATION OF ANNUAL INDEXING OF INCOME
13 THRESHOLDS FOR REDUCED PART B PREMIUM SUB-
14 SIDIES.—

15 (1) IN GENERAL.—Paragraph (5) of section
16 1839(i) of the Social Security Act (42 U.S.C.
17 1395r(i)) is repealed.

18 (2) EFFECTIVE DATE.—The repeal made by
19 paragraph (1) shall apply to premiums for months
20 beginning after December 2010.

21 (b) INCOME-RELATED REDUCTION IN PART D PRE-
22 MIUM SUBSIDY.—

23 (1) INCOME-RELATED REDUCTION IN PART D
24 PREMIUM SUBSIDY.—

1 (A) IN GENERAL.—Section 1860D–13(a)
2 of the Social Security Act (42 U.S.C. 1395w–
3 113(a)) is amended by adding at the end the
4 following new paragraph:

5 “(7) REDUCTION IN PREMIUM SUBSIDY BASED
6 ON INCOME.—

7 “(A) IN GENERAL.—In the case of an indi-
8 vidual whose modified adjusted gross income
9 exceeds the threshold amount applicable under
10 paragraph (2) of section 1839(i) (including ap-
11 plication of paragraph (5) of such section) for
12 the calendar year, the monthly amount of the
13 premium subsidy applicable to the premium
14 under this section for a month after December
15 2010 shall be reduced (and the monthly bene-
16 ficiary premium shall be increased) by the
17 monthly adjustment amount specified in sub-
18 paragraph (B).

19 “(B) MONTHLY ADJUSTMENT AMOUNT.—
20 The monthly adjustment amount specified in
21 this subparagraph for an individual for a month
22 in a year is equal to the product of—

23 “(i) the quotient obtained by divid-
24 ing—

1 “(I) the applicable percentage de-
2 termined under paragraph (3)(C) of
3 section 1839(i) (including application
4 of paragraph (5) of such section) for
5 the individual for the calendar year
6 reduced by 25.5 percent; by

7 “(II) 25.5 percent; and

8 “(ii) the base beneficiary premium (as
9 computed under paragraph (2)).

10 “(C) MODIFIED ADJUSTED GROSS IN-
11 COME.—For purposes of this paragraph, the
12 term ‘modified adjusted gross income’ has the
13 meaning given such term in subparagraph (A)
14 of section 1839(i)(4), determined for the tax-
15 able year applicable under subparagraphs (B)
16 and (C) of such section.

17 “(D) DETERMINATION BY COMMISSIONER
18 OF SOCIAL SECURITY.—The Commissioner of
19 Social Security shall make any determination
20 necessary to carry out the income-related reduc-
21 tion in premium subsidy under this paragraph.

22 “(E) PROCEDURES TO ASSURE CORRECT
23 INCOME-RELATED REDUCTION IN PREMIUM
24 SUBSIDY.—

1 “(i) DISCLOSURE OF BASE BENE-
2 FICIARY PREMIUM.—Not later than Sep-
3 tember 15 of each year beginning with
4 2010, the Secretary shall disclose to the
5 Commissioner of Social Security the
6 amount of the base beneficiary premium
7 (as computed under paragraph (2)) for the
8 purpose of carrying out the income-related
9 reduction in premium subsidy under this
10 paragraph with respect to the following
11 year.

12 “(ii) ADDITIONAL DISCLOSURE.—Not
13 later than October 15 of each year begin-
14 ning with 2010, the Secretary shall dis-
15 close to the Commissioner of Social Secu-
16 rity the following information for the pur-
17 pose of carrying out the income-related re-
18 duction in premium subsidy under this
19 paragraph with respect to the following
20 year:

21 “(I) The modified adjusted gross
22 income threshold applicable under
23 paragraph (2) of section 1839(i) (in-
24 cluding application of paragraph (5)
25 of such section).

1 “(II) The applicable percentage
2 determined under paragraph (3)(C) of
3 section 1839(i) (including application
4 of paragraph (5) of such section).

5 “(III) The monthly adjustment
6 amount specified in subparagraph
7 (B).

8 “(IV) Any other information the
9 Commissioner of Social Security de-
10 termines necessary to carry out the
11 income-related reduction in premium
12 subsidy under this paragraph.

13 “(F) RULE OF CONSTRUCTION.—The for-
14 mula used to determine the monthly adjustment
15 amount specified under subparagraph (B) shall
16 only be used for the purpose of determining
17 such monthly adjustment amount under such
18 subparagraph.”.

19 (B) COLLECTION OF MONTHLY ADJUST-
20 MENT AMOUNT.—Section 1860D–13(c) of the
21 Social Security Act (42 U.S.C. 1395w–113(c))
22 is amended—

23 (i) in paragraph (1), by striking “(2)
24 and (3)” and inserting “(2), (3), and (4)”;
25 and

1 (ii) by adding at the end the following
2 new paragraph:

3 “(4) COLLECTION OF MONTHLY ADJUSTMENT
4 AMOUNT.—

5 “(A) IN GENERAL.—Notwithstanding any
6 provision of this subsection or section
7 1854(d)(2), subject to subparagraph (B), the
8 amount of the income-related reduction in pre-
9 mium subsidy for an individual for a month (as
10 determined under subsection (a)(7)) shall be
11 paid through withholding from benefit pay-
12 ments in the manner provided under section
13 1840.

14 “(B) AGREEMENTS.—In the case where
15 the monthly benefit payments of an individual
16 that are withheld under subparagraph (A) are
17 insufficient to pay the amount described in such
18 subparagraph, the Commissioner of Social Se-
19 curity shall enter into agreements with the Sec-
20 retary, the Director of the Office of Personnel
21 Management, and the Railroad Retirement
22 Board as necessary in order to allow other
23 agencies to collect the amount described in sub-
24 paragraph (A) that was not withheld under
25 such subparagraph.”.

1 (2) CONFORMING AMENDMENTS.—

2 (A) MEDICARE.—Part D of title XVIII of
3 the Social Security Act (42 U.S.C. 1395w–101
4 et seq.) is amended—

5 (i) in section 1860D–13(a)(1)—

6 (I) by redesignating subpara-
7 graph (F) as subparagraph (G);

8 (II) in subparagraph (G), as re-
9 designated by subparagraph (A), by
10 striking “(D) and (E)” and inserting
11 “(D), (E), and (F)”; and

12 (III) by inserting after subpara-
13 graph (E) the following new subpara-
14 graph:

15 “(F) INCREASE BASED ON INCOME.—The
16 monthly beneficiary premium shall be increased
17 pursuant to paragraph (7).”; and

18 (ii) in section 1860D–15(a)(1)(B), by
19 striking “paragraph (1)(B)” and inserting
20 “paragraphs (1)(B) and (1)(F)”.

21 (B) INTERNAL REVENUE CODE.—Section
22 6103(l)(20) of the Internal Revenue Code of
23 1986 (relating to disclosure of return informa-
24 tion to carry out Medicare part B premium sub-
25 sidy adjustment) is amended—

1 (i) in the heading, by striking “PART
2 B PREMIUM SUBSIDY ADJUSTMENT” and
3 inserting “PARTS B AND D PREMIUM SUB-
4 SIDY ADJUSTMENTS”;

5 (ii) in subparagraph (A)—

6 (I) in the matter preceding clause
7 (i), by inserting “or 1860D–13(a)(7)”
8 after “1839(i)”; and

9 (II) in clause (vii), by inserting
10 after “subsection (i) of such section”
11 the following: “or under section
12 1860D–13(a)(7) of such Act”;

13 (iii) in subparagraph (B)—

14 (I) by inserting “or such section
15 1860D–13(a)(7)” before the period at
16 the end;

17 (II) as amended by clause (i), by
18 inserting “or for the purpose of re-
19 solving tax payer appeals with respect
20 to any such premium adjustment” be-
21 fore the period at the end; and

22 (III) by adding at the end the
23 following new sentence: “Officers, em-
24 ployees, and contractors of the Social
25 Security Administration may disclose

1 such return information to officers,
2 employees, and contractors of the De-
3 partment of Health and Human Serv-
4 ices, the Office of Personnel Manage-
5 ment, the Railroad Retirement Board,
6 the Department of Justice, and the
7 courts of the United States to the ex-
8 tent necessary to carry out the pur-
9 poses described in the preceding sen-
10 tence.”; and

11 (iv) by adding at the end the following
12 new subparagraph:

13 “(C) TIMING OF DISCLOSURE.—Return in-
14 formation shall be disclosed to officers, employ-
15 ees, and contractors of the Social Security Ad-
16 ministration under subparagraph (A) not later
17 than the date that is 90 days prior to the date
18 on which the taxpayer first becomes entitled to
19 benefits under part A of title XVIII of the So-
20 cial Security Act or eligible to enroll for benefits
21 under part B of such title.”.

22 **SEC. 504. REWARDING PREVENTION.**

23 Section 1839 of the Social Security Act (42 U.S.C.
24 1395r) is amended—

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

3 (2) by adding at the end the following new sub-
4 section:

5 “(j)(1) With respect to the monthly premium amount
6 for months after December 2010, the Secretary may ad-
7 just (under procedures established by the Secretary) the
8 amount of such premium for an individual based on
9 whether or not the individual participates in certain
10 healthy behaviors, such as weight management, exercise,
11 nutrition counseling, refraining from tobacco use, desig-
12 nating a health home, and other behaviors determined ap-
13 propriate by the Secretary.

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

21 **SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANS-**
22 **PARENCY.**

23 (a) **TRANSPARENCY.**—Title XVIII of the Social Secu-
24 rity Act is amended by adding at the end the following
25 new section:

1 “PRICE TRANSPARENCY REQUIREMENTS

2 “SEC. 1899. (a) PRE-TREATMENT DISCLOSURE.—A
3 provider of services (as defined in section 1861(u)) and
4 a supplier (as defined in section 1861(d)) shall provide
5 to each individual (regardless of whether or not the indi-
6 vidual is a beneficiary under this title) who is scheduled
7 to receive a treatment (or to begin a course of treatment)
8 that is not for an emergency medical condition the esti-
9 mated price that the provider of services or supplier will
10 charge for the treatment (or course of treatment). Such
11 price shall be determined at the time of scheduling.

12 “(b) POST-TREATMENT DISCLOSURE.—A provider of
13 services (as so defined) and a supplier (as so defined) shall
14 include with any bill that includes the charges for a treat-
15 ment with respect to an individual (regardless of whether
16 or not the individual is a beneficiary under this title), an
17 itemized list of component charges for such treatment, in-
18 cluding charges for drugs and medical equipment involved,
19 as determined at the time of billing. With respect to each
20 item included on such list, the provider of services or sup-
21 plier shall include the price charged for the item.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to providers of services and sup-
24 pliers on and after January 1, 2011.

1 **SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID**
2 **CLAIMS AND PATIENT ENCOUNTER DATA.**

3 (a) PUBLIC AVAILABILITY.—Not later than 1 year
4 after the date of enactment of this Act (and annually
5 thereafter), the Secretary of Health and Human Services
6 (in this section referred to as the “Secretary”), shall make
7 available to the public (including through an Internet
8 website) data on claims and patient encounters under ti-
9 tles XVIII and XIX of the Social Security Act during the
10 preceding calendar year. Such data shall be appropriately
11 disaggregated and patient deidentified, as determined nec-
12 essary by the Secretary in order to comply with the Fed-
13 eral regulations (concerning the privacy of individually
14 identifiable health information) promulgated under section
15 264(c) of the Health Insurance Portability and Account-
16 ability Act of 1996.

17 (b) PROVISION OF DATA TO STATE EXCHANGES AND
18 HEALTH INSURANCE ISSUERS UNDER THE STATE EX-
19 CHANGE.—The Secretary shall submit such data directly
20 to a State Exchange under title II and health insurance
21 issuers under such Exchange (in a form and manner de-
22 termined appropriate by the Secretary).

23 (c) MATCHING OF DATA.—The Secretary shall en-
24 sure that the total amount of claims under such titles dur-
25 ing the preceding year for which data is made available
26 under subsection (a) is equal to the reported outlays from

1 the Federal government and the States under such titles
2 during the preceding years.

3 **Subtitle B—Reducing Fraud and**
4 **Abuse**

5 **SEC. 511. REQUIRING THE SECRETARY OF HEALTH AND**
6 **HUMAN SERVICES TO CHANGE THE MEDI-**
7 **CARE BENEFICIARY IDENTIFIER USED TO**
8 **IDENTIFY MEDICARE BENEFICIARIES UNDER**
9 **THE MEDICARE PROGRAM.**

10 (a) PROCEDURES.—

11 (1) IN GENERAL.—Not later than 1 year after
12 the date of enactment of this Act, in order to protect
13 beneficiaries from identity theft, the Secretary of
14 Health and Human Services (in this section referred
15 to as the “Secretary”) shall establish and implement
16 procedures to change the Medicare beneficiary iden-
17 tifier used to identify individuals entitled to benefits
18 under part A of title XVIII of the Social Security
19 Act or enrolled under part B of such title so that
20 such an individual’s social security account number
21 is not used. Such procedures shall provide that the
22 new Medicare beneficiary identifier includes biomet-
23 ric identification protections.

24 (2) MAINTAINING EXISTING HICN STRUC-
25 TURE.—In order to minimize the impact of the

1 change under paragraph (1) on systems that com-
2 municate with Medicare beneficiary eligibility sys-
3 tems, the procedures under paragraph (1) shall pro-
4 vide that the new Medicare beneficiary identifier
5 maintain the existing Health Insurance Claim Num-
6 ber structure.

7 (3) PROTECTION AGAINST FRAUD.—The proce-
8 dures under paragraph (1) shall provide for a proc-
9 ess for changing the Medicare beneficiary identifier
10 for an individual to a different identifier in the case
11 of the discovery of fraud, including identity theft.

12 (4) PHASE-IN AUTHORITY.—

13 (A) IN GENERAL.—Subject to subpara-
14 graphs (B) and (C), the Secretary may phase in
15 the change under paragraph (1) in such man-
16 ner as the Secretary determines appropriate.

17 (B) LIMIT.—The phase-in period under
18 subparagraph (A) shall not exceed 10 years.

19 (C) NEWLY ENTITLED AND ENROLLED IN-
20 DIVIDUALS.—The Secretary shall ensure that
21 the change under paragraph (1) is implemented
22 not later than January 1, 2010, with respect to
23 any individual who first becomes entitled to
24 benefits under part A of title XVIII of the So-

1 cial Security Act or enrolled under part B of
2 such title on or after such date.

3 (b) EDUCATION AND OUTREACH.—The Secretary
4 shall establish a program of education and outreach for
5 individuals entitled to, or enrolled for, benefits under part
6 A of title XVIII of the Social Security Act or enrolled
7 under part B of such title, providers of services (as defined
8 in subsection (u) of section 1861 of such Act (42 U.S.C.
9 1395x)), and suppliers (as defined in subsection (d) of
10 such section) on the change under paragraph (1).

11 (c) DATA MATCHING.—

12 (1) ACCESS TO CERTAIN INFORMATION.—Sec-
13 tion 205(r) of the Social Security Act (42 U.S.C.
14 405(r)) is amended by adding at the end the fol-
15 lowing new paragraph:

16 “(9)(A) The Commissioner of Social Security
17 shall, upon the request of the Secretary—

18 “(i) enter into an agreement with the Sec-
19 retary for the purpose of matching data in the
20 system of records of the Commissioner with
21 data in the system of records of the Secretary,
22 so long as the requirements of subparagraphs
23 (A) and (B) of paragraph (3) are met, in order
24 to determine—

1 “(I) whether a beneficiary under the
2 program under title XVIII, XIX, or XXI is
3 dead, imprisoned, or otherwise not eligible
4 for benefits under such program; and

5 “(II) whether a provider of services or
6 a supplier under the program under title
7 XVIII, XIX, or XXI is dead, imprisoned,
8 or otherwise not eligible to furnish or re-
9 ceive payment for furnishing items and
10 services under such program; and

11 “(ii) include in such agreement safeguards
12 to assure the maintenance of the confidentiality
13 of any information disclosed and procedures to
14 permit the Secretary to use such information
15 for the purpose described in clause (i).

16 “(B) Information provided pursuant to an
17 agreement under this paragraph shall be provided at
18 such time, in such place, and in such manner as the
19 Commissioner determines appropriate.

20 “(C) Information provided pursuant to an
21 agreement under this paragraph shall include infor-
22 mation regarding whether—

23 “(i) the name (including the first name
24 and any family name or surname), the date of
25 birth (including the month, day, and year), and

1 social security number of an individual provided
2 to the Commissioner match the information
3 contained in the Commissioner's records, and

4 “(ii) such individual is shown on the
5 records of the Commissioner as being de-
6 ceased.”.

7 (2) INVESTIGATION BASED ON CERTAIN INFOR-
8 MATION.—Title XI of the Social Security Act (42
9 U.S.C. 1301 et seq.) is amended by inserting after
10 section 1128F the following new section:

11 **“SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGA-**
12 **TION OF CLAIMS INVOLVING INDIVIDUALS**
13 **WHO ARE NOT ELIGIBLE FOR BENEFITS OR**
14 **ARE NOT ELIGIBLE PROVIDERS OF SERVICES**
15 **OR SUPPLIERS.**

16 “(a) DATA AGREEMENT.—The Secretary shall enter
17 into an agreement with the Commissioner of Social Secu-
18 rity pursuant to section 205(r)(9).

19 “(b) INVESTIGATION OF CLAIMS INVOLVING CER-
20 TAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENE-
21 FITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR
22 SUPPLIERS.—

23 “(1) IN GENERAL.—The Secretary shall, in the
24 case where a provider of services or a supplier under
25 the program under title XVIII, XIX, or XXI sub-

1 mits a claim for payment for items or services fur-
2 nished to an individual who the Secretary deter-
3 mines, as a result of information provided pursuant
4 to such agreement, is not eligible for benefits under
5 such program, or where the Secretary determines, as
6 a result of such information, that such provider of
7 services or supplier is not eligible to furnish or re-
8 ceive payment for furnishing such items or services,
9 conduct an investigation with respect to the provider
10 of services or supplier. If the Secretary determines
11 further action is appropriate, the Secretary shall
12 refer the investigation to the Inspector General of
13 the Department of Health and Human Services as
14 soon as practicable.

15 “(2) ASSESSMENT OF IMPLEMENTATION AND
16 EFFECTIVENESS BY THE OIG.—The Inspector Gen-
17 eral of the Department of Health and Human Serv-
18 ices shall test the implementation of the provisions
19 of this section (including the implementation of the
20 agreement under section 205(r)(9)) and conduct
21 such period assessments of such implementation as
22 the Inspector General determines necessary to deter-
23 mine the effectiveness of such implementation.”.

1 (d) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section.

4 **SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA RE-**
5 **VIEW.**

6 Title XVIII of the Social Security Act, as amended
7 by this Act, is amended by adding at the end the following
8 new section:

9 “USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

10 “SEC. 1899A. (a) IN GENERAL.—The Secretary shall
11 establish procedures for the use of technology (including
12 front-end, pre-payment technology similar to that used by
13 hedge funds, investment funds, and banks) to provide real-
14 time data analysis of claims for payment under this title
15 to identify and investigate unusual billing or order prac-
16 tices under this title that could indicate fraud or abuse.

17 “(b) COMPETITIVE BIDDING.—The procedures estab-
18 lished under subsection (a) shall ensure that the imple-
19 mentation of such technology is conducted through a com-
20 petitive bidding process.”.

21 **SEC. 513. DETECTION OF MEDICARE FRAUD AND ABUSE.**

22 (a) IN GENERAL.—Section 1893 of the Social Secu-
23 rity Act (42 U.S.C. 1395ddd) is amended—

24 (1) in subsection (b), by adding at the end the
25 following new paragraph:

1 “(7) Implementation of fraud and abuse detec-
2 tion methods under subsection (i).”;

3 (2) in subsection (c), by adding at the end of
4 the flush matter following paragraph (4), the fol-
5 lowing new sentence “In the case of an activity de-
6 scribed in subsection (b)(8), an entity shall only be
7 eligible to enter into a contract under the Program
8 to carry out the activity if the entity is selected
9 through a competitive bidding process in accordance
10 with subsection (i)(3).”; and

11 (3) by adding at the end the following new sub-
12 section:

13 “(i) DETECTION OF MEDICARE FRAUD AND
14 ABUSE.—

15 “(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY
16 COUNTIES MOST VULNERABLE TO FRAUD.—Not
17 later than 6 months after the date of enactment of
18 this subsection, the Secretary shall establish a sys-
19 tem to identify the 50 counties most vulnerable to
20 fraud with respect to items and services furnished by
21 providers of services (other than hospitals and crit-
22 ical access hospitals) and suppliers based on the de-
23 gree of county-specific reimbursement and analysis
24 of payment trends under this title. The Secretary

1 shall designate the counties identified under the pre-
2 ceding sentence as ‘high risk areas’.

3 “(2) FRAUD AND ABUSE DETECTION.—

4 “(A) INITIAL IMPLEMENTATION.—The
5 Secretary shall establish procedures for the im-
6 plementation of fraud and abuse detection
7 methods under this title with respect to items
8 and services furnished by such providers of
9 services and suppliers in high risk areas des-
10 ignated under paragraph (1) (and, beginning
11 not later than 18 months after the date of en-
12 actment of this subsection, with respect to
13 items and services furnished by such providers
14 of services and suppliers in areas not so des-
15 ignated) including the following:

16 “(i) Data analysis to establish prepay-
17 ment claim edits designed to target the
18 claims for payment under this title for
19 such items and services that are most like-
20 ly to be fraudulent.

21 “(ii) Prepayment benefit integrity re-
22 views for claims for payment under this
23 title for such items and services that are
24 suspended as a result of such edits.

1 “(B) REQUIREMENT FOR PARTICIPA-
2 TION.—In no case may a provider of services or
3 supplier who does not meet the requirements
4 under subparagraph (A) participate in the pro-
5 gram under this title.

6 “(C) EXPANDED IMPLEMENTATION.—Not
7 later than 24 months after the date of enact-
8 ment of this subsection, the Secretary shall es-
9 tablish procedures for the implementation of
10 such fraud and abuse detection methods under
11 this title with respect to items and services fur-
12 nished by all providers of services and suppliers,
13 including those not in high risk areas des-
14 ignated under paragraph (1).

15 “(3) COMPETITIVE BIDDING.—In selecting enti-
16 ties to carry out this subsection, the Secretary shall
17 use a competitive bidding process.

18 “(4) REPORT TO CONGRESS.—The Secretary
19 shall submit to Congress an annual report on the ef-
20 fectiveness of activities conducted under this sub-
21 section, including a description of any savings to the
22 program under this title as a result of such activities
23 and the overall administrative cost of such activities
24 and a determination as to the amount of funding
25 needed to carry out this subsection for subsequent

1 fiscal years, together with recommendations for such
2 legislation and administrative action as the Sec-
3 retary determines appropriate.”.

4 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out the amendments made by this section, there are au-
6 thorized to be appropriated—

7 (1) such sums as may be necessary, not to ex-
8 ceed \$50,000,000, for each of fiscal years 2010
9 through 2014; and

10 (2) such sums as may be necessary, not to ex-
11 ceed an amount the Secretary determines appro-
12 priate in the most recent report submitted to Con-
13 gress under section 1893(j)(4) of the Social Security
14 Act, as added by subsection (a), for each subsequent
15 fiscal year.

16 **SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLI-**
17 **CATION AND EXEMPTION OF PHARMACISTS**
18 **FROM SURETY BOND REQUIREMENT.**

19 (a) EDITS ON 855S MEDICARE ENROLLMENT APPLI-
20 CATION.—Section 1834(a) of the Social Security Act (42
21 U.S.C. 1395m(a)) is amended by adding at the end the
22 following new paragraphs:

23 “(22) CONFIRMATION WITH NATIONAL SUP-
24 PLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

1 “(A) IN GENERAL.—Not later than 1 year
2 after the date of enactment of this paragraph,
3 the Secretary shall establish procedures to re-
4 quire carriers, prior to paying a claim for pay-
5 ment for durable medical equipment, pros-
6 thetics, orthotics, and supplies under this title,
7 to confirm with the National Supplier Clearing-
8 house—

9 “(i) that the National Provider Identifi-
10 fier of the physician or practitioner pre-
11 scribing or ordering the item or service is
12 valid and active;

13 “(ii) that the Medicare identification
14 number of the supplier is valid and active;
15 and

16 “(iii) that the item or service for
17 which the claim for payment is submitted
18 was properly identified on the CMS–855S
19 Medicare enrollment application.

20 “(B) ONLINE DATABASE FOR IMPLEMEN-
21 TATION.—Not later than 18 months after the
22 date of enactment of this paragraph, the Sec-
23 retary shall establish an online database similar
24 to that used for the National Provider Identifier
25 to enable providers of services, accreditors, car-

1 riers, and the National Supplier Clearinghouse
2 to view information on specialties and the types
3 of items and services each supplier has indi-
4 cated on the CMS–855S Medicare enrollment
5 application submitted by the supplier.

6 “(C) NOTIFICATION OF CLAIM DENIAL
7 AND RESUBMISSION.—In the case where a claim
8 for payment for durable medical equipment,
9 prosthetics, orthotics, and supplies under this
10 title is denied because the item or service fur-
11 nished does not correctly match up with the in-
12 formation on file with the National Supplier
13 Clearinghouse—

14 “(i) the National Supplier Clearing-
15 house shall—

16 “(I) provide the supplier written
17 notification of the reason for such de-
18 nial; and

19 “(II) allow the supplier 60 days
20 to provide the National Supplier
21 Clearinghouse with appropriate certifi-
22 cation, licensing, or accreditation; and

23 “(ii) the Secretary shall waive applica-
24 ble requirements relating to the time frame
25 for the submission of claims for payment

1 under this title in order to permit the re-
2 submission of such claim if payment of
3 such claim would otherwise be allowed
4 under this title.

5 “(D) IMPROVEMENTS TO MEDICARE EN-
6 ROLLMENT APPLICATION.—The Secretary shall
7 establish procedures under which a prospective
8 supplier of durable medical equipment, pros-
9 thetics, orthotics, and supplies under this title
10 shall certify, as part of the CMS–855S Medi-
11 care enrollment application submitted by such
12 supplier, under penalty of perjury, that the in-
13 formation provided by the supplier on such ap-
14 plication is accurate to the best of the supplier’s
15 knowledge.

16 “(23) TERMINATION OF PARTICIPATION FOR
17 SUBMISSION OF FRAUDULENT CLAIMS.—If the Sec-
18 retary finds that a supplier of durable medical
19 equipment, prosthetics, orthotics, and supplies under
20 this title has submitted fraudulent claims for pay-
21 ment under this title, the Secretary shall terminate
22 the suppliers participation under this title. Not later
23 than 1 year after the date of enactment of this para-
24 graph, the Secretary shall establish a process under
25 which a supplier whose participation has been termi-

1 nated under the preceding sentence may appeal such
2 termination and such appeal shall be resolved not
3 later than 60 days after the date on which the ap-
4 peal was made.”.

5 (b) EXEMPTION OF PHARMACISTS FROM SURETY
6 BOND REQUIREMENT.—Section 1834(a)(16) of the Social
7 Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the
8 second sentence, by inserting “and shall waive such re-
9 quirement in the case of a pharmacist” before the period
10 at the end.

11 **SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS OF**
12 **SURETY BOND REQUIREMENTS FOR SUP-**
13 **PLIERS OF DURABLE MEDICAL EQUIPMENT**
14 **IN COMBATING FRAUD.**

15 (a) STUDY.—The Comptroller General of the United
16 States shall conduct a study on the effectiveness of the
17 surety bond requirement under section 1834(a)(16) of the
18 Social Security Act (42 U.S.C. 1395m(a)(16)) in com-
19 bating fraud.

20 (b) REPORT.—Not later than 1 year after the date
21 of enactment of this Act, the Comptroller General shall
22 submit to Congress a report containing the results of the
23 study conducted under subsection (a), together with rec-
24 ommendations for such legislation and administrative ac-
25 tion as the Comptroller General determines appropriate.

1 **TITLE VI—ENDING LAWSUIT**
2 **ABUSE**

3 **SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLU-**
4 **TIONS.**

5 Part P of title III of the Public Health Service Act
6 (42 U.S.C. 280g et seq.) is amended by adding at the end
7 the following:

8 **“SEC. 399R. STATE GRANTS TO CREATE HEALTH COURT SO-**
9 **LUTIONS.**

10 “(a) **IN GENERAL.**—The Secretary may award grants
11 to States for the development, implementation, and eval-
12 uation of alternatives to current tort litigation that comply
13 with this section, for the resolution of disputes concerning
14 injuries allegedly caused by health care providers or health
15 care organizations.

16 “(b) **CONDITIONS FOR DEMONSTRATION GRANTS.**—

17 “(1) **APPLICATION.**—To be eligible to receive a
18 grant under this section, a State shall submit to the
19 Secretary an application at such time, in such man-
20 ner, and containing such information as may be re-
21 quired by the Secretary. A grant shall be awarded
22 under this section on such terms and conditions as
23 the Secretary determines appropriate.

24 “(2) **STATE REQUIREMENTS.**—To be eligible to
25 receive a grant under this section, a State shall—

1 “(A) develop and implement an alternative
2 to current tort litigation for resolving disputes
3 over injuries allegedly caused by health care
4 providers or health care organizations based on
5 one or more of the models described in sub-
6 section (d); and

7 “(B) implement policies that provide for a
8 reduction in health care errors through the col-
9 lection and analysis by organizations that en-
10 gage in voluntary efforts to improve patient
11 safety and the quality of health care delivery, of
12 patient safety data related to disputes resolved
13 under the alternatives under subparagraph (A).

14 “(3) DEMONSTRATION OF EFFECTIVENESS.—
15 To be eligible to receive a grant under subsection
16 (a), a State shall demonstrate how the proposed al-
17 ternative to be implemented under paragraph (2)(A)
18 will—

19 “(A) make the medical liability system of
20 the State more reliable through the prompt and
21 fair resolution of disputes;

22 “(B) encourage the early disclosure of
23 health care errors;

24 “(C) enhance patient safety; and

1 “(D) maintain access to medical liability
2 insurance.

3 “(4) SOURCES OF COMPENSATION.—To be eligi-
4 ble to receive a grant under subsection (a), a State
5 shall identify the sources from, and methods by
6 which, compensation would be paid for medical li-
7 ability claims resolved under the proposed alter-
8 native to current tort litigation implemented under
9 paragraph (2)(A). Funding methods shall, to the ex-
10 tent practicable, provide financial incentives for ac-
11 tivities that improve patient safety.

12 “(5) SCOPE.—

13 “(A) IN GENERAL.—To be eligible to re-
14 ceive a grant under subsection (a), a State shall
15 utilize the proposed alternative identified under
16 paragraph (2)(A) for the resolution of all types
17 of disputes concerning injuries allegedly caused
18 by health care providers or health care organi-
19 zations.

20 “(B) CURRENT STATE EFFORTS TO ESTAB-
21 LISH ALTERNATIVE TO TORT LITIGATION.—

22 “(i) IN GENERAL.—Nothing in this
23 section shall be construed to limit the ef-
24 forts that any State has made prior to the

1 date of enactment of this section to estab-
2 lish any alternative to tort litigation.

3 “(ii) ALTERNATIVE FOR PRACTICE
4 AREAS OR INJURIES.—In the case of a
5 State that has established an alternative to
6 tort litigation for a certain area of health
7 care practice or a category of injuries, the
8 alternative selected as provided for in this
9 section shall supplement not replace or in-
10 validate such established alternative unless
11 the State intends otherwise.

12 “(6) NOTIFICATION OF PATIENTS.—To be eligi-
13 ble to receive a grant under subsection (a), the State
14 shall demonstrate how patients will be notified when
15 they are receiving health care services that fall with-
16 in the scope of the alternative selected under this
17 section by the State to current tort litigation.

18 “(c) REPRESENTATION BY COUNSEL.—A State that
19 receives a grant under this section may not preclude any
20 party to a dispute that falls within the jurisdiction of the
21 alternative to current tort litigation that is implemented
22 under the grant from obtaining legal representation at any
23 point during the consideration of the claim under such al-
24 ternative.

25 “(d) MODELS.—

1 “(1) IN GENERAL.—The models in this section
2 are the following:

3 “(2) EXPERT PANEL REVIEW AND EARLY
4 OFFER GUIDELINES.—

5 “(A) IN GENERAL.—A State may use
6 amounts received under a grant under this sec-
7 tion to develop and implement an expert panel
8 and early offer review system that meets the re-
9 quirements of this paragraph.

10 “(B) ESTABLISHMENT OF PANEL.—Under
11 the system under this paragraph, the State
12 shall establish an expert panel to review any
13 disputes concerning injuries allegedly caused by
14 health care providers or health care organiza-
15 tions according to the guidelines described in
16 this paragraph.

17 “(C) COMPOSITION.—

18 “(i) IN GENERAL.—An expert panel
19 under this paragraph shall be composed of
20 3 medical experts (either physicians or
21 health care professionals) and 3 attorneys
22 to be appointed by the head of the State
23 agency responsible for health.

24 “(ii) LICENSURE AND EXPERTISE.—
25 Each physician or health care professional

1 appointed to an expert panel under clause
2 (i) shall—

3 “(I) be appropriately credentialed
4 or licensed in the State in which the
5 dispute takes place to deliver health
6 care services; and

7 “(II) typically treat the condi-
8 tion, make the diagnosis, or provide
9 the type of treatment that is under re-
10 view.

11 “(iii) INDEPENDENCE.—

12 “(I) IN GENERAL.—Subject to
13 subclause (II), each individual ap-
14 pointed to an expert panel under this
15 paragraph shall—

16 “(aa) not have a material
17 familial, financial, or professional
18 relationship with a party involved
19 in the dispute reviewed by the
20 panel; and

21 “(bb) not otherwise have a
22 conflict of interest with such a
23 party.

24 “(II) EXCEPTION.—Nothing in
25 subclause (I) shall be construed to

1 prohibit an individual who has staff
2 privileges at an institution where the
3 treatment involved in the dispute was
4 provided from serving as a member of
5 an expert panel merely on the basis of
6 such affiliation, if the affiliation is
7 disclosed to the parties and neither
8 party objects.

9 “(iv) PRACTICING HEALTH CARE PRO-
10 FESSIONAL IN SAME FIELD.—

11 “(I) IN GENERAL.—In a dispute
12 before an expert panel that involves
13 treatment, or the provision of items or
14 services—

15 “(aa) by a physician, the
16 medical experts on the expert
17 panel shall be practicing physi-
18 cians (allopathic or osteopathic)
19 of the same or similar specialty
20 as a physician who typically
21 treats the condition, makes the
22 diagnosis, or provides the type of
23 treatment under review; or

24 “(bb) by a health care pro-
25 fessional other than a physician,

1 at least two medical experts on
2 the expert panel shall be prac-
3 ticing physicians (allopathic or
4 osteopathic) of the same or simi-
5 lar specialty as the health care
6 professional who typically treats
7 the condition, makes the diag-
8 nosis, or provides the type of
9 treatment under review, and, if
10 determined appropriate by the
11 State agency, the third medical
12 expert shall be a practicing
13 health care professional (other
14 than such a physician) of such a
15 same or similar specialty.

16 “(II) PRACTICING DEFINED.—In
17 this paragraph, the term ‘practicing’
18 means, with respect to an individual
19 who is a physician or other health
20 care professional, that the individual
21 provides health care services to indi-
22 vidual patients on average at least 2
23 days a week.

24 “(V) PEDIATRIC EXPERTISE.—In the
25 case of dispute relating to a child, at least

1 1 medical expert on the expert panel shall
2 have expertise described in clause (iv)(I) in
3 pediatrics.

4 “(D) DETERMINATION.—After a review,
5 an expert panel shall make a determination as
6 to the liability of the parties involved and com-
7 pensation based on a schedule of compensation
8 that is developed by the panel. Such a schedule
9 shall at least include—

10 “(i) payment for the net economic loss
11 incurred by the patient, on a periodic
12 basis, reduced by any payments received by
13 the patient under—

14 “(I) any health or accident insur-
15 ance;

16 “(II) any wage or salary continu-
17 ation plan; or

18 “(III) any disability income in-
19 surance;

20 “(ii) payment for the non-economic
21 damages incurred by the patient, if appro-
22 priate for the injury, based on a defined
23 payment schedule developed by the State,
24 in consultation with relevant experts and
25 with the Secretary;

1 “(iii) reasonable attorney’s fees; and

2 “(iv) regular updates of the schedule
3 under clause (ii) as necessary.

4 “(E) ACCEPTANCE.—If the parties to a
5 dispute who come before an expert panel under
6 this paragraph accept the determination of the
7 expert panel concerning liability and compensa-
8 tion, such compensation shall be paid to the
9 claimant and the claimant shall agree to forgo
10 any further action against the health care pro-
11 viders or health care organizations involved.

12 “(F) FAILURE TO ACCEPT.—If any party
13 decides not to accept the expert panel’s deter-
14 mination under this paragraph, the State may
15 choose whether to allow the panel to review the
16 determination de novo, with deference, or to
17 provide an opportunity for parties to reject the
18 determination of the panel.

19 “(G) REVIEW BY STATE COURT AFTER EX-
20 HAUSTION OF ADMINISTRATIVE REMEDIES.—

21 “(i) RIGHT TO FILE.—If the State
22 elects not to permit the expert panel under
23 this paragraph to conduct its own reviews
24 of determinations, or if the State elects to
25 permit such reviews but a party is not sat-

1 isfied with the final decision of the panel
2 after such a review, the party shall have
3 the right to file a claim relating to the in-
4 jury involved in a State court of competent
5 jurisdiction.

6 “(ii) FORFEIT OF AWARDS.—Any
7 party filing an action in a State court
8 under clause (i) shall forfeit any compensa-
9 tion award made under subparagraph (C).

10 “(iii) ADMISSIBILITY.—The deter-
11 minations of the expert panel pursuant to
12 a review under subparagraph (C) shall be
13 admissible into evidence in any State court
14 proceeding under this subparagraph.

15 “(3) ADMINISTRATIVE HEALTH CARE TRIBU-
16 NALS.—

17 “(A) IN GENERAL.—A State may use
18 amounts received under a grant under this sec-
19 tion to develop and implement an administra-
20 tive health care tribunal system under which
21 the parties involved shall have the right to re-
22 quest a hearing to review any dispute con-
23 cerning injuries allegedly caused by health care
24 providers or health care organizations before an

1 administrative health care tribunal established
2 by the State involved.

3 “(B) REQUIREMENTS.—In establishing an
4 administrative health care tribunal under this
5 paragraph, a State shall—

6 “(i) ensure that such tribunals are
7 presided over by special judges with health
8 care expertise who meet applicable State
9 standards for judges and who agree to pre-
10 side over such court voluntarily;

11 “(ii) provide authority to such judges
12 to make binding rulings, rendered in writ-
13 ten decisions, on standards of care, causa-
14 tion, compensation, and related issues with
15 reliance on independent expert witnesses
16 commissioned by the tribunal;

17 “(iii) establish a legal standard for
18 the tribunal that shall be the same as the
19 standard that would apply in the State
20 court of competent jurisdiction which
21 would otherwise handle the claim; and

22 “(iv) provide for an appeals process to
23 allow for review of decisions by State
24 courts.

1 “(C) DETERMINATION.—After a tribunal
2 conducts a review under this paragraph, the tri-
3 bunal shall make a determination as to the li-
4 ability of the parties involved and the amount
5 of compensation that should be paid based on
6 a schedule of compensation developed by the
7 tribunal. Such a schedule shall at a minimum
8 include—

9 “(i) payment for the net economic loss
10 incurred by the patient, on a periodic
11 basis, reduced by any payments received by
12 the patient under—

13 “(I) any health or accident insur-
14 ance;

15 “(II) any wage or salary continu-
16 ation plan; or

17 “(III) any disability income in-
18 surance;

19 “(ii) payment for the non-economic
20 damages incurred by the patient, if appro-
21 priate for the injury, based on a defined
22 payment schedule developed by the State
23 in consultation with relevant experts and
24 with the Secretary;

25 “(iii) reasonable attorney’s fees; and

1 “(iv) regular updates of the schedule
2 under clause (ii) as necessary.

3 “(D) REVIEW BY STATE COURT AFTER EX-
4 HAUSTION OF ADMINISTRATIVE REMEDIES.—

5 “(i) RIGHT TO FILE.—Nothing in this
6 paragraph shall be construed to prohibit
7 any individual who is not satisfied with the
8 determinations of a tribunal under this
9 paragraph, from filing a claim for the in-
10 jury involved in a State court of competent
11 jurisdiction.

12 “(ii) FORFEIT OF AWARD.—Any party
13 filing an action in a State court under
14 clause (i) shall forfeit any compensation
15 award made under subparagraph (C).

16 “(iii) ADMISSIBILITY.—The deter-
17 minations of the tribunal under subpara-
18 graph (C) shall be admissible into evidence
19 in any State court proceeding under this
20 subparagraph.

21 “(4) EXPERT PANEL REVIEW AND ADMINISTRA-
22 TIVE HEALTH CARE TRIBUNAL COMBINATION
23 MODEL.—

24 “(A) IN GENERAL.—A State may use
25 amounts received under a grant under this sec-

1 tion to develop and implement an expert panel
2 review and administrative health care tribunal
3 combination system to review any dispute con-
4 cerning injuries allegedly caused by health care
5 providers or health care organizations. Under
6 such system, a dispute concerning injuries al-
7 legedly caused by health care providers or
8 health care organizations shall proceed through
9 the procedures described in this subparagraph
10 prior to the submission of such dispute to a
11 State court.

12 “(B) GENERAL PROCEDURE.—

13 “(i) ESTABLISHMENT OF EXPERT
14 PANEL.—Prior to submitting any dispute
15 described in subparagraph (A) to an ad-
16 ministrative health care tribunal under the
17 system established under this paragraph,
18 the State shall establish an expert panel
19 (in accordance with subparagraph (C)) to
20 review the allegations involved in such dis-
21 pute.

22 “(ii) REFERRAL TO TRIBUNAL.—If ei-
23 ther party to a dispute described in clause
24 (i) fails to accept the determination of the
25 expert panel, the dispute shall then be re-

1 ferred to an administrative health care tri-
2 bunal (in accordance with subparagraph
3 (D)).

4 “(C) EXPERT REVIEW PANEL.—

5 “(i) IN GENERAL.—The provisions of
6 paragraph (2) shall apply with respect to
7 the establishment and operation of an ex-
8 pert review panel under this subparagraph,
9 except that the subparagraphs (F) and (G)
10 of such paragraph shall not apply.

11 “(ii) FAILURE TO ACCEPT DETER-
12 MINATION OF PANEL.—If any party to a
13 dispute before an expert panel under this
14 subparagraph refuses to accept the panel’s
15 determination, the dispute shall be referred
16 to an administrative health care tribunal
17 under subparagraph (D).

18 “(D) ADMINISTRATIVE HEALTH CARE TRI-
19 BUNALS.—

20 “(i) IN GENERAL.—Upon the failure
21 of any party to accept the determination of
22 an expert panel under subparagraph (C),
23 the parties shall request a hearing con-
24 cerning the liability or compensation in-
25 volved by an administrative health care tri-

1 bunal established by the State involved
2 under this subparagraph.

3 “(ii) REQUIREMENTS.—The provisions
4 of paragraph (3) shall apply with respect
5 to the establishment and operation of an
6 administrative health care tribunal under
7 this subparagraph.

8 “(iii) FORFEIT OF AWARDS.—Any
9 party proceeding to the second step-admin-
10 istrative health care tribunal-under this
11 model shall forfeit any compensation
12 awarded by the expert panel.

13 “(iv) ADMISSIBILITY.—The deter-
14 minations of the expert panel under sub-
15 paragraph (C) shall be admissible into evi-
16 dence in any administrative health care tri-
17 bunal proceeding under this subparagraph.

18 “(E) RIGHT TO FILE.—Nothing in this
19 paragraph shall be construed to prohibit any in-
20 dividual who is not satisfied with the deter-
21 mination of the tribunal (after having proceeded
22 through both the expert panel under subpara-
23 graph (C) and the tribunal under subparagraph
24 (D)) from filing a claim for the injury involved
25 in a State court of competent jurisdiction.

1 “(F) ADMISSIBILITY.—The determinations
2 of both the expert panel and the tribunal under
3 this paragraph shall be admissible into evidence
4 in any State court proceeding under this para-
5 graph.

6 “(G) FORFEIT OF AWARDS.—Any party fil-
7 ing an action in State court under subpara-
8 graph (E) shall forfeit any compensation award
9 made by both the expert panel and the adminis-
10 trative health care tribunal under this para-
11 graph.

12 “(e) DEFINITIONS.—In this section:

13 “(1) CURRENT TORT LITIGATION.—The term
14 ‘current tort litigation’ means the tort litigation sys-
15 tem existing in the State on the date on which the
16 State submits an application under subsection
17 (b)(1), for the resolution of disputes concerning inju-
18 ries allegedly caused by health care providers or
19 health care organizations.

20 “(2) HEALTH CARE ORGANIZATION.—The term
21 ‘health care organization’ means any individual or
22 entity that is obligated to provide, pay for, or admin-
23 ister health benefits under any health plan.

24 “(3) NET ECONOMIC LOSS.—The term ‘net eco-
25 nomic loss’ means—

1 “(A) reasonable expenses incurred for
2 products, services and accommodations needed
3 for health care, training and other remedial
4 treatment and care of an injured individual;

5 “(B) reasonable and appropriate expenses
6 for rehabilitation treatment and occupational
7 training;

8 “(C) 100 percent of the loss of income
9 from work that an injured individual would
10 have performed if not injured, reduced by any
11 income from substitute work actually per-
12 formed; and

13 “(D) reasonable expenses incurred in ob-
14 taining ordinary and necessary services to re-
15 place services an injured individual would have
16 performed for the benefit of the individual or
17 the family of such individual if the individual
18 had not been injured.

19 “(4) NON-ECONOMIC DAMAGES.—The term
20 ‘non-economic damages’ means losses for physical
21 and emotional pain, suffering, inconvenience, phys-
22 ical impairment, mental anguish, disfigurement, loss
23 of enjoyment of life, loss of society and companion-
24 ship, loss of consortium (other than loss of domestic
25 service), injury to reputation, and all other non-pe-

1 cuniary losses of any kind or nature, to the extent
2 permitted under State law.

3 “(f) FUNDING.—

4 “(1) ONE-TIME INCREASE IN MEDICAID PAY-
5 MENT.—In the case of a State awarded a grant to
6 carry out this section, the total amount of the Fed-
7 eral payment determined for the State under section
8 1913 of the Social Security Act (as amended by sec-
9 tion 401) for fiscal year 2011 (in addition to the any
10 increase applicable for that fiscal year under section
11 203(b) but determined without regard to any such
12 increase) shall be increased by an amount equal to
13 1 percent of the total amount of payments made to
14 the State for fiscal year 2010 under section 1903(a)
15 of the Social Security Act (42 U.S.C. 1396b(a)) for
16 purposes of carrying out a grant awarded under this
17 section. Amounts paid to a State pursuant to this
18 subsection shall remain available until expended.

19 “(2) AUTHORIZATION OF APPROPRIATIONS.—

20 There are authorized to be appropriated for any fis-
21 cal year such sums as may be necessary for purposes
22 of making payments to States pursuant to para-
23 graph (1).”.

1 **TITLE VII—PROMOTING HEALTH**
2 **INFORMATION TECHNOLOGY**
3 **Subtitle A—Assisting the Develop-**
4 **ment of Health Information**
5 **Technology**

6 **SEC. 701. PURPOSE.**

7 It is the purpose of this subtitle to promote the utili-
8 zation of health record banking by improving the coordina-
9 tion of health information through an infrastructure for
10 the secure and authorized exchange and use of healthcare
11 information.

12 **SEC. 702. HEALTH RECORD BANKING.**

13 (a) **ESTABLISHMENT.**—Not later than 1 year after
14 the date of enactment of this Act, the Secretary of Health
15 and Human Services shall promulgate regulations to pro-
16 vide for the certification and auditing of the banking of
17 electronic medical records.

18 (b) **GENERAL RIGHTS.**—An individual who has a
19 health record contained in a health record bank shall
20 maintain ownership over the health record and shall have
21 the right to review the contents of the record.

22 **SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY**
23 **AND CONFIDENTIALITY STANDARDS.**

24 (a) **IN GENERAL.**—Current Federal security and con-
25 fidentiality standards and State security and confiden-

1 tiality laws shall apply to this subtitle until such time as
2 Congress acts to amend such standards.

3 (b) DEFINITIONS.—In this section:

4 (1) CURRENT FEDERAL SECURITY AND CON-
5 FIDENTIALITY STANDARDS.—The term “current
6 Federal security and confidentiality standards”
7 means the Federal privacy standards established
8 pursuant to section 264(c) of the Health Insurance
9 Portability and Accountability Act of 1996 (42
10 U.S.C. 1320d–2 note) and security standards estab-
11 lished under section 1173(d) of the Social Security
12 Act (42 U.S.C. 1320d–2(d)).

13 (2) STATE SECURITY AND CONFIDENTIALITY
14 LAWS.—The term “State security and confidentiality
15 laws” means State laws and regulations relating to
16 the privacy and confidentiality of individually identi-
17 fiable health information or to the security of such
18 information.

19 (3) STATE.—The term “State” has the mean-
20 ing given such term for purposes of title XI of the
21 Social Security Act, as provided under section
22 1101(a) of such Act (42 U.S.C. 1301(a)).

1 **Subtitle B—Removing Barriers to**
2 **the Use of Health Information**
3 **Technology to Better Coordi-**
4 **nate Health Care**

5 **SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**
6 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**
7 **VISION OF HEALTH INFORMATION TECH-**
8 **NOLOGY AND TRAINING SERVICES.**

9 (a) FOR CIVIL PENALTIES.—Section 1128A of the
10 Social Security Act (42 U.S.C. 1320a–7a) is amended—

11 (1) in subsection (b), by adding at the end the
12 following new paragraph:

13 “(4) For purposes of this subsection, inducements to
14 reduce or limit services described in paragraph (1) shall
15 not include the practical or other advantages resulting
16 from health information technology or related installation,
17 maintenance, support, or training services.”; and

18 (2) in subsection (i), by adding at the end the
19 following new paragraph:

20 “(8) The term ‘health information technology’
21 means hardware, software, license, right, intellectual
22 property, equipment, or other information tech-
23 nology (including new versions, upgrades, and
24 connectivity) designed or provided primarily for the
25 electronic creation, maintenance, or exchange of

1 health information to better coordinate care or im-
2 prove health care quality, efficiency, or research.”.

3 (b) FOR CRIMINAL PENALTIES.—Section 1128B of
4 such Act (42 U.S.C. 1320a–7b) is amended—

5 (1) in subsection (b)(3)—

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

8 (B) in the subparagraph (H) added by sec-
9 tion 237(d) of the Medicare Prescription Drug,
10 Improvement, and Modernization Act of 2003
11 (Public Law 108–173; 117 Stat. 2213)—

12 (i) by moving such subparagraph 2
13 ems to the left; and

14 (ii) by striking the period at the end
15 and inserting a semicolon;

16 (C) in the subparagraph (H) added by sec-
17 tion 431(a) of such Act (117 Stat. 2287)—

18 (i) by redesignating such subpara-
19 graph as subparagraph (I);

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

22 (iii) by striking the period at the end
23 and inserting “; and”; and

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

1 “(J) any nonmonetary remuneration (in the
2 form of health information technology, as defined in
3 section 1128A(i)(8), or related installation, mainte-
4 nance, support or training services) made to a per-
5 son by a specified entity (as defined in subsection
6 (g)) if—

7 “(i) the provision of such remuneration is
8 without an agreement between the parties or
9 legal condition that—

10 “(I) limits or restricts the use of the
11 health information technology to services
12 provided by the physician to individuals re-
13 ceiving services at the specified entity;

14 “(II) limits or restricts the use of the
15 health information technology in conjunc-
16 tion with other health information tech-
17 nology; or

18 “(III) conditions the provision of such
19 remuneration on the referral of patients or
20 business to the specified entity;

21 “(ii) such remuneration is arranged for in
22 a written agreement that is signed by the par-
23 ties involved (or their representatives) and that
24 specifies the remuneration solicited or received
25 (or offered or paid) and states that the provi-

1 sion of such remuneration is made for the pri-
2 mary purpose of better coordination of care or
3 improvement of health quality, efficiency, or re-
4 search; and

5 “(iii) the specified entity providing the re-
6 muneration (or a representative of such entity)
7 has not taken any action to disable any basic
8 feature of any hardware or software component
9 of such remuneration that would permit inter-
10 operability.”; and

11 (2) by adding at the end the following new sub-
12 section:

13 “(g) SPECIFIED ENTITY DEFINED.—For purposes of
14 subsection (b)(3)(J), the term ‘specified entity’ means an
15 entity that is a hospital, group practice, prescription drug
16 plan sponsor, a Medicare Advantage organization, or any
17 other such entity specified by the Secretary, considering
18 the goals and objectives of this section, as well as the goals
19 to better coordinate the delivery of health care and to pro-
20 mote the adoption and use of health information tech-
21 nology.”.

22 (c) EFFECTIVE DATE AND EFFECT ON STATE
23 LAWS.—

24 (1) EFFECTIVE DATE.—The amendments made
25 by subsections (a) and (b) shall take effect on the

1 date that is 120 days after the date of the enact-
2 ment of this Act.

3 (2) PREEMPTION OF STATE LAWS.—No State
4 (as defined in section 1101(a) of the Social Security
5 Act (42 U.S.C. 1301(a)) for purposes of title XI of
6 such Act) shall have in effect a State law that im-
7 poses a criminal or civil penalty for a transaction de-
8 scribed in section 1128A(b)(4) or section
9 1128B(b)(3)(J) of such Act, as added by subsections
10 (a)(1) and (b), respectively, if the conditions de-
11 scribed in the respective provision, with respect to
12 such transaction, are met.

13 (d) STUDY AND REPORT TO ASSESS EFFECT OF
14 SAFE HARBORS ON HEALTH SYSTEM.—

15 (1) IN GENERAL.—The Secretary of Health and
16 Human Services shall conduct a study to determine
17 the impact of each of the safe harbors described in
18 paragraph (3). In particular, the study shall examine
19 the following:

20 (A) The effectiveness of each safe harbor
21 in increasing the adoption of health information
22 technology.

23 (B) The types of health information tech-
24 nology provided under each safe harbor.

1 (C) The extent to which the financial or
2 other business relationships between providers
3 under each safe harbor have changed as a re-
4 sult of the safe harbor in a way that adversely
5 affects or benefits the health care system or
6 choices available to consumers.

7 (D) The impact of the adoption of health
8 information technology on health care quality,
9 cost, and access under each safe harbor.

10 (2) REPORT.—Not later than 3 years after the
11 effective date described in subsection (c)(1), the Sec-
12 retary of Health and Human Services shall submit
13 to Congress a report on the study under paragraph
14 (1).

15 (3) SAFE HARBORS DESCRIBED.—For purposes
16 of paragraphs (1) and (2), the safe harbors de-
17 scribed in this paragraph are—

18 (A) the safe harbor under section
19 1128A(b)(4) of such Act (42 U.S.C. 1320a-
20 7a(b)(4)), as added by subsection (a)(1); and

21 (B) the safe harbor under section
22 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-
23 7b(b)(3)(J)), as added by subsection (b).

1 **SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**
2 **CIAN REFERRALS (UNDER STARK) FOR PRO-**
3 **VISION OF HEALTH INFORMATION TECH-**
4 **NOLOGY AND TRAINING SERVICES TO**
5 **HEALTH CARE PROFESSIONALS.**

6 (a) IN GENERAL.—Section 1877(b) of the Social Se-
7 curity Act (42 U.S.C. 1395nn(b)) is amended by adding
8 at the end the following new paragraph:

9 “(6) INFORMATION TECHNOLOGY AND TRAIN-
10 ING SERVICES.—

11 “(A) IN GENERAL.—Any nonmonetary re-
12 munerated (in the form of health information
13 technology or related installation, maintenance,
14 support or training services) made by a speci-
15 fied entity to a physician if—

16 “(i) the provision of such remunera-
17 tion is without an agreement between the
18 parties or legal condition that—

19 “(I) limits or restricts the use of
20 the health information technology to
21 services provided by the physician to
22 individuals receiving services at the
23 specified entity;

24 “(II) limits or restricts the use of
25 the health information technology in

1 conjunction with other health informa-
2 tion technology; or

3 “(III) conditions the provision of
4 such remuneration on the referral of
5 patients or business to the specified
6 entity;

7 “(ii) such remuneration is arranged
8 for in a written agreement that is signed
9 by the parties involved (or their represent-
10 atives) and that specifies the remuneration
11 made and states that the provision of such
12 remuneration is made for the primary pur-
13 pose of better coordination of care or im-
14 provement of health quality, efficiency, or
15 research; and

16 “(iii) the specified entity (or a rep-
17 resentative of such entity) has not taken
18 any action to disable any basic feature of
19 any hardware or software component of
20 such remuneration that would permit
21 interoperability.

22 “(B) HEALTH INFORMATION TECHNOLOGY
23 DEFINED.—For purposes of this paragraph, the
24 term ‘health information technology’ means
25 hardware, software, license, right, intellectual

1 property, equipment, or other information tech-
2 nology (including new versions, upgrades, and
3 connectivity) designed or provided primarily for
4 the electronic creation, maintenance, or ex-
5 change of health information to better coordi-
6 nate care or improve health care quality, effi-
7 ciency, or research.

8 “(C) SPECIFIED ENTITY DEFINED.—For
9 purposes of this paragraph, the term ‘specified
10 entity’ means an entity that is a hospital, group
11 practice, prescription drug plan sponsor, a
12 Medicare Advantage organization, or any other
13 such entity specified by the Secretary, consid-
14 ering the goals and objectives of this section, as
15 well as the goals to better coordinate the deliv-
16 ery of health care and to promote the adoption
17 and use of health information technology.”.

18 (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

19 (1) EFFECTIVE DATE.—The amendment made
20 by subsection (a) shall take effect on the date that
21 is 120 days after the date of the enactment of this
22 Act.

23 (2) PREEMPTION OF STATE LAWS.—No State
24 (as defined in section 1101(a) of the Social Security
25 Act (42 U.S.C. 1301(a)) for purposes of title XI of

1 such Act) shall have in effect a State law that im-
2 poses a criminal or civil penalty for a transaction de-
3 scribed in section 1877(b)(6) of such Act, as added
4 by subsection (a), if the conditions described in such
5 section, with respect to such transaction, are met.

6 (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-
7 CEPTION ON HEALTH SYSTEM.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services shall conduct a study to determine
10 the impact of the exception under section 1877(b)(6)
11 of such Act (42 U.S.C. 1395nn(b)(6)), as added by
12 subsection (a). In particular, the study shall examine
13 the following:

14 (A) The effectiveness of the exception in
15 increasing the adoption of health information
16 technology.

17 (B) The types of health information tech-
18 nology provided under the exception.

19 (C) The extent to which the financial or
20 other business relationships between providers
21 under the exception have changed as a result of
22 the exception in a way that adversely affects or
23 benefits the health care system or choices avail-
24 able to consumers.

1 (D) The impact of the adoption of health
2 information technology on health care quality,
3 cost, and access under the exception.

4 (2) REPORT.—Not later than 3 years after the
5 effective date described in subsection (b)(1), the Sec-
6 retary of Health and Human Services shall submit
7 to Congress a report on the study under paragraph
8 (1).

9 **SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF**
10 **CONSORTIA.**

11 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL
12 PENALTIES.—Section 1128B(b)(3) of the Social Security
13 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding
14 after and below subparagraph (J), as added by section
15 711(b)(1), the following: “For purposes of subparagraph
16 (J), nothing in such subparagraph shall be construed as
17 preventing a specified entity, consistent with the specific
18 requirements of such subparagraph, from forming a con-
19 sortium composed of health care providers, payers, em-
20 ployers, and other interested entities to collectively pur-
21 chase and donate health information technology, or from
22 offering health care providers a choice of health informa-
23 tion technology products in order to take into account the
24 varying needs of such providers receiving such products.”.

1 (b) APPLICATION TO STARK EXCEPTION.—Para-
2 graph (6) of section 1877(b) of the Social Security Act
3 (42 U.S.C. 1395m(b)), as added by section 712(a), is
4 amended by adding at the end the following new subpara-
5 graph:

6 “(D) RULE OF CONSTRUCTION.—For pur-
7 poses of subparagraph (A), nothing in such
8 subparagraph shall be construed as preventing
9 a specified entity, consistent with the specific
10 requirements of such subparagraph, from—

11 “(i) forming a consortium composed
12 of health care providers, payers, employers,
13 and other interested entities to collectively
14 purchase and donate health information
15 technology; or

16 “(ii) offering health care providers a
17 choice of health information technology
18 products in order to take into account the
19 varying needs of such providers receiving
20 such products.”.

1 **TITLE VIII—HEALTH CARE**
2 **SERVICES COMMISSION**
3 **Subtitle A—Establishment and**
4 **General Duties**

5 **SEC. 801. ESTABLISHMENT.**

6 (a) IN GENERAL.—There is hereby established a
7 Health Care Services Commission (in this title, referred
8 to as the “Commission”) to be composed of 5 commis-
9 sioners (in this title referred to as the “Commissioners”)
10 to be appointed by the President by and with the advice
11 and consent of the Senate. Not more than 3 of such Com-
12 missioners shall be members of the same political party,
13 and in making appointments members of different political
14 parties shall be appointed alternately as nearly as may be
15 practicable. No Commissioner shall engage in any other
16 business, vocation, or employment than that of serving as
17 Commissioner. Each Commissioner shall hold office for a
18 term of 5 years and until a successor is appointed and
19 has qualified, except that—

20 (1) such Commissioner shall not so continue to
21 serve beyond the expiration of the next session of
22 Congress subsequent to the expiration of said fixed
23 term of office;

24 (2) any Commissioner appointed to fill a va-
25 cancy occurring prior to the expiration of the term

1 for which a predecessor was appointed shall be ap-
2 pointed for the remainder of such term; and

3 (3) the terms of office of the Commissioners
4 first taking office after the date of the enactment of
5 this Act shall expire as designated by the President
6 at the time of nomination, 1 at the end of 1 year,
7 1 at the end of 2 years, 1 at the end of 3 years, 1
8 at the end of 4 years, and 1 at the end of 5 years,
9 after the date of the enactment of this Act.

10 (b) PURPOSE.—The purpose of the Commission is to
11 enhance the quality, appropriateness, and effectiveness of
12 health care services, and access to such services, through
13 the establishment of a broad base of scientific research
14 and through the promotion of improvements in clinical
15 practice and in the organization, financing, and delivery
16 of health care services.

17 (c) APPOINTMENT OF CHAIRMAN.—The President
18 shall, from among the Commissioners appointed under
19 subsection (a), designate an individual to serve as the
20 Chairman of the Commission.

21 **SEC. 802. GENERAL AUTHORITIES AND DUTIES.**

22 (a) IN GENERAL.—In carrying out section 801(b),
23 the Commissioners shall conduct and support research,
24 demonstration projects, evaluations, training, guideline de-
25 velopment, and the dissemination of information, on

1 health care services and on systems for the delivery of
2 such services, including activities with respect to—

3 (1) the effectiveness, efficiency, and quality of
4 health care services;

5 (2) the outcomes of health care services and
6 procedures;

7 (3) clinical practice, including primary care and
8 practice-oriented research;

9 (4) health care technologies, facilities, and
10 equipment;

11 (5) health care costs, productivity, and market
12 forces;

13 (6) health promotion and disease prevention;

14 (7) health statistics and epidemiology; and

15 (8) medical liability.

16 (b) REQUIREMENTS WITH RESPECT TO RURAL
17 AREAS AND UNDERSERVED POPULATIONS.—In carrying
18 out subsection (a), the Commissioners shall undertake and
19 support research, demonstration projects, and evaluations
20 with respect to—

21 (1) the delivery of health care services in rural
22 areas (including frontier areas); and

23 (2) the health of low-income groups, minority
24 groups, and the elderly.

1 **SEC. 803. DISSEMINATION.**

2 (a) IN GENERAL.—The Commissioners shall—

3 (1) promptly publish, make available, and oth-
4 erwise disseminate, in a form understandable and on
5 as broad a basis as practicable so as to maximize its
6 use, the results of research, demonstration projects,
7 and evaluations conducted or supported under this
8 title and the guidelines, standards, and review cri-
9 teria developed under this title;

10 (2) promptly make available to the public data
11 developed in such research, demonstration projects,
12 and evaluations; and

13 (3) as appropriate, provide technical assistance
14 to State and local government and health agencies
15 and conduct liaison activities to such agencies to fos-
16 ter dissemination.

17 (b) PROHIBITION AGAINST RESTRICTIONS.—Except
18 as provided in subsection (c), the Commissioners may not
19 restrict the publication or dissemination of data from, or
20 the results of, projects conducted or supported under this
21 title.

22 (c) LIMITATION ON USE OF CERTAIN INFORMA-
23 TION.—No information, if an establishment or person sup-
24 plying the information or described in it is identifiable,
25 obtained in the course of activities undertaken or sup-
26 ported under this title may be used for any purpose other

1 than the purpose for which it was supplied unless such
2 establishment or person has consented (as determined
3 under regulations of the Secretary) to its use for such
4 other purpose. Such information may not be published or
5 released in other form if the person who supplied the infor-
6 mation or who is described in it is identifiable unless such
7 person has consented (as determined under regulations of
8 the Secretary) to its publication or release in other form.

9 (d) CERTAIN INTERAGENCY AGREEMENT.—The
10 Commissioners and the Director of the National Library
11 of Medicine shall enter into an agreement providing for
12 the implementation of subsection (a)(1).

13 **Subtitle B—Forum for Quality and** 14 **Effectiveness in Health Care**

15 **SEC. 811. ESTABLISHMENT OF OFFICE.**

16 There is established within the Commission an office
17 to be known as the Office of the Forum for Quality and
18 Effectiveness in Health Care. The office shall be headed
19 by a director (referred to in this title as the “Director”)
20 who shall be appointed by the Commissioners.

21 **SEC. 812. MEMBERSHIP.**

22 (a) IN GENERAL.—The Office of the Forum for Qual-
23 ity and Effectiveness in Health Care shall be composed
24 of 15 individuals nominated by private sector health care

1 organizations and appointed by the Commission and shall
2 include representation from at least the following:

3 (1) Health insurance industry.

4 (2) Health care provider groups.

5 (3) Non-profit organizations.

6 (4) Rural health organizations.

7 (b) TERMS.—

8 (1) IN GENERAL.—Except as provided in para-
9 graph (2), members of the Office of the Forum for
10 Quality and Effectiveness in Health Care shall serve
11 for a term of 5 years.

12 (2) STAGGERED ROTATION.—Of the members
13 first appointed to the Office of the Forum for Qual-
14 ity and Effectiveness in Health Care, the Commis-
15 sion shall appoint 5 members to serve for a term of
16 2 years, 5 members to serve for a term of 3 years,
17 and 5 members to serve for a term of 4 years.

18 (c) TREATMENT OF OTHER EMPLOYMENT.—Each
19 member of the Office of the Forum for Quality and Effec-
20 tiveness in Health Care shall serve the Office independ-
21 ently from any other position of employment.

22 **SEC. 813. DUTIES.**

23 (a) ESTABLISHMENT OF FORUM PROGRAM.—The
24 Commissioners, acting through the Director, shall estab-
25 lish a program to be known as the Forum for Quality and

1 Effectiveness in Health Care. For the purpose of pro-
2 moting transparency in price, quality, appropriateness,
3 and effectiveness of health care, the Director, using the
4 process set forth in section 814, shall arrange for the de-
5 velopment and periodic review and updating of standards
6 of quality, performance measures, and medical review cri-
7 teria through which health care providers and other appro-
8 priate entities may assess or review the provision of health
9 care and assure the quality of such care.

10 (b) CERTAIN REQUIREMENTS.—Guidelines, stand-
11 ards, performance measures, and review criteria under
12 subsection (a) shall—

13 (1) be based on the best available research and
14 professional judgment regarding the effectiveness
15 and appropriateness of health care services and pro-
16 cedures; and

17 (2) be presented in formats appropriate for use
18 by physicians, health care practitioners, providers,
19 medical educators, and medical review organizations
20 and in formats appropriate for use by consumers of
21 health care.

22 (c) AUTHORITY FOR CONTRACTS.—In carrying out
23 this subtitle, the Director may enter into contracts with
24 public or nonprofit private entities.

1 (d) PUBLIC DISCLOSURE OF RECOMMENDATIONS.—
2 For each fiscal year beginning with 2010, the Director
3 shall make publicly available the following:

4 (1) Quarterly reports for public comment that
5 include proposed recommendations for guidelines,
6 standards, performance measures, and review cri-
7 teria under subsection (a) and any updates to such
8 guidelines, standards, performance measures, and
9 review criteria.

10 (2) After consideration of such comments, a
11 final report that contains final recommendations for
12 such guidelines, standards, performance measures,
13 review criteria, and updates.

14 (e) DATE CERTAIN FOR INITIAL GUIDELINES AND
15 STANDARDS.—The Commissioners, by not later than Jan-
16 uary 1, 2012, shall assure the development of an initial
17 set of guidelines, standards, performance measures, and
18 review criteria under subsection (a).

19 **SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES**
20 **AND STANDARDS.**

21 (a) ADOPTION OF RECOMMENDATIONS OF FORUM
22 FOR QUALITY AND EFFECTIVENESS IN HEALTH CARE.—
23 For each fiscal year, the Commissioners shall adopt the
24 recommendations made for such year in the final report
25 under subsection (d)(2) of section 813 for guidelines,

1 standards, performance measures, and review criteria de-
2 scribed in subsection (a) of such section.

3 (b) ENFORCEMENT AUTHORITY.—The Commis-
4 sioners, in consultation with the Secretary of Health and
5 Human Services, have the authority to make recommenda-
6 tions to the Secretary to enforce compliance of health care
7 providers with the guidelines, standards, performance
8 measures, and review criteria adopted under subsection
9 (a). Such recommendations may include the following,
10 with respect to a health care provider who is not in compli-
11 ance with such guidelines, standards, measures, and cri-
12 teria:

13 (1) Exclusion from participation in Federal
14 health care programs (as defined in section
15 1128B(f) of the Social Security Act (42 U.S.C.
16 1320a–7b(f))).

17 (2) Imposition of a civil money penalty on such
18 provider.

19 **SEC. 815. ADDITIONAL REQUIREMENTS.**

20 (a) PROGRAM AGENDA.—The Commissioners shall
21 provide for an agenda for the development of the guide-
22 lines, standards, performance measures, and review cri-
23 teria described in section 813(a), including with respect
24 to the standards, performance measures, and review cri-
25 teria, identifying specific aspects of health care for which

1 the standards, performance measures, and review criteria
2 are to be developed and those that are to be given priority
3 in the development of the standards, performance meas-
4 ures, and review criteria.

5 **Subtitle C—General Provisions**

6 **SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.**

7 The Commissioners, in carrying out this title, may
8 accept voluntary and uncompensated services.

9 **SEC. 822. FUNDING.**

10 For the purpose of carrying out this title, there are
11 authorized to be appropriated such sums as may be nec-
12 essary for fiscal years 2010 through 2014.

13 **SEC. 823. DEFINITIONS.**

14 For purposes of this title:

15 (1) The term “Commissioners” means the Com-
16 missioners of the Health Care Services Commission.

17 (2) The term “Commission” means the Health
18 Care Services Commission.

19 (3) The term “Director” means the Director of
20 the Office of the Forum for Quality and Effective-
21 ness in Health Care.

22 (4) The term “Secretary” means the Secretary
23 of Health and Human Services.

1 **Subtitle D—Terminations and**
2 **Transition**

3 **SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RE-**
4 **SEARCH AND QUALITY.**

5 As of the date of the enactment of this Act, the Agen-
6 cy for Healthcare Research and Quality is terminated, and
7 title IX of the Public Health Service Act is repealed.

8 **SEC. 832. TRANSITION.**

9 All orders, grants, contracts, privileges, and other de-
10 terminations or actions of the Agency for Healthcare Re-
11 search and Quality that are effective as of the date before
12 the date of the enactment of this Act, shall be transferred
13 to the Secretary and shall continue in effect according to
14 their terms unless changed pursuant to law.

15 **Subtitle E—Independent Health**
16 **Record Trust**

17 **SEC. 841. SHORT TITLE.**

18 This subtitle may be cited as the “Independent
19 Health Record Trust Act of 2009”.

20 **SEC. 842. PURPOSE.**

21 It is the purpose of this subtitle to provide for the
22 establishment of a nationwide health information tech-
23 nology network that—

24 (1) improves health care quality, reduces med-
25 ical errors, increases the efficiency of care, and ad-

1 vances the delivery of appropriate, evidence-based
2 health care services;

3 (2) promotes wellness, disease prevention, and
4 the management of chronic illnesses by increasing
5 the availability and transparency of information re-
6 lated to the health care needs of an individual;

7 (3) ensures that appropriate information nec-
8 essary to make medical decisions is available in a us-
9 able form at the time and in the location that the
10 medical service involved is provided;

11 (4) produces greater value for health care ex-
12 penditures by reducing health care costs that result
13 from inefficiency, medical errors, inappropriate care,
14 and incomplete information;

15 (5) promotes a more effective marketplace,
16 greater competition, greater systems analysis, in-
17 creased choice, enhanced quality, and improved out-
18 comes in health care services;

19 (6) improves the coordination of information
20 and the provision of such services through an effec-
21 tive infrastructure for the secure and authorized ex-
22 change and use of health information; and

23 (7) ensures that the health information privacy,
24 security, and confidentiality of individually identifi-
25 able health information is protected.

1 **SEC. 843. DEFINITIONS.**

2 In this subtitle:

3 (1) **ACCESS.**—The term “access” means, with
4 respect to an electronic health record, entering infor-
5 mation into such account as well as retrieving infor-
6 mation from such account.

7 (2) **ACCOUNT.**—The term “account” means an
8 electronic health record of an individual contained in
9 an independent health record trust.

10 (3) **AFFIRMATIVE CONSENT.**—The term “af-
11 firmative consent” means, with respect to an elec-
12 tronic health record of an individual contained in an
13 IHRT, express consent given by the individual for
14 the use of such record in response to a clear and
15 conspicuous request for such consent or at the indi-
16 vidual’s own initiative.

17 (4) **AUTHORIZED EHR DATA USER.**—The term
18 “authorized EHR data user” means, with respect to
19 an electronic health record of an IHRT participant
20 contained as part of an IHRT, any entity (other
21 than the participant) authorized (in the form of af-
22 firmative consent) by the participant to access the
23 electronic health record.

24 (5) **CONFIDENTIALITY.**—The term “confiden-
25 tiality” means, with respect to individually identifi-
26 able health information of an individual, the obliga-

1 tion of those who receive such information to respect
2 the health information privacy of the individual.

3 (6) ELECTRONIC HEALTH RECORD.—The term
4 “electronic health record” means a longitudinal col-
5 lection of information concerning a single individual,
6 including medical records and personal health infor-
7 mation, that is stored electronically.

8 (7) HEALTH INFORMATION PRIVACY.—The
9 term “health information privacy” means, with re-
10 spect to individually identifiable health information
11 of an individual, the right of such individual to con-
12 trol the acquisition, uses, or disclosures of such in-
13 formation.

14 (8) HEALTH PLAN.—The term “health plan”
15 means a group health plan (as defined in section
16 2208(1) of the Public Health Service Act (42 U.S.C.
17 300bb–8(1))) as well as a plan that offers health in-
18 surance coverage in the individual market.

19 (9) HIPAA PRIVACY REGULATIONS.—The term
20 “HIPAA privacy regulations” means the regulations
21 promulgated under section 264(c) of the Health In-
22 surance Portability and Accountability Act of 1996
23 (42 U.S.C. 1320d–2 note).

24 (10) INDEPENDENT HEALTH RECORD TRUST;
25 IHRT.—The terms “independent health record trust”

1 and “IHRT” mean a legal arrangement under the
2 administration of an IHRT operator that meets the
3 requirements of this subtitle with respect to elec-
4 tronic health records of individuals participating in
5 the trust or IHRT.

6 (11) IHRT OPERATOR.—The term “IHRT op-
7 erator” means, with respect to an IHRT, the organi-
8 zation that is responsible for the administration and
9 operation of the IHRT in accordance with this sub-
10 title.

11 (12) IHRT PARTICIPANT.—The term “IHRT
12 participant” means, with respect to an IHRT, an in-
13 dividual who has a participation agreement in effect
14 with respect to the maintenance of the individual’s
15 electronic health record by the IHRT.

16 (13) INDIVIDUALLY IDENTIFIABLE HEALTH IN-
17 FORMATION.—The term “individually identifiable
18 health information” has the meaning given such
19 term in section 1171(6) of the Social Security Act
20 (42 U.S.C. 1320d(6)).

21 (14) SECURITY.—The term “security” means,
22 with respect to individually identifiable health infor-
23 mation of an individual, the physical, technological,
24 or administrative safeguards or tools used to protect

1 such information from unwarranted access or dislo-
2 sure.

3 **SEC. 844. ESTABLISHMENT, CERTIFICATION, AND MEMBER-**
4 **SHIP OF INDEPENDENT HEALTH RECORD**
5 **TRUSTS.**

6 (a) ESTABLISHMENT.—Not later than one year after
7 the date of the enactment of this Act, the Federal Trade
8 Commission, in consultation with the National Committee
9 on Vital and Health Statistics, shall prescribe standards
10 for the establishment, certification, operation, and inter-
11 operability of IHRTs to carry out the purposes described
12 in section 842 in accordance with the provisions of this
13 subtitle.

14 (b) CERTIFICATION.—

15 (1) CERTIFICATION BY FTC.—The Federal
16 Trade Commission shall provide for the certification
17 of IHRTs. No IHRT may be certified unless the
18 IHRT is determined to meet the standards for cer-
19 tification established under subsection (a).

20 (2) DECERTIFICATION.—The Federal Trade
21 Commission shall establish a process for the revoca-
22 tion of certification of an IHRT under this section
23 in the case that the IHRT violates the standards es-
24 tablished under subsection (a).

25 (c) MEMBERSHIP.—

1 (1) IN GENERAL.—To be eligible to be a partic-
2 ipant in an IHRT, an individual shall—

3 (A) submit to the IHRT information as re-
4 quired by the IHRT to establish an electronic
5 health record with the IHRT; and

6 (B) enter into a privacy protection agree-
7 ment described in section 846(b)(1) with the
8 IHRT.

9 The process to determine eligibility of an individual
10 under this subsection shall allow for the establish-
11 ment by such individual of an electronic health
12 record as expeditiously as possible if such individual
13 is determined so eligible.

14 (2) NO LIMITATION ON MEMBERSHIP.—Nothing
15 in this subsection shall be construed to permit an
16 IHRT to restrict membership, including on the basis
17 of health condition.

18 **SEC. 845. DUTIES OF IHRT TO IHRT PARTICIPANTS.**

19 (a) FIDUCIARY DUTY OF IHRT; PENALTIES FOR
20 VIOLATIONS OF FIDUCIARY DUTY.—

21 (1) FIDUCIARY DUTY.—With respect to the
22 electronic health record of an IHRT participant
23 maintained by an IHRT, the IHRT shall have a fi-
24 duciary duty to act for the benefit and in the inter-
25 ests of such participant and of the IHRT as a whole.

1 Such duty shall include obtaining the affirmative
2 consent of such participant prior to the release of in-
3 formation in such participant's electronic health
4 record in accordance with the requirements of this
5 subtitle.

6 (2) PENALTIES.—If the IHRT knowingly or
7 recklessly breaches the fiduciary duty described in
8 paragraph (1), the IHRT shall be subject to the fol-
9 lowing penalties:

10 (A) Loss of certification of the IHRT.

11 (B) A fine that is not in excess of \$50,000.

12 (C) A term of imprisonment for the indi-
13 viduals involved of not more than 5 years.

14 (b) ELECTRONIC HEALTH RECORD DEEMED TO BE
15 HELD IN TRUST BY IHRT.—With respect to an indi-
16 vidual, an electronic health record maintained by an IHRT
17 shall be deemed to be held in trust by the IHRT for the
18 benefit of the individual and the IHRT shall have no legal
19 or equitable interest in such electronic health record.

20 **SEC. 846. AVAILABILITY AND USE OF INFORMATION FROM**
21 **RECORDS IN IHRT CONSISTENT WITH PRI-**
22 **VACY PROTECTIONS AND AGREEMENTS.**

23 (a) PROTECTED ELECTRONIC HEALTH RECORDS
24 USE AND ACCESS.—

1 (1) GENERAL RIGHTS REGARDING USES OF IN-
2 FORMATION.—

3 (A) IN GENERAL.—With respect to the
4 electronic health record of an IHRT participant
5 maintained by an IHRT, subject to paragraph
6 (2)(C), primary uses and secondary uses (de-
7 scribed in subparagraphs (B) and (C), respec-
8 tively) of information within such record (other
9 than by such participant) shall be permitted
10 only upon the authorization of such use, prior
11 to such use, by such participant.

12 (B) PRIMARY USES.—For purposes of sub-
13 paragraph (A) and with respect to an electronic
14 health record of an individual, a primary use is
15 a use for purposes of the individual's self-care
16 or care by health care professionals.

17 (C) SECONDARY USES.—For purposes of
18 subparagraph (B) and with respect to an elec-
19 tronic health record of an individual, a sec-
20 ondary use is any use not described in subpara-
21 graph (B) and includes a use for purposes of
22 public health research or other related activi-
23 ties. Additional authorization is required for a
24 secondary use extending beyond the original
25 purpose of the secondary use authorized by the

1 IHERT participant involved. Nothing in this
2 paragraph shall be construed as requiring au-
3 thorization for every secondary use that is with-
4 in the authorized original purpose.

5 (2) RULES FOR PRIMARY USE OF RECORDS FOR
6 HEALTH CARE PURPOSES.—With respect to the elec-
7 tronic health record of an IHERT participant (or
8 specified parts of such electronic health record)
9 maintained by an IHERT standards for access to
10 such record shall provide for the following:

11 (A) ACCESS BY IHERT PARTICIPANTS TO
12 THEIR ELECTRONIC HEALTH RECORDS.—

13 (i) OWNERSHIP.—The participant
14 maintains ownership over the entire elec-
15 tronic health record (and all portions of
16 such record) and shall have the right to
17 electronically access and review the con-
18 tents of the entire record (and any portion
19 of such record) at any time, in accordance
20 with this subparagraph.

21 (ii) ADDITION OF PERSONAL INFOR-
22 MATION.—The participant may add per-
23 sonal health information to the health
24 record of that participant, except that such
25 participant shall not alter information that

1 is entered into the electronic health record
2 by any authorized EHR data user. Such
3 participant shall have the right to propose
4 an amendment to information that is en-
5 tered by an authorized EHR data user
6 pursuant to standards prescribed by the
7 Federal Trade Commission for purposes of
8 amending such information.

9 (iii) IDENTIFICATION OF INFORMA-
10 TION ENTERED BY PARTICIPANT.—Any ad-
11 ditions or amendments made by the partic-
12 ipant to the health record shall be identi-
13 fied and disclosed within such record as
14 being made by such participant.

15 (B) ACCESS BY ENTITIES OTHER THAN
16 IHRT PARTICIPANT.—

17 (i) AUTHORIZED ACCESS ONLY.—Ex-
18 cept as provided under subparagraph (C)
19 and paragraph (4), access to the electronic
20 health record (or any portion of the
21 record)—

22 (I) may be made only by author-
23 ized EHR data users and only to such
24 portions of the record as specified by
25 the participant; and

1 (II) may be limited by the partic-
2 ipant for purposes of entering infor-
3 mation into such record, retrieving in-
4 formation from such record, or both.

5 (ii) IDENTIFICATION OF ENTITY THAT
6 ENTERS INFORMATION.—Any information
7 that is added by an authorized EHR data
8 user to the health record shall be identified
9 and disclosed within such record as being
10 made by such user.

11 (iii) SATISFACTION OF HIPAA PRIVACY
12 REGULATIONS.—In the case of a record of
13 a covered entity (as defined for purposes of
14 HIPAA privacy regulations), with respect
15 to an individual, if such individual is an
16 IHRT participant with an independent
17 health record trust and such covered entity
18 is an authorized EHR data user, the re-
19 quirement under the HIPAA privacy regu-
20 lations for such entity to provide the
21 record to the participant shall be deemed
22 met if such entity, without charge to the
23 IHRT or the participant—

24 (I) forwards to the trust an ap-
25 propriately formatted electronic copy

1 of the record (and updates to such
2 records) for inclusion in the electronic
3 health record of the participant main-
4 tained by the trust;

5 (II) enters such record into the
6 electronic health record of the partici-
7 pant so maintained; or

8 (III) otherwise makes such
9 record available for electronic access
10 by the IHRT or the individual in a
11 manner that permits such record to
12 be included in the account of the indi-
13 vidual contained in the IHRT.

14 (iv) NOTIFICATION OF SENSITIVE IN-
15 FORMATION.—Any information, with re-
16 spect to the participant, that is sensitive
17 information, as specified by the Federal
18 Trade Commission, shall not be forwarded
19 or entered by an authorized EHR data
20 user into the electronic health record of the
21 participant maintained by the trust unless
22 the user certifies that the participant has
23 been notified of such information.

24 (C) DEEMED AUTHORIZATION FOR ACCESS
25 FOR EMERGENCY HEALTH CARE.—

1 (i) FINDINGS.—Congress finds that—

2 (I) given the size and nature of
3 visits to emergency departments in
4 the United States, readily available
5 health information could make the dif-
6 ference between life and death; and

7 (II) because of the case mix and
8 volume of patients treated, emergency
9 departments are well positioned to
10 provide information for public health
11 surveillance, community risk assess-
12 ment, research, education, training,
13 quality improvement, and other uses.

14 (ii) USE OF INFORMATION.—With re-
15 spect to the electronic health record of an
16 IHRT participant (or specified parts of
17 such electronic health record) maintained
18 by an IHRT, the participant shall be
19 deemed as providing authorization (in the
20 form of affirmative consent) for health
21 care providers to access, in connection with
22 providing emergency care services to the
23 participant, a limited, authenticated infor-
24 mation set concerning the participant for
25 emergency response purposes, unless the

1 participant specifies that such information
2 set (or any portion of such information
3 set) may not be so accessed. Such limited
4 information set may include information—

5 (I) patient identification data, as
6 determined appropriate by the partici-
7 pant;

8 (II) provider identification that
9 includes the use of unique provider
10 identifiers;

11 (III) payment information;

12 (IV) information related to the
13 individual's vitals, allergies, and medi-
14 cation history;

15 (V) information related to exist-
16 ing chronic problems and active clin-
17 ical conditions of the participant; and

18 (VI) information concerning
19 physical examinations, procedures, re-
20 sults, and diagnosis data.

21 (3) RULES FOR SECONDARY USES OF RECORDS
22 FOR RESEARCH AND OTHER PURPOSES.—

23 (A) IN GENERAL.—With respect to the
24 electronic health record of an IHRT participant
25 (or specified parts of such electronic health

1 record) maintained by an IHRT, the IHRT
2 may sell such record (or specified parts of such
3 record) only if—

4 (i) the transfer is authorized by the
5 participant pursuant to an agreement be-
6 tween the participant and the IHRT and is
7 in accordance with the privacy protection
8 agreement described in subsection (b)(1)
9 entered into between such participant and
10 such IHRT;

11 (ii) such agreement includes param-
12 eters with respect to the disclosure of in-
13 formation involved and a process for the
14 authorization of the further disclosure of
15 information in such record;

16 (iii) the information involved is to be
17 used for research or other activities only as
18 provided for in the agreement;

19 (iv) the recipient of the information
20 provides assurances that the information
21 will not be further transferred or reused in
22 violation of such agreement; and

23 (v) the transfer otherwise meets the
24 requirements and standards prescribed by
25 the Federal Trade Commission.

1 (B) TREATMENT OF PUBLIC HEALTH RE-
2 PORTING.—Nothing in this paragraph shall be
3 construed as prohibiting or limiting the use of
4 health care information of an individual, includ-
5 ing an individual who is an IHRT participant,
6 for public health reporting (or other research)
7 purposes prior to the inclusion of such informa-
8 tion in an electronic health record maintained
9 by an IHRT.

10 (4) LAW ENFORCEMENT CLARIFICATION.—
11 Nothing in this subtitle shall prevent an IHRT from
12 disclosing information contained in an electronic
13 health record maintained by the IHRT when re-
14 quired for purposes of a lawful investigation or offi-
15 cial proceeding inquiring into a violation of, or fail-
16 ure to comply with, any criminal or civil statute or
17 any regulation, rule, or order issued pursuant to
18 such a statute.

19 (5) RULE OF CONSTRUCTION.—Nothing in this
20 section shall be construed to require a health care
21 provider that does not utilize electronic methods or
22 appropriate levels of health information technology
23 on the date of the enactment of this Act to adopt
24 such electronic methods or technology as a require-

1 ment for participation or compliance under this sub-
2 title.

3 (b) PRIVACY PROTECTION AGREEMENT; TREATMENT
4 OF STATE PRIVACY AND SECURITY LAWS.—

5 (1) PRIVACY PROTECTION AGREEMENT.—A pri-
6 vacy protection agreement described in this sub-
7 section is an agreement, with respect to an electronic
8 health record of an IHRT participant to be main-
9 tained by an independent health record trust, be-
10 tween the participant and the trust—

11 (A) that is consistent with the standards
12 described in subsection (a)(2);

13 (B) under which the participant specifies
14 the portions of the record that may be accessed,
15 under what circumstances such portions may be
16 accessed, any authorizations for indicated au-
17 thorized EHR data users to access information
18 contained in the record, and the purposes for
19 which the information (or portions of the infor-
20 mation) in the record may be used;

21 (C) which provides a process for the au-
22 thorization of the transfer of information con-
23 tained in the record to a third party, including
24 for the sale of such information for purposes of
25 research, by an authorized EHR data user and

1 reuse of such information by such third party,
2 including a provision requiring that such trans-
3 fer and reuse is not in violation of any privacy
4 or transfer restrictions placed by the partici-
5 pant on the independent health record of such
6 participant; and

7 (D) under which the trust provides assur-
8 ances that the trust will not transfer, disclose,
9 or provide access to the record (or any portion
10 of the record) in violation of the parameters es-
11 tablished in the agreement or to any person or
12 entity who has not agreed to use and transfer
13 such record (or portion of such record) in ac-
14 cordance with such agreement.

15 (2) TREATMENT OF STATE LAWS.—

16 (A) IN GENERAL.—Except as provided
17 under subparagraph (B), the provisions of a
18 privacy protection agreement entered into be-
19 tween an IHRT and an IHRT participant shall
20 preempt any provision of State law (or any
21 State regulation) relating to the privacy and
22 confidentiality of individually identifiable health
23 information or to the security of such health in-
24 formation.

1 (B) EXCEPTION FOR PRIVILEGED INFOR-
2 MATION.—The provisions of a privacy protec-
3 tion agreement shall not preempt any provision
4 of State law (or any State regulation) that rec-
5 ognizes privileged communications between phy-
6 sicians, health care practitioners, and patients
7 of such physicians or health care practitioners,
8 respectively.

9 (C) STATE DEFINED.—For purposes of
10 this section, the term “State” has the meaning
11 given such term when used in title XI of the
12 Social Security Act, as provided under section
13 1101(a) of such Act (42 U.S.C. 1301(a)).

14 **SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION**
15 **AND INFORMATION SHARING.**

16 (a) IN GENERAL.—Participation in an independent
17 health record trust, or authorizing access to information
18 from such a trust, is voluntary. No employer, health insur-
19 ance issuer, group health plan, health care provider, or
20 other person may require, as a condition of employment,
21 issuance of a health insurance policy, coverage under a
22 group health plan, the provision of health care services,
23 payment for such services, or otherwise, that an individual
24 participate in, or authorize access to information from, an
25 independent health record trust.

1 (b) ENFORCEMENT.—The penalties provided for in
2 subsection (a) of section 1177 of the Social Security Act
3 (42 U.S.C. 1320d–6) shall apply to a violation of sub-
4 section (a) in the same manner as such penalties apply
5 to a person in violation of subsection (a) of such section.

6 **SEC. 848. FINANCING OF ACTIVITIES.**

7 (a) IN GENERAL.—Except as provided in subsection
8 (b), an IHRT may generate revenue to pay for the oper-
9 ations of the IHRT through—

10 (1) charging IHRT participants account fees
11 for use of the trust;

12 (2) charging authorized EHR data users for ac-
13 cessing electronic health records maintained in the
14 trust;

15 (3) the sale of information contained in the
16 trust (as provided for in section 846(a)(3)(A)); and

17 (4) any other activity determined appropriate
18 by the Federal Trade Commission.

19 (b) PROHIBITION AGAINST ACCESS FEES FOR
20 HEALTH CARE PROVIDERS.—For purposes of providing
21 incentives to health care providers to access information
22 maintained in an IHRT, as authorized by the IHRT par-
23 ticipants involved, the IHRT may not charge a fee for
24 services specified by the IHRT. Such services shall include
25 the transmittal of information from a health care provider

1 to be included in an independent electronic health record
2 maintained by the IHRT (or permitting such provider to
3 input such information into the record), including the
4 transmission of or access to information described in sec-
5 tion 846(a)(2)(C)(ii) by appropriate emergency respond-
6 ers.

7 (c) **REQUIRED DISCLOSURES.**—The sources and
8 amounts of revenue derived under subsection (a) for the
9 operations of an IHRT shall be fully disclosed to each
10 IHRT participant of such IHRT and to the public.

11 (d) **TREATMENT OF INCOME.**—For purposes of the
12 Internal Revenue Code of 1986, any revenue described in
13 subsection (a) shall not be included in gross income of any
14 IHRT, IHRT participant, or authorized EHR data user.

15 **SEC. 849. REGULATORY OVERSIGHT.**

16 (a) **IN GENERAL.**—In carrying out this subtitle, the
17 Federal Trade Commission shall promulgate regulations
18 for independent health record trusts.

19 (b) **ESTABLISHMENT OF INTERAGENCY STEERING**
20 **COMMITTEE.**—

21 (1) **IN GENERAL.**—The Secretary of Health and
22 Human Services shall establish an Interagency
23 Steering Committee in accordance with this sub-
24 section.

1 (2) CHAIRPERSON.—The Secretary of Health
2 and Human Services shall serve as the chairperson
3 of the Interagency Steering Committee.

4 (3) MEMBERSHIP.—The members of the Inter-
5 agency Steering Committee shall consist of the At-
6 torney General, the Chairperson of the Federal
7 Trade Commission, the Chairperson for the National
8 Committee for Vital and Health Statistics, a rep-
9 resentative of the Federal Reserve, and other Fed-
10 eral officials determined appropriate by the Sec-
11 retary of Health and Human Services.

12 (4) DUTIES.—The Interagency Steering Com-
13 mittee shall coordinate the implementation of this
14 title, including the implementation of policies de-
15 scribed in subsection (d) based upon the rec-
16 ommendations provided under such subsection, and
17 regulations promulgated under this subtitle.

18 (c) FEDERAL ADVISORY COMMITTEE.—

19 (1) IN GENERAL.—The National Committee for
20 Vital and Health Statistics shall serve as an advisory
21 committee for the IHRTs. The membership of such
22 advisory committee shall include a representative
23 from the Federal Trade Commission and the chair-
24 person of the Interagency Steering Committee. Not
25 less than 60 percent of such membership shall con-

1 sist of representatives of nongovernment entities, at
2 least one of whom shall be a representative from an
3 organization representing health care consumers.

4 (2) DUTIES.—The National Committee for
5 Vital and Health Statistics shall issue periodic re-
6 ports and review policies concerning IHRTs based
7 on each of the following factors:

8 (A) Privacy and security policies.

9 (B) Economic progress.

10 (C) Interoperability standards.

11 (d) POLICIES RECOMMENDED BY FEDERAL TRADE
12 COMMISSION.—The Federal Trade Commission, in con-
13 sultation with the National Committee for Vital and
14 Health Statistics, shall recommend policies to—

15 (1) provide assistance to encourage the growth
16 of independent health record trusts;

17 (2) track economic progress as it pertains to
18 operators of independent health records trusts and
19 individuals receiving nontaxable income with respect
20 to accounts;

21 (3) conduct public education activities regarding
22 the creation and usage of the independent health
23 records trusts;

24 (4) establish standards for the interoperability
25 of health information technology to ensure that in-

1 formation contained in such record may be shared
2 between the trust involved, the participant, and au-
3 thorized EHR data users, including for the stand-
4 ardized collection and transmission of individual
5 health records (or portions of such records) to au-
6 thorized EHR data users through a common inter-
7 face and for the portability of such records among
8 independent health record trusts; and

9 (5) carry out any other activities determined
10 appropriate by the Federal Trade Commission.

11 (e) REGULATIONS PROMULGATED BY FEDERAL
12 TRADE COMMISSION.—The Federal Trade Commission
13 shall promulgate regulations based on, at a minimum, the
14 following factors:

15 (1) Requiring that an IHRT participant, who
16 has an electronic health record that is maintained by
17 an IHRT, be notified of a security breach with re-
18 spect to such record, and any corrective action taken
19 on behalf of the participant.

20 (2) Requiring that information sent to, or re-
21 ceived from, an IHRT that has been designated as
22 high-risk should be authenticated through the use of
23 methods such as the periodic changing of passwords,
24 the use of biometrics, the use of tokens or other
25 technology as determined appropriate by the council.

1 (3) Requiring a delay in releasing sensitive
2 health care test results and other similar informa-
3 tion to patients directly in order to give physicians
4 time to contact the patient.

5 (4) Recommendations for entities operating
6 IHRTs, including requiring analysis of the potential
7 risk of health transaction security breeches based on
8 set criteria.

9 (5) The conduct of audits of IHRTs to ensure
10 that they are in compliance with the requirements
11 and standards established under this subtitle.

12 (6) Disclosure to IHRT participants of the
13 means by which such trusts are financed, including
14 revenue from the sale of patient data.

15 (7) Prevention of certification of an entity seek-
16 ing independent health record trust certification
17 based on—

18 (A) the potential for conflicts between the
19 interests of such entity and the security of the
20 health information involved; and

21 (B) the involvement of the entity in any
22 activity that is contrary to the best interests of
23 a patient.

24 (8) Prevention of the use of revenue sources
25 that are contrary to a patient's interests.

1 (9) Public disclosure of audits in a manner
2 similar to financial audits required for publicly trad-
3 ed stock companies.

4 (10) Requiring notification to a participating
5 entity that the information contained in such record
6 may not be representative of the complete or accu-
7 rate electronic health record of such account holder.

8 (f) COMPLIANCE REPORT.—Not later than 1 year
9 after the date of the enactment of this Act, and annually
10 thereafter, the Commission shall submit to the Committee
11 on Health, Education, Labor, and Pensions and the Com-
12 mittee on Finance of the Senate and the Committee on
13 Energy and Commerce and the Committee on Ways and
14 Means of the House of Representatives, a report on com-
15 pliance by and progress of independent health record
16 trusts with this subtitle. Such report shall describe the fol-
17 lowing:

18 (1) The number of complaints submitted about
19 independent health record trusts, which shall be di-
20 vided by complaints related to security breaches, and
21 complaints not related to security breaches, and may
22 include other categories as the Interagency Steering
23 Committee established under subsection (b) deter-
24 mines appropriate.

1 (2) The number of enforcement actions under-
2 taken by the Commission against independent health
3 record trusts in response to complaints under para-
4 graph (1), which shall be divided by enforcement ac-
5 tions related to security breaches and enforcement
6 actions not related to security breaches and may in-
7 clude other categories as the Interagency Steering
8 Committee established under subsection (b) deter-
9 mines appropriate.

10 (3) The economic progress of the individual
11 owner or institution operator as achieved through
12 independent health record trust usage and existing
13 barriers to such usage.

14 (4) The progress in security auditing as pro-
15 vided for by the Interagency Steering Committee
16 council under subsection (b).

17 (5) The other core responsibilities of the Com-
18 mission as described in subsection (a).

19 (g) INTERAGENCY MEMORANDUM OF UNDER-
20 STANDING.—The Interagency Steering Committee shall
21 ensure, through the execution of an interagency memo-
22 randum of understanding, that—

23 (1) regulations, rulings, and interpretations
24 issued by Federal officials relating to the same mat-
25 ter over which 2 or more such officials have respon-

1 sibility under this subtitle are administered so as to
2 have the same effect at all times; and

3 (2) the memorandum provides for the coordina-
4 tion of policies related to enforcing the same require-
5 ments through such officials in order to have coordi-
6 nated enforcement strategy that avoids duplication
7 of enforcement efforts and assigns priorities in en-
8 forcement.

9 **TITLE IX—MISCELLANEOUS**

10 **SEC. 901. HEALTH CARE CHOICE FOR VETERANS.**

11 Beginning not later than 2 years after the date of
12 the enactment of this Act, the Secretary of Veterans Af-
13 fairs may—

14 (1) permit veterans, and survivors and depend-
15 ents of veterans, who are eligible for health care and
16 services under the laws administered by the Sec-
17 retary to receive such care and services through such
18 non-Department of Veterans Affairs providers and
19 facilities as the Secretary may approve for purposes
20 of this section; and

21 (2) pursuant to such procedures as the Sec-
22 retary of Veteran Affairs shall prescribe for purposes
23 of this section, make payments to such providers
24 and facilities for the provision of such care and serv-
25 ices to veterans, and such survivors and dependents,

1 at such rates as the Secretary may specify in such
2 procedures and in such manner so that the Sec-
3 retary ensures that the aggregate payments made by
4 the Secretary to such providers and facilities do not
5 exceed the aggregate amounts which the Secretary
6 would have paid for such care and services if this
7 section had not been enacted.

8 **SEC. 902. HEALTH CARE CHOICE FOR INDIANS.**

9 (a) IN GENERAL.—Beginning not later than 2 years
10 after the date of enactment of this Act, the Secretary of
11 Health and Human Services shall—

12 (1) permit Indians who are eligible for health
13 care and services under a health care program oper-
14 ated or financed by the Indian Health Service or by
15 an Indian Tribe, Tribal Organization, or Urban In-
16 dian Organization (and any such other individuals
17 who are so eligible as the Secretary may specify), to
18 receive such care and services through such non- In-
19 dian Health Service, Indian Tribe, Tribal Organiza-
20 tion, or Urban Indian Organization providers and
21 facilities as the Secretary shall approve for purposes
22 of this section; and

23 (2) pursuant to such procedures as the Sec-
24 retary of Health and Human Services shall prescribe
25 for purposes of this section, make payments to such

1 providers and facilities for the provision of such care
2 and services to Indians and individuals described in
3 paragraph (1), at such rates as the Secretary shall
4 specify in such procedures and in such manner so
5 that the Secretary ensures that the aggregate pay-
6 ments made by the Secretary to such providers and
7 facilities do not exceed the aggregate amounts which
8 the Secretary would have paid for such care and
9 services if this section had not been enacted.

10 (b) DEFINITIONS.—In this section, the terms “In-
11 dian”, “Indian Health Program”, “Indian Tribe”, “Tribal
12 Organization”, and “Urban Indian Organization” have
13 the meanings given those terms in section 4 of the Indian
14 Health Care Improvement Act.

15 **SEC. 903. TERMINATION OF FEDERAL COORDINATING**
16 **COUNCIL FOR COMPARATIVE EFFECTIVE-**
17 **NESS RESEARCH.**

18 The Federal Coordinating Council for Comparative
19 Effectiveness Research is hereby terminated and section
20 804 of the American Recovery and Reinvestment Act of
21 2009 establishing and funding such Council is hereby re-
22 pealed.

1 **SEC. 904. HHS AND GAO JOINT STUDY AND REPORT ON**
2 **COSTS OF THE 5 MEDICAL CONDITIONS THAT**
3 **HAVE THE GREATEST IMPACT.**

4 (a) **STUDY.**—The Secretary of Health and Human
5 Services (in this section referred to as the “Secretary”)
6 and the Comptroller General of the United States (in this
7 section referred to as the “Comptroller General”) shall
8 jointly conduct a study on the costs of the top 5 medical
9 conditions facing the public which have the greatest im-
10 pact in terms of morbidity, mortality, and financial cost.
11 Such study shall include—

12 (1) current estimates as well as a “generational
13 score” to capture the financial cost and health toll
14 certain medical conditions will inflict on the baby
15 boomer generation and on other individuals; and

16 (2) a careful review of certain medical condi-
17 tions, including heart disease, obesity, diabetes,
18 stroke, cancer, Alzheimers, and other medical condi-
19 tions the Secretary and Comptroller General deter-
20 mine appropriate.

21 (b) **REPORT.**—Not later than 1 year after the date
22 of enactment of this Act, the Secretary and the Comp-
23 troller General shall jointly submit to Congress a report
24 containing the results of the study conducted under sub-
25 section (a), together with recommendations for such legis-

1 lation and administrative action as the Secretary and the
2 Comptroller General determine appropriate.

3 (c) TARGETING OF PREVENTION AND WELLNESS EF-
4 FORTS.—The Secretary shall target prevention and
5 wellness efforts conducted under the provisions of and
6 amendments made by this Act in order to combat medical
7 conditions identified in the report submitted under sub-
8 section (b), including such medical conditions identified as
9 the top 5 medical conditions facing the public which have
10 the greatest impact in terms of morbidity, mortality, and
11 financial cost as of or after the date of enactment of this
12 Act.

○