

110TH CONGRESS  
1ST SESSION

# H. R. 3163

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

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## IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2007

Mr. BAIRD (for himself, Mrs. EMERSON, Mr. BLUMENAUER, and Mr. COOPER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, and Oversight and Government Reform, 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

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## A BILL

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

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

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

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

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.

TITLE I—HEALTHY AMERICANS PRIVATE INSURANCE PLANS

Subtitle A—Guaranteed Private Coverage

- Sec. 101. Guarantee of Healthy Americans Private Insurance coverage.
- Sec. 102. Individual responsibility to enroll in a Healthy Americans Private Insurance plan.

Subtitle B—Standards for Healthy Americans Private Insurance Coverage

- Sec. 111. Healthy Americans Private Insurance Plans.
- Sec. 112. Specific coverage requirements.
- Sec. 113. Updating Healthy Americans Private Insurance plan requirements.

Subtitle C—Eligibility for Premium and Personal Responsibility Contribution Subsidies

- Sec. 121. Eligibility for premium subsidies.
- Sec. 122. Eligibility for personal responsibility contribution subsidies.
- Sec. 123. Definitions and special rules.

Subtitle D—Wellness Programs

- Sec. 131. Requirements for wellness programs.

TITLE II—HEALTHY START FOR CHILDREN

Subtitle A—Benefits and Eligibility

- Sec. 201. General goal and authorization of appropriations for HAPI plan coverage for children.
- Sec. 202. Coordination of supplemental coverage under the Medicaid program to HAPI plan coverage for children.

Subtitle B—Service Providers

- Sec. 211. Inclusion of providers under HAPI plans.
- Sec. 212. Use of school-based health centers.

TITLE III—BETTER HEALTH FOR OLDER AND DISABLED AMERICANS

- Sec. 301. Coordination of supplemental coverage under the Medicaid program for elderly and disabled individuals.

TITLE IV—HEALTHIER MEDICARE

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

- Sec. 401. Authority to adjust amount of Medicare part B premium to reward positive health behavior.

Subtitle B—Promoting Primary Care for Medicare Beneficiaries

- Sec. 411. Primary care services management payment.

Subtitle C—Chronic Care Disease Management

- Sec. 421. Chronic care disease management.  
 Sec. 422. Chronic Care Education Centers.

Subtitle D—Improving Quality in Hospitals for All Patients

- Sec. 431. Improving quality in hospitals for all patients.

Subtitle E—Additional Provisions

- Sec. 441. Additional cost information.  
 Sec. 442. Reducing Medicare paperwork and regulatory burdens.

TITLE V—STATE HEALTH HELP AGENCIES

- Sec. 501. Establishment.  
 Sec. 502. Responsibilities and authorities.  
 Sec. 503. Appropriations for Transition to State Health Help Agencies.

TITLE VI—SHARED RESPONSIBILITIES

Subtitle A—Individual Responsibilities

- Sec. 601. Individual responsibility to ensure HAPI plan coverage.

Subtitle B—Employer Responsibilities

- Sec. 611. Health care responsibility payments.  
 Sec. 612. Distribution of individual responsibility payments to HHAs.

Subtitle C—Insurer Responsibilities

- Sec. 621. Insurer responsibilities.

Subtitle D—State Responsibilities

- Sec. 631. State responsibilities.  
 Sec. 632. Empowering States to innovate through waivers.

Subtitle E—Federal Fallback Guarantee Responsibility

- Sec. 641. Federal guarantee of access to coverage.

Subtitle F—Federal Financing Responsibilities

- Sec. 651. Appropriation for subsidy payments.  
 Sec. 652. Recapture of Medicare and 90 percent of Medicaid Federal DSH funds to strengthen Medicare and ensure continued support for public health programs.

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

PART 1—TAX TREATMENT OF HEALTH CARE COVERAGE UNDER HEALTHY AMERICANS PROGRAM

- Sec. 661. Limited employee income and payroll tax exclusion for employer shared responsibility payments, historic retiree health contributions, and transitional coverage contributions.

- Sec. 662. Exclusion for limited employer-provided health care fringe benefits.
- Sec. 663. Limited employer deduction for employer shared responsibility payments, historic retiree health contributions, and other health care expenses.
- Sec. 664. Refundable credit for individual shared responsibility payments.
- Sec. 665. Modification of other tax incentives to complement Healthy Americans program.
- Sec. 666. Termination of certain employer incentives when replaced by lower health care costs.

PART 2—TERMINATION OF COVERAGE UNDER OTHER GOVERNMENTAL  
PROGRAMS AND TRANSITION RULES FOR MEDICAID AND SCHIP

- Sec. 671. Group and individual health plan requirements not applicable to HAPI plans.
- Sec. 672. Federal Employees Health Benefits Plan.
- Sec. 673. Medicaid and SCHIP.

TITLE VII—PURCHASING HEALTH SERVICES AND PRODUCTS  
THAT ARE MOST EFFECTIVE

- Sec. 701. One time disallowance of deduction for advertising and promotional expenses for certain prescription pharmaceuticals.
- Sec. 702. Enhanced new drug and device approval.
- Sec. 703. Medical schools and finding what works in health care.
- Sec. 704. Finding affordable health care providers nearby.

TITLE VIII—ENHANCED HEALTH CARE VALUE

- Sec. 801. Short title.
- Sec. 802. Research on comparative effectiveness of health care items and services.
- Sec. 803. Health Care Comparative Effectiveness Research Trust Fund; financing for Trust Fund.
- Sec. 804. Coordination of Health Services Research.

TITLE IX—CONTAINING MEDICAL COSTS AND GETTING MORE  
VALUE FOR THE HEALTH CARE DOLLAR

- Sec. 901. Cost-containment results of the Healthy Americans Act.

**1 SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Americans want affordable, guaranteed pri-  
4 vate health coverage that makes them healthier and  
5 can never be taken away.

6 (2) American health care provides primarily  
7 “sick care” and does not do enough to prevent  
8 chronic illnesses like heart disease, stroke, and dia-

1        betes. This results in significantly higher health  
2        costs for all Americans.

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

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

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

14           (6) Financing this guarantee should be a  
15       shared responsibility between individuals, the Gov-  
16       ernment, and employers.

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

20           (8) This guarantee must include easier access  
21       to understandable information about the quality,  
22       cost, and effectiveness of health care providers, prod-  
23       ucts, and services.

24           (9) The fact that businesses in the United  
25       States compete globally against businesses whose

1 governments pay for health care, coupled with the  
2 aging of the American population and the explosive  
3 growth of preventable health problems, makes the  
4 status quo in American health care unacceptable.

5 **SEC. 3. DEFINITIONS.**

6 In this Act:

7 (1) **ADULT INDIVIDUAL.**—The term “adult indi-  
8 vidual” means an individual who—

9 (A) is—

10 (i) age 19 or older;

11 (ii) a resident of a State;

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

13 (II) an alien with permanent resi-  
14 dence;

15 (iv) not a dependent child; and

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

18 (B) in the case of an incarcerated indi-  
19 vidual, such an individual who is incarcerated  
20 for less than 1 month.

21 (2) **ALIEN WITH PERMANENT RESIDENCE.**—

22 The term “alien with permanent residence” has the  
23 meaning given the term “qualified alien” in section  
24 431 of the Personal Responsibility and Work Oppor-  
25 tunity Reconciliation Act of 1996 (8 U.S.C. 1641).

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

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

8           (5) HAPI PLAN.—The term “HAPI plan”  
9 means a Healthy Americans Private Insurance plan  
10 described under subtitle B of title I.

11          (6) HHA.—The term “HHA” means the  
12 Health Help Agency of a State as described under  
13 title V.

14          (7) HEALTH INSURANCE ISSUER.—The term  
15 “health insurance issuer” means an insurance com-  
16 pany, insurance service, or insurance organization  
17 (including a health maintenance organization, as de-  
18 fined in paragraph (8)) which is licensed to engage  
19 in the business of insurance in a State and which is  
20 subject to State law which regulates insurance (with-  
21 in the meaning of section 514(b)(2) of the Employee  
22 Retirement Income Security Act of 1974). Such  
23 term does not include a group health plan.

1 (8) HEALTH MAINTENANCE ORGANIZATION.—

2 The term “health maintenance organization”  
3 means—

4 (A) a federally qualified health mainte-  
5 nance organization (as defined in section  
6 1301(a)),

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

9 (C) a similar organization regulated under  
10 State law for solvency in the same manner and  
11 to the same extent as such a health mainte-  
12 nance organization.

13 (9) PERSONAL RESPONSIBILITY CONTRIBU-  
14 TION.—The term “personal responsibility contribu-  
15 tion” means a payment made by a covered individual  
16 to a health care provider or a health insurance  
17 issuer with respect to the provision of health care  
18 services under a HAPI plan, not including any  
19 health insurance premium payment.

20 (10) QUALIFIED COLLECTIVE BARGAINING  
21 AGREEMENT.—

22 (A) IN GENERAL.—The term “qualified  
23 collective bargaining agreement” means an  
24 agreement between a qualified collective bar-  
25 gaining employer and an employee organization



1 that represents the employees of such employer  
2 that is in effect until the date that is the earlier  
3 of—

4 (i) January 1 of the first year which  
5 is more than 9 years after the date of en-  
6 actment of this Act, or

7 (ii) the date the collective bargaining  
8 agreement expires.

9 (B) QUALIFIED COLLECTIVE BARGAINING  
10 EMPLOYER.—The term “qualified collective bar-  
11 gaining employer” means an employer who pro-  
12 vides health insurance to employees under the  
13 terms of a collective bargaining agreement  
14 which is entered into before the date of the en-  
15 actment of this Act.

16 (11) SECRETARY.—The term “Secretary”  
17 means the Secretary of Health and Human Services.

18 (12) STATE.—The term “State” means each of  
19 the several States of the United States, the District  
20 of Columbia, the Commonwealth of Puerto Rico, the  
21 Virgin Islands, American Samoa, Guam, the Com-  
22 monwealth of the Northern Mariana Islands, and  
23 other territories of the United States.

24 (13) STATE OF RESIDENCE.—The term “State  
25 of residence”, with respect to an individual, means

1 the State in which the individual has primary resi-  
2 dence.

3 **TITLE I—HEALTHY AMERICANS**  
4 **PRIVATE INSURANCE PLANS**  
5 **Subtitle A—Guaranteed Private**  
6 **Coverage**

7 **SEC. 101. GUARANTEE OF HEALTHY AMERICANS PRIVATE**  
8 **INSURANCE COVERAGE.**

9 Not later than the date that is 4 years after the date  
10 of enactment of this Act, each adult individual shall have  
11 the opportunity to purchase a Healthy Americans Private  
12 Insurance plan that meets the requirements of subtitle B,  
13 (referred to in this Act as “HAPI plan”) for such indi-  
14 vidual and the dependent children of such individual.

15 **SEC. 102. INDIVIDUAL RESPONSIBILITY TO ENROLL IN A**  
16 **HEALTHY AMERICANS PRIVATE INSURANCE**  
17 **PLAN.**

18 (a) INDIVIDUAL RESPONSIBILITY.—

19 (1) ADULT INDIVIDUALS.—Each adult indi-  
20 vidual shall have the responsibility to enroll in a  
21 HAPI plan offered through the HHA of the adult  
22 individual’s State of residence, unless the adult indi-  
23 vidual—

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

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

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

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

10 (iv) a qualified collective bargaining  
11 agreement;

12 (v) the Department of Veterans Af-  
13 fairs; or

14 (vi) the Indian Health Service; or

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

20 (2) DEPENDENT CHILDREN.—Each adult indi-  
21 vidual shall have the responsibility to enroll each de-  
22 pendent child of the adult individual in a HAPI plan  
23 offered through the HHA of the adult individual's  
24 State of residence, unless the adult individual—

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

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

6 (3) VERIFICATION OF RELIGIOUS EXCEPTION.—  
7 Each State shall develop guidelines for determining  
8 and verifying the individuals who qualify for the ex-  
9 ception under paragraph (1)(B).

10 (b) PENALTY FOR FAILURE TO PURCHASE COV-  
11 ERAGE.—

12 (1) PENALTY.—

13 (A) IN GENERAL.—In the case of an indi-  
14 vidual described in subparagraph (B), such in-  
15 dividual shall be subject to a late enrollment  
16 penalty in an amount determined under sub-  
17 paragraph (C).

18 (B) INDIVIDUALS SUBJECT TO PENALTY.—  
19 An individual described in this subparagraph is  
20 an adult individual for whom there is a contin-  
21 uous period of 63 days or longer, beginning on  
22 the applicable date (as defined in subparagraph  
23 (E)) and ending on the date of enrollment in a  
24 HAPI plan, during all of which the individual—

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

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

7 (C) AMOUNT OF PENALTY.—

8 (i) IN GENERAL.—The amount deter-  
9 mined under this subparagraph for an in-  
10 dividual is an amount equal to the sum  
11 of—

12 (I) the number of uncovered  
13 months multiplied by the weighted av-  
14 erage of the monthly premium for  
15 HAPI plans of the same class of cov-  
16 erage as the individual's in the appli-  
17 cable coverage area (determined with-  
18 out regard to any subsidy under sec-  
19 tion 121); and

20 (II) 15 percent of the amount de-  
21 termined under subclause (I).

22 (ii) UNCOVERED MONTH DEFINED.—  
23 For purposes of this subsection, the term  
24 “uncovered month” means, with respect to  
25 an individual, any month beginning on or

1 after the applicable date (as defined in  
2 subparagraph (E)) unless the individual  
3 can demonstrate that the individual—

4 (I) was covered under a HAPI  
5 plan or a health plan offered through  
6 a program described in paragraph  
7 (1)(A) of section 102(a) for any por-  
8 tion of such month; or

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

12 A month shall not be treated as an uncov-  
13 ered month if the individual has already  
14 paid a late enrollment penalty under this  
15 subsection for such month or if the indi-  
16 vidual was incarcerated for the entire  
17 month.

18 (D) PAYMENT.—Payment of any late en-  
19 rollment penalty by an individual under this  
20 subsection shall be made to the HHA of the in-  
21 dividual’s State of residence under procedures  
22 established by the State.

23 (E) APPLICABLE DATE.—In this para-  
24 graph, the term “applicable date” means the  
25 earlier of—

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

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

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

14 (3) ENFORCEMENT.—Each State shall deter-  
15 mine appropriate mechanisms, which may not in-  
16 clude revocation or ineligibility for coverage under a  
17 HAPI plan, to enforce the responsibility of each  
18 adult individual to purchase HAPI plan coverage for  
19 such individual and any dependent children of such  
20 individual under subsection (a).

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

1 **Subtitle B—Standards for Healthy**  
2 **Americans Private Insurance**  
3 **Coverage**

4 **SEC. 111. HEALTHY AMERICANS PRIVATE INSURANCE**  
5 **PLANS.**

6 (a) OPTIONS.—A State HHA—

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

11 (2) shall require the offering of 1 or more  
12 HAPI plans that include coverage for benefits,  
13 items, or services in addition to the standardized  
14 benefits, items, or services required under subsection  
15 (b) for HAPI plans if—

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

19 (B) a list of such additional benefits,  
20 items, or services, and the prices applicable to  
21 such additional benefits, items, and services, is  
22 displayed in a manner that is separate from the  
23 description of the standardized benefits, items,  
24 or services required under the plan under this  
25 section (and consistent with the manner in



1 which such items are displayed by medigap poli-  
2 cies) and that enables a consumer to identify  
3 such additional benefits, items, and services and  
4 the cost associated with such; and

5 (C) no premium subsidies are available  
6 under subtitle C for any portion of the pre-  
7 miums for a HAPI plan that are attributable to  
8 such additional benefits, items, or services; and

9 (3) may permit the offering of 1 or more actu-  
10 arially equivalent HAPI plans through the HHA as  
11 provided for in subsection (c).

12 (b) STANDARDIZED COVERAGE REQUIREMENTS FOR  
13 HAPI PLANS.—

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

16 (A) provide benefits for health care items  
17 and services that are actuarially equivalent or  
18 greater in value than the benefits offered as of  
19 January 1, 2007, under the Blue Cross/Blue  
20 Shield Standard Plan provided under the Fed-  
21 eral Employees Health Benefit Program under  
22 chapter 89 of title 5, United States Code, in-  
23 cluding coverage of an initial primary care as-  
24 sessment and annual physical examinations;

1 (B) provide benefits for wellness programs  
2 and incentives to promote the use of such pro-  
3 grams;

4 (C) provide coverage for catastrophic med-  
5 ical events that result in out-of-pocket costs for  
6 an individual or family if lifetime limits are ex-  
7 hausted;

8 (D) designate a health care provider, such  
9 as a primary care physician, nurse practitioner,  
10 or other qualified health provider, to monitor  
11 the health and health care of a covered individ-  
12 uals (such provider shall be known as the  
13 “health home” of the covered individual);

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

20 (F) provide benefits for comprehensive dis-  
21 ease prevention, early detection, disease man-  
22 agement, and chronic condition management  
23 that meets minimum standards developed by  
24 the Secretary;

1 (G) provide for the application of personal  
2 responsibility contribution requirements with re-  
3 spect to covered benefits in a manner that may  
4 be similar to the cost sharing requirements ap-  
5 plied as of January 1, 2007, under the Blue  
6 Cross/Blue Shield Standard Plan provided  
7 under the Federal Employees Health Benefit  
8 Program under chapter 89 of title 5, United  
9 States Code, except that no contributions shall  
10 be required for—

11 (i) preventive items or services; and

12 (ii) early detection, disease manage-  
13 ment, or chronic pain treatment items or  
14 services; and

15 (H) comply with the requirements of sec-  
16 tion 112.

17 (2) DETERMINATION OF BENEFITS BY SEC-  
18 RETARY.—Not later than 1 year after the date of  
19 enactment of this Act, the Secretary shall promul-  
20 gate guidelines concerning the benefits, items, and  
21 services that are covered under paragraph (1).

22 (3) COVERAGE FOR FAMILY PLANNING.—

23 (A) IN GENERAL.—Except as provided in  
24 subparagraph (B), a health insurance issuer  
25 shall make available supplemental coverage for

1           abortion services that may be purchased in con-  
2           junction with enrollment in a HAPI plan or an  
3           actuarially equivalent healthy American plan.

4           (B) RELIGIOUS AND MORAL EXCEPTION.—

5           Nothing in this paragraph shall be construed to  
6           require a health insurance issuer affiliated with  
7           a religious institution to provide the coverage  
8           described in subparagraph (A).

9           (4) RULE OF CONSTRUCTION.—Nothing in this  
10          subsection shall be construed to prohibit a HAPI  
11          plan from providing coverage for benefits, items, and  
12          services in addition to the coverage required under  
13          this subsection. No premium subsidies shall be avail-  
14          able under subtitle C for any portion of the pre-  
15          miums for a HAPI plan that are attributable to  
16          such additional benefits, items, or services.

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

20                 (1) cover all treatments, items, services, and  
21                 providers at least to the same extent as those cov-  
22                 ered under a HAPI plan that—

23                         (A) shall include coverage for—

24                                 (i) preventive items and services (in-  
25                                 cluding well baby care and well child care

1 and appropriate immunizations) and dis-  
2 ease management services;

3 (ii) inpatient and outpatient hospital  
4 services;

5 (iii) physicians' surgical and medical  
6 services; and

7 (iv) laboratory and x-ray services; and

8 (B) may include additional supplemental  
9 benefits to the extent approved by the State  
10 and provided for in advance in the plan con-  
11 tract; and

12 (2) ensure that no personal responsibility con-  
13 tribution requirements are applied for prevention  
14 and chronic disease management benefits, items, or  
15 services.

16 (d) PREMIUMS AND RATING REQUIREMENTS.—

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

20 (A) Coverage of an individual.

21 (B) Coverage of a married couple or do-  
22 mestic partnership (as determined by a State)  
23 without dependent children.

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

1           (D) Coverage of a married couple or do-  
2           mestic partnership (as determined by a State)  
3           with 1 or more dependent children.

4           (2) DETERMINATIONS OF PREMIUMS.—With re-  
5           spect to each class of coverage described in para-  
6           graph (1), a health insurance issuer shall determine  
7           the premium amount for a HAPI plan using ad-  
8           justed community rating principals, as described in  
9           paragraphs (3) and (4) established by the State.  
10          States may permit premium variations based only on  
11          geography, tobacco use, and family size. A State  
12          may determine to have no variation.

13          (3) REWARDS.—A State shall permit a health  
14          insurance issuer to provide premium discounts and  
15          other incentives to enrollees based on the participa-  
16          tion of such enrollees in wellness, chronic disease  
17          management, and other programs designed to im-  
18          prove the health of the enrollees.

19          (4) LIMITATION.—A health insurance issuer  
20          shall not consider age, gender, industry, health sta-  
21          tus, or claims experience in determining premiums  
22          under this subsection.

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

1 **SEC. 112. SPECIFIC COVERAGE REQUIREMENTS.**

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

4 (1) provide for increased portability through  
5 limitations on the application of preexisting condi-  
6 tion exclusions, in a manner similar to that provided  
7 for under section 2701 of the Public Health Service  
8 Act (42 U.S.C. 300gg), as such section existed on  
9 the day before the date of enactment of this Act, ex-  
10 cept that the State shall develop procedures to en-  
11 sure that preexisting exclusion limitations do not  
12 apply to new enrollees who had no applicable cred-  
13 itable coverage immediately prior to the first enroll-  
14 ment period;

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

21 (3) provide for the guaranteed renewability of  
22 coverage in a manner similar to that provided for  
23 under section 2712 of the Public Health Service Act  
24 (42 U.S.C. 300gg–12), as such section existed on  
25 the day before the date of enactment of this Act, ex-

1       cept that the prohibition on market reentry provided  
2       for under such section shall be deemed to be 2 years;

3           (4) prohibit discrimination against individual  
4       enrollees and prospective enrollees based on health  
5       status in a manner similar to that provided for  
6       under section 2702 of the Public Health Service Act  
7       (42 U.S.C. 300gg-1), as such section existed on the  
8       day before the date of enactment of this Act;

9           (5) provide coverage protections for enrollees  
10      who are mothers and newborns in a manner similar  
11      to that provided for under section 2704 of the Pub-  
12      lic Health Service Act (42 U.S.C. 300gg-3), as such  
13      section existed on the day before the date of enact-  
14      ment of this Act;

15          (6) provide for full parity in the application of  
16      certain limits to mental health benefits in a manner  
17      similar to that provided for under section 2705 of  
18      the Public Health Service Act (42 U.S.C. 300gg-4),  
19      as such section would be in effect if the amendments  
20      described in subsection (e) had been made;

21          (7) provide coverage for reconstructive surgery  
22      following a mastectomy in a manner similar to that  
23      provided for under section 2706 of the Public  
24      Health Service Act (42 U.S.C. 300gg-5), as such



1 section existed on the day before the date of enact-  
2 ment of this Act; and

3 (8) prohibit discrimination on the basis of ge-  
4 netic information, as provided for under subsection  
5 (b).

6 (b) GENETIC NONDISCRIMINATION.—

7 (1) PROHIBITION ON GENETIC INFORMATION AS  
8 A CONDITION OF ELIGIBILITY.—A HAPI plan shall  
9 not establish rules for the eligibility (including con-  
10 tinued eligibility) of any individual to enroll in cov-  
11 erage under the plan based on genetic information  
12 (including information about a request for or receipt  
13 of genetic services by an individual or family mem-  
14 ber of such individual).

15 (2) PROHIBITION ON GENETIC INFORMATION IN  
16 SETTING PREMIUM RATES.—A HAPI plan shall not  
17 adjust premium or personal responsibility contribu-  
18 tion amounts for an individual on the basis of ge-  
19 netic information concerning the individual or a fam-  
20 ily member of the individual (including information  
21 about a request for or receipt of genetic services by  
22 an individual or family member of such individual).

23 (3) GENETIC TESTING.—

24 (A) LIMITATION ON REQUESTING OR RE-  
25 QUIRING GENETIC TESTING.—A HAPI plan

1 shall not request or require an individual or a  
2 family member of such individual to undergo a  
3 genetic test.

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

6 (i) limit the authority of a health care  
7 professional who is providing health care  
8 services with respect to an individual to re-  
9 quest that such individual or a family  
10 member of such individual undergo a ge-  
11 netic test;

12 (ii) limit the authority of a health care  
13 professional who is employed by or affili-  
14 ated with a HAPI plan and who is pro-  
15 viding health care services to an individual  
16 as part of a bona fide wellness program to  
17 notify such individual of the availability of  
18 a genetic test or to provide information to  
19 such individual regarding such genetic test;  
20 or

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

24 (c) AMENDMENTS PROVIDING FULL MENTAL  
25 HEALTH PARITY.—For purposes of subsection (a)(6), the

1 amendments to section 2705 of the Public Health Service  
2 Act (42 U.S.C. 300gg-5) referred to in such subsection  
3 are as follows:

4 (1) EXTENSION OF PARITY TO TREATMENT  
5 LIMITS AND BENEFICIARY FINANCIAL REQUIRE-  
6 MENTS.—In such section—

7 (A) in subsection (a), add at the end the  
8 following new paragraphs:

9 “(3) TREATMENT LIMITS.—

10 “(A) NO TREATMENT LIMIT.—If the plan  
11 or coverage does not include a treatment limit  
12 (as defined in subparagraph (D)) on substan-  
13 tially all medical and surgical benefits in any  
14 category of items or services (specified in sub-  
15 paragraph (C)), the plan or coverage may not  
16 impose any treatment limit on mental health  
17 and substance-related disorder benefits that are  
18 classified in the same category of items or serv-  
19 ices.

20 “(B) TREATMENT LIMIT.—If the plan or  
21 coverage includes a treatment limit on substan-  
22 tially all medical and surgical benefits in any  
23 category of items or services, the plan or cov-  
24 erage may not impose such a treatment limit on  
25 mental health and substance-related disorder

1 benefits for items and services within such cat-  
2 egory that are more restrictive than the pre-  
3 dominant treatment limit that is applicable to  
4 medical and surgical benefits for items and  
5 services within such category.

6 “(C) CATEGORIES OF ITEMS AND SERV-  
7 ICES FOR APPLICATION OF TREATMENT LIMITS  
8 AND BENEFICIARY FINANCIAL REQUIRE-  
9 MENTS.—For purposes of this paragraph and  
10 paragraph (4), there shall be the following four  
11 categories of items and services for benefits,  
12 whether medical and surgical benefits or mental  
13 health and substance-related disorder benefits,  
14 and all medical and surgical benefits and all  
15 mental health and substance related benefits  
16 shall be classified into one of the following cat-  
17 egories:

18 “(i) INPATIENT, IN-NETWORK.—Items  
19 and services furnished on an inpatient  
20 basis and within a network of providers es-  
21 tablished or recognized under such plan or  
22 coverage.

23 “(ii) INPATIENT, OUT-OF-NETWORK.—  
24 Items and services furnished on an inpa-  
25 tient basis and outside any network of pro-

1           viders established or recognized under such  
2           plan or coverage.

3           “(iii) OUTPATIENT, IN-NETWORK.—  
4           Items and services furnished on an out-  
5           patient basis and within a network of pro-  
6           viders established or recognized under such  
7           plan or coverage.

8           “(iv) OUTPATIENT, OUT-OF-NET-  
9           WORK.—Items and services furnished on  
10          an outpatient basis and outside any net-  
11          work of providers established or recognized  
12          under such plan or coverage.

13          “(D) TREATMENT LIMIT DEFINED.—For  
14          purposes of this paragraph, the term ‘treatment  
15          limit’ means, with respect to a plan or coverage,  
16          limitation on the frequency of treatment, num-  
17          ber of visits or days of coverage, or other simi-  
18          lar limit on the duration or scope of treatment  
19          under the plan or coverage.

20          “(E) PREDOMINANCE.—For purposes of  
21          this subsection, a treatment limit or financial  
22          requirement with respect to a category of items  
23          and services is considered to be predominant if  
24          it is the most common or frequent of such type

1 of limit or requirement with respect to such cat-  
2 egory of items and services.

3 “(4) BENEFICIARY FINANCIAL REQUIRE-  
4 MENTS.—

5 “(A) NO BENEFICIARY FINANCIAL RE-  
6 QUIREMENT.—If the plan or coverage does not  
7 include a beneficiary financial requirement (as  
8 defined in subparagraph (C)) on substantially  
9 all medical and surgical benefits within a cat-  
10 egory of items and services (specified in para-  
11 graph (3)(C)), the plan or coverage may not im-  
12 pose such a beneficiary financial requirement on  
13 mental health and substance-related disorder  
14 benefits for items and services within such cat-  
15 egory.

16 “(B) BENEFICIARY FINANCIAL REQUIRE-  
17 MENT.—

18 “(i) TREATMENT OF DEDUCTIBLES,  
19 OUT-OF-POCKET LIMITS, AND SIMILAR FI-  
20 NANCIAL REQUIREMENTS.—If the plan or  
21 coverage includes a deductible, a limitation  
22 on out-of-pocket expenses, or similar bene-  
23 ficiary financial requirement that does not  
24 apply separately to individual items and  
25 services on substantially all medical and

1 surgical benefits within a category of items  
2 and services, the plan or coverage shall  
3 apply such requirement (or, if there is  
4 more than one such requirement for such  
5 category of items and services, the pre-  
6 dominant requirement for such category)  
7 both to medical and surgical benefits with-  
8 in such category and to mental health and  
9 substance-related disorder benefits within  
10 such category and shall not distinguish in  
11 the application of such requirement be-  
12 tween such medical and surgical benefits  
13 and such mental health and substance-re-  
14 lated disorder benefits.

15 “(ii) OTHER FINANCIAL REQUIRE-  
16 MENTS.—If the plan or coverage includes a  
17 beneficiary financial requirement not de-  
18 scribed in clause (i) on substantially all  
19 medical and surgical benefits within a cat-  
20 egory of items and services, the plan or  
21 coverage may not impose such financial re-  
22 quirement on mental health and substance-  
23 related disorder benefits for items and  
24 services within such category in a way that  
25 is more costly to the participant or bene-

1            beneficiary than the predominant beneficiary fi-  
 2            nancial requirement applicable to medical  
 3            and surgical benefits for items and services  
 4            within such category.

5            “(C) BENEFICIARY FINANCIAL REQUIRE-  
 6            MENT DEFINED.—For purposes of this para-  
 7            graph, the term ‘beneficiary financial require-  
 8            ment’ includes, with respect to a plan or cov-  
 9            erage, any deductible, coinsurance, co-payment,  
 10          other cost sharing, and limitation on the total  
 11          amount that may be paid by a participant or  
 12          beneficiary with respect to benefits under the  
 13          plan or coverage, but does not include the appli-  
 14          cation of any aggregate lifetime limit or annual  
 15          limit.”; and

16          (B) in subsection (b)—

17            (i) strike “construed—” and all that  
 18            follows through “(1) as requiring” and in-  
 19            sert “construed as requiring”;

20            (ii) by strike “; or” and insert a pe-  
 21            riod; and

22            (iii) by strike paragraph (2).

23          (2) EXPANSION TO SUBSTANCE-RELATED DIS-  
 24          ORDER BENEFITS AND REVISION OF DEFINITION.—

25          In such section—



1 (A) strike “mental health benefits” and in-  
2 sert “mental health and substance-related dis-  
3 order benefits” each place it appears; and

4 (B) in paragraph (4) of subsection (e)—

5 (i) strike “MENTAL HEALTH BENE-  
6 FITS” and insert “MENTAL HEALTH AND  
7 SUBSTANCE-RELATED DISORDER BENE-  
8 FITS”;

9 (ii) strike “benefits with respect to  
10 mental health services” and insert “bene-  
11 fits with respect to services for mental  
12 health conditions or substance-related dis-  
13 orders”; and

14 (iii) strike “, but does not include  
15 benefits with respect to treatment of sub-  
16 stances abuse or chemical dependency”.

17 (3) AVAILABILITY OF PLAN INFORMATION  
18 ABOUT CRITERIA FOR MEDICAL NECESSITY.—In sub-  
19 section (a) of such section, as amended by para-  
20 graph (1)(A), add at the end the following new para-  
21 graph:

22 “(5) AVAILABILITY OF PLAN INFORMATION.—  
23 The criteria for medical necessity determinations  
24 made under the plan with respect to mental health  
25 and substance-related disorder benefits (or the

1 health insurance coverage offered in connection with  
2 the plan with respect to such benefits) shall be made  
3 available by the plan administrator (or the health in-  
4 surance issuer offering such coverage) to any cur-  
5 rent or potential participant, beneficiary, or con-  
6 tracting provider upon request. The reason for any  
7 denial under the plan (or coverage) of reimburse-  
8 ment or payment for services with respect to mental  
9 health and substance-related disorder benefits in the  
10 case of any participant or beneficiary shall, upon re-  
11 quest, be made available by the plan administrator  
12 (or the health insurance issuer offering such cov-  
13 erage) to the participant or beneficiary.”.

14 (4) MINIMUM BENEFIT REQUIREMENTS.—In  
15 subsection (a) of such section, add at the end the  
16 following new paragraph:

17 “(6) MINIMUM SCOPE OF COVERAGE AND EQ-  
18 UITY IN OUT-OF-NETWORK BENEFITS.—

19 “(A) MINIMUM SCOPE OF MENTAL  
20 HEALTH AND SUBSTANCE-RELATED DISORDER  
21 BENEFITS.—In the case of a group health plan  
22 (or health insurance coverage offered in connec-  
23 tion with such a plan) that provides any mental  
24 health and substance-related disorder benefits,  
25 the plan or coverage shall include benefits for

1 any mental health condition or substance-re-  
2 lated disorder for which benefits are provided  
3 under the benefit plan option offered under  
4 chapter 89 of title 5, United States Code, with  
5 the highest average enrollment as of the begin-  
6 ning of the most recent year beginning on or  
7 before the beginning of the plan year involved.

8 “(B) EQUITY IN COVERAGE OF OUT-OF-  
9 NETWORK BENEFITS.—

10 “(i) IN GENERAL.—In the case of a  
11 plan or coverage that provides both med-  
12 ical and surgical benefits and mental  
13 health and substance-related disorder bene-  
14 fits, if medical and surgical benefits are  
15 provided for substantially all items and  
16 services in a category specified in clause  
17 (ii) furnished outside any network of pro-  
18 viders established or recognized under such  
19 plan or coverage, the mental health and  
20 substance-related disorder benefits shall  
21 also be provided for items and services in  
22 such category furnished outside any net-  
23 work of providers established or recognized  
24 under such plan or coverage in accordance  
25 with the requirements of this section.

1           “(ii) CATEGORIES OF ITEMS AND  
2 SERVICES.—For purposes of clause (i),  
3 there shall be the following three categories  
4 of items and services for benefits, whether  
5 medical and surgical benefits or mental  
6 health and substance-related disorder bene-  
7 fits, and all medical and surgical benefits  
8 and all mental health and substance-re-  
9 lated disorder benefits shall be classified  
10 into one of the following categories:

11           “(I) EMERGENCY.—Items and  
12 services, whether furnished on an in-  
13 patient or outpatient basis, required  
14 for the treatment of an emergency  
15 medical condition (including an emer-  
16 gency condition relating to mental  
17 health and substance-related dis-  
18 orders).

19           “(II) INPATIENT.—Items and  
20 services not described in subclause (I)  
21 furnished on an inpatient basis.

22           “(III) OUTPATIENT.—Items and  
23 services not described in subclause (I)  
24 furnished on an outpatient basis.”.

1           (5) REVISION OF INCREASED COST EXEMP-  
2           TION.—Amend paragraph (2) of subsection (c) of  
3           such section to read as follows:

4           “(2) INCREASED COST EXEMPTION.—

5           “(A) IN GENERAL.—With respect to a  
6           group health plan (or health insurance coverage  
7           offered in connection with such a plan), if the  
8           application of this section to such plan (or cov-  
9           erage) results in an increase for the plan year  
10          involved of the actual total costs of coverage  
11          with respect to medical and surgical benefits  
12          and mental health and substance-related dis-  
13          order benefits under the plan (as determined  
14          and certified under subparagraph (C)) by an  
15          amount that exceeds the applicable percentage  
16          described in subparagraph (B) of the actual  
17          total plan costs, the provisions of this section  
18          shall not apply to such plan (or coverage) dur-  
19          ing the following plan year, and such exemption  
20          shall apply to the plan (or coverage) for 1 plan  
21          year.

22          “(B) APPLICABLE PERCENTAGE.—With re-  
23          spect to a plan (or coverage), the applicable  
24          percentage described in this paragraph shall  
25          be—

1           “(i) 2 percent in the case of the first  
2           plan year which begins after the date of  
3           the enactment of the Paul Wellstone Men-  
4           tal Health and Addiction Equity Act of  
5           2007; and

6           “(ii) 1 percent in the case of each  
7           subsequent plan year.

8           “(C) DETERMINATIONS BY ACTUARIES.—  
9           Determinations as to increases in actual costs  
10          under a plan (or coverage) for purposes of this  
11          subsection shall be made by a qualified actuary  
12          who is a member in good standing of the Amer-  
13          ican Academy of Actuaries. Such determina-  
14          tions shall be certified by the actuary and be  
15          made available to the general public.

16          “(D) 6-MONTH DETERMINATIONS.—If a  
17          group health plan (or a health insurance issuer  
18          offering coverage in connection with such a  
19          plan) seeks an exemption under this paragraph,  
20          determinations under subparagraph (A) shall be  
21          made after such plan (or coverage) has com-  
22          plied with this section for the first 6 months of  
23          the plan year involved.

24          “(E) NOTIFICATION.—A group health plan  
25          under this part shall comply with the notice re-

1           requirement under section 712(c)(2)(E) of the  
2           Employee Retirement Income Security Act of  
3           1974 with respect to the a modification of men-  
4           tal health and substance-related disorder bene-  
5           fits as permitted under this paragraph as if  
6           such section applied to such plan.”.

7           (6) CHANGE IN EXCLUSION FOR SMALLEST EM-  
8           PLOYERS.—In subsection (c)(1)(B) of such section—

9                   (A) insert “(or 1 in the case of an em-  
10                  ployer residing in a State that permits small  
11                  groups to include a single individual)” after “at  
12                  least 2” the first place it appears; and

13                   (B) strike “and who employs at least 2  
14                  employees on the first day of the plan year”.

15           (7) ELIMINATION OF SUNSET PROVISION.—  
16           Strike subsection (f) of such section.

17           (8) CLARIFICATION REGARDING PREEMP-  
18           TION.—In such section, insert after subsection (e)  
19           the following new subsection:

20           “(f) PREEMPTION, RELATION TO STATE LAWS.—

21                   “(1) IN GENERAL.—Nothing in this section  
22                  shall be construed to preempt any State law that  
23                  provides greater consumer protections, benefits,  
24                  methods of access to benefits, rights or remedies  
25                  that are greater than the protections, benefits, meth-

1       ods of access to benefits, rights or remedies provided  
2       under this section.

3               “(2) CONSTRUCTION.—Nothing in this section  
4       shall be construed to affect or modify the provisions  
5       of section 2723 with respect to group health plans.”.

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

10   **SEC. 113. UPDATING HEALTHY AMERICANS PRIVATE IN-**  
11                           **SURANCE PLAN REQUIREMENTS.**

12       (a) IN GENERAL.—The Secretary shall establish the  
13       Healthy America Advisory Committee (referred to in this  
14       section as the “Advisory Committee”) to provide annual  
15       recommendations to the Secretary and Congress con-  
16       cerning modifications to the benefits, items, and services  
17       required under section 111(a)(1).

18       (b) COMPOSITION.—

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

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

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



1 (C) at least 1 such member shall be a rep-  
2 resentative of health care providers, including  
3 nurses and other nonphysician providers;

4 (D) at least 1 such member shall be a rep-  
5 resentative of health insurance issuers;

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

8 (F) at least 1 such member shall be a rep-  
9 resentative of the United States Preventive  
10 Services Task Force; and

11 (G) at least 1 such member shall be an ac-  
12 tuary.

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

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

1 term of a vacant member within 2 months of being noti-  
2 fied of such vacancy.

3 (d) COMPENSATION AND EXPENSES.—Each member  
4 of the Advisory Committee who is not otherwise employed  
5 by the United States Government shall receive compensa-  
6 tion at a rate equal to the daily rate prescribed for GS-  
7 18 under the General Schedule under section 5332 of title  
8 5, United States Code, for each day, including travel time,  
9 such member is engaged in the actual performance of du-  
10 ties as a member of the Committee. A member of the Advi-  
11 sory Committee who is an officer or employee of the  
12 United States Government shall serve without additional  
13 compensation. All members of the Advisory Committee  
14 shall be reimbursed for travel, subsistence, and other nec-  
15 essary expenses incurred by them in the performance of  
16 their duties.

17 (e) REPORTS.—

18 (1) ANNUAL REPORTS.—Not later than Decem-  
19 ber 31 of the fourth full calendar year following the  
20 date of enactment of this Act, and each December  
21 31 thereafter, the Advisory Committee shall provide  
22 to Congress and the Secretary a report that—

23 (A) describes any recommendations for  
24 modifications to the benefits, items, and serv-

1           ices that are required to be covered under a  
2           HAPI plan; and

3                   (B) includes any recommendations to mod-  
4           ify HAPI plans to improve the quality of life for  
5           United States citizens and to ensure that bene-  
6           fits in such plans are medically- and cost-effec-  
7           tive.

8           (2) REPORT ON STANDARDIZATION OF ENROLL-  
9           MENT.—Not later than December 31 of the second  
10          full calendar year following the date of enactment of  
11          this Act, the Advisory Committee, in consultation  
12          with the States, shall provide to Congress and the  
13          Secretary a report that includes recommendations  
14          relating to the standardization of enrollment forms  
15          for HAPI plans throughout the country and the  
16          transfer of basic information (such as identity and  
17          basic health information) from one HAPI plan to  
18          another HAPI plan, including across State lines.

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

1 **Subtitle C—Eligibility for Premium**  
2 **and Personal Responsibility**  
3 **Contribution Subsidies**

4 **SEC. 121. ELIGIBILITY FOR PREMIUM SUBSIDIES.**

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

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

15 (1) IN GENERAL.—For any calendar year, in  
16 the case of a covered individual who is determined  
17 to have a modified adjusted gross income that is  
18 greater than 100 percent of the poverty line, as ap-  
19 plicable to a family of the size involved, but below  
20 the applicable percentage of the poverty line, as ap-  
21 plicable to a family of the size involved, the covered  
22 individual is entitled under this section to an in-  
23 come-related premium subsidy equal to the basic  
24 premium subsidy amount reduced by the amount de-  
25 termined under paragraph (2).

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

5                   (A) the excess of—

6                           (i) such individual’s modified adjusted  
7                           gross income, over

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

11                   (B) the excess of—

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

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

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

21           (c) BASIC PREMIUM SUBSIDY AMOUNT.—For pur-  
22           poses of this section, the term “basic premium subsidy  
23           amount” means, with respect to any individual, the lesser  
24           of—

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

3           (2) the weighted average of the premium for  
4 HAPI plans of the same class of coverage (as de-  
5 scribed in section 111(d)(1)) as the individual's in  
6 the applicable coverage area.

7 (d) CHANGE IN STATUS NOTIFICATION.—

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

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

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

4 **SEC. 122. ELIGIBILITY FOR PERSONAL RESPONSIBILITY**  
5 **CONTRIBUTION SUBSIDIES.**

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

14 (b) PARTIAL SUBSIDY.—To meet the eligibility re-  
15 quirements under subtitle B for an HHA, for any taxable  
16 year, in the case of a covered individual who is determined  
17 to have a modified adjusted gross income that is at or  
18 above 100 percent of the poverty line as applicable to a  
19 family of the size involved, an HHA may provide to such  
20 an individual a subsidy equal to the part of the amount  
21 of any personal responsibility contributions applicable to  
22 such individual.

23 **SEC. 123. DEFINITIONS AND SPECIAL RULES.**

24 (a) DETERMINATION OF MODIFIED ADJUSTED  
25 GROSS INCOME.—

1           (1) IN GENERAL.—In this subtitle, the term  
2           “modified adjusted gross income” means adjusted  
3           gross income (as defined in section 62 of the Inter-  
4           nal Revenue Code of 1986)—

5                   (A) determined without regard to sections  
6                   86, 135, 137, 199, 221, 222, 911, 931, and  
7                   933 of such Code; and

8                   (B) increased by—

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

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

16           (2) TAXABLE YEAR TO BE USED TO DETER-  
17           MINE MODIFIED ADJUSTED GROSS INCOME.—In ap-  
18           plying this subtitle to determine an individual’s an-  
19           nual premiums, the covered individual’s modified ad-  
20           justed gross income shall be such income determined  
21           using the individual’s most recent income tax return  
22           or other information furnished to the Secretary by  
23           such individual, as the Secretary may require.

24           (b) POVERTY LINE.—In this subtitle, the term “pov-  
25           erty line” has the meaning given such term in section



1 673(2) of the Community Health Services Block Grant  
2 Act (42 U.S.C. 9902(2)), including any revision required  
3 by such section.

4 (c) OTHER PROCEDURES TO DETERMINE SUB-  
5 SIDIES.—The Secretary shall promulgate regulations to be  
6 used by HHAs to calculate the premium subsidies under  
7 section 121 and personal responsibility subsidies under  
8 section 122 for individuals whose modified adjusted gross  
9 income described in subsection (a)(2) is significantly lower  
10 than the modified adjusted gross income of the year in-  
11 volved.

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

18 (e) SPECIAL RULE FOR ALIENS.—The Secretary of  
19 Homeland Security may not extend or renew an alien's  
20 eligibility for status in the United States or adjust the sta-  
21 tus of an alien in the United States if the alien owes—

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

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

1 (f) NO DISCHARGE IN BANKRUPTCY.—In the case of  
2 any bankruptcy filed by or on behalf of any person after  
3 the date that is 4 years after the date of enactment of  
4 this Act, under title 11, United States Code, any penalty  
5 imposed with respect to such person for failure to pay a  
6 HAPI plan premium shall not be subject to discharge  
7 under such title.

## 8 **Subtitle D—Wellness Programs**

### 9 **SEC. 131. REQUIREMENTS FOR WELLNESS PROGRAMS.**

10 (a) DEFINITION.—In this Act, the term “wellness  
11 program” means a program that consists of a combination  
12 of activities that are designed to increase awareness, as-  
13 sess risks, educate, and promote voluntary behavior  
14 change to improve the health of an individual, modify his  
15 or her consumer health behavior, enhance his or her per-  
16 sonal well-being and productivity, and prevent illness and  
17 injury.

18 (b) DISCOUNTS.—

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

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

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

6 (B) the wellness program meets the re-  
7 quirements of this subsection.

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

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

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

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

18 (D) permits any enrollee for whom it is un-  
19 reasonably difficult to meet the initial program  
20 standard for participation due to a medical con-  
21 dition (or for whom it is medically inadvisable  
22 to attempt) an opportunity to meet a reason-  
23 able alternative participation standard—

24 (i)(I) that is developed prior to enroll-  
25 ment of the enrollee; or

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

6 (ii) the availability of which is dis-  
7 closed in the original documents relating to  
8 participation in the program;

9 (E) applies procedures for determining  
10 whether an enrollee is participating in a mean-  
11 ingful manner in the program, including proce-  
12 dures to determine if such participation is re-  
13 sulting in lifestyle changes that are indicative of  
14 an improved health outcome or outcomes; and

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

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

21 (4) AVAILABILITY OF DISCOUNTS.—

22 (A) OFFERING OF ENROLLMENT.—A  
23 HAPI plan shall provide enrollees with the op-  
24 portunity to participate in a wellness program

1 (for purposes of qualifying for premium dis-  
2 counts) at least once each year.

3 (B) DETERMINATIONS.—Determinations  
4 with respect to the successful participation by  
5 an enrollee in a wellness program for purposes  
6 of qualifying for discounts shall be made by the  
7 HAPI plan based on a retrospective review of  
8 the scope of activities of the enrollee under the  
9 program. The HAPI plan may require a min-  
10 imum level of successful participation in such a  
11 program prior to applying any premium dis-  
12 count.

13 (C) PARTICIPATION IN MULTIPLE PRO-  
14 GRAMS.—An enrollee may participate in mul-  
15 tiple wellness programs to reach the maximum  
16 premium discount permitted by the HAPI plan  
17 under applicable State law.

18 (5) PERSONAL RESPONSIBILITY CONTRIBUTION  
19 DISCOUNT.—A HAPI plan may elect to provide dis-  
20 counts in the amount of the personal responsibility  
21 contribution that is required of an enrollee if the en-  
22 rollee participates in an approved wellness program.

23 (e) EMPLOYER INCENTIVE FOR WELLNESS PRO-  
24 GRAMS.—For provisions relating to employers deducting  
25 the costs of offering wellness programs or worksite health

1 centers see section 162(l) of the Internal Revenue Code  
2 of 1986.

3 **TITLE II—HEALTHY START FOR**  
4 **CHILDREN**  
5 **Subtitle A—Benefits and Eligibility**

6 **SEC. 201. GENERAL GOAL AND AUTHORIZATION OF APPRO-**  
7 **PRIATIONS FOR HAPI PLAN COVERAGE FOR**  
8 **CHILDREN.**

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

13 (b) AUTHORIZATION OF APPROPRIATIONS.—There is  
14 authorized to be appropriated, such sums as may be nec-  
15 essary for each fiscal year to enable the Secretary to pro-  
16 vide assistance to States to enable such States to ensure  
17 that each child who is a member of a family with a modi-  
18 fied adjusted gross income that is below 300 percent of  
19 the poverty line as applicable to a family of the size in-  
20 volved, who is not otherwise eligible for coverage as a de-  
21 pendent under a HAPI plan maintained by his or her par-  
22 ents, is covered under a HAPI plan provided through the  
23 State HHA.

24 (c) POLICIES AND PROCEDURES.—The Secretary  
25 shall develop policies and procedures to be applied by the

1 States to identify children described in subsection (a) and  
2 to provide such children with coverage under a HAPI plan.  
3 States shall determine, in consultation with health insur-  
4 ance issuers, a separate class of coverage to assure afford-  
5 able child coverage.

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

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

13 (a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—  
14 The Secretary shall provide guidance to States and health  
15 insurance issuers that ensures that, after December 31 of  
16 the last calendar year ending before the first calendar year  
17 in which coverage under a HAPI plan begins, any child  
18 covered under a HAPI plan provided through the State  
19 HHA continues to receive medical assistance under State  
20 Medicaid plans in a manner that—

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

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

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

12          (b) DEFINITION.—In this section, the term “child”,  
13          in addition to the meaning given that term under section  
14          201(d), includes any individual who would be considered  
15          a child under the Medicaid program of the State in which  
16          the individual resides.

## 17           **Subtitle B—Service Providers**

### 18          **SEC. 211. INCLUSION OF PROVIDERS UNDER HAPI PLANS.**

19          (a) IN GENERAL.—To ensure that children have ac-  
20          cess to health care in their communities, and that such  
21          care is provided to such children for no cost or on a reim-  
22          bursable basis, a HAPI plan shall ensure that health care  
23          items and services may be obtained by such children from,  
24          at a minimum, the providers described in subsection (b)  
25          if available in the area involved.



1 (b) PROVIDERS DESCRIBED.—The providers de-  
2 scribed in this subsection include the following:

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

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

7 (3) A federally qualified health center.

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

10 (5) An Indian health service facility.

11 **SEC. 212. USE OF SCHOOL-BASED HEALTH CENTERS.**

12 (a) DEFINITION.—In this section, the term “school-  
13 based health center” means a health center that—

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

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

18 (3) is administered by a community-based orga-  
19 nization including a hospital, public health depart-  
20 ment, community health center, or nonprofit health  
21 care agency;

22 (4) at a minimum, provides to school-aged chil-  
23 dren—

24 (A) primary health care services, including  
25 comprehensive health assessments, and diag-

1           nosis and treatment of minor, acute, and chron-  
2           ic medical conditions and Healthy Start bene-  
3           fits;

4           (B) mental health services, including crisis  
5           intervention, counseling, and emergency psy-  
6           chiatric care at the school or by referral;

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

12          (D) services through the use of a qualified  
13          and appropriately credentialed individual, in-  
14          cluding a nurse practitioner or physician assist-  
15          ant, a mental health professional, a physician,  
16          and a health assistant; and

17          (E) by not later than January 1, 2012, an  
18          electronic medical record relating to the indi-  
19          vidual; and

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

1 (b) ACCESS TO SCHOOL-BASED HEALTH CEN-  
2 TERS.—

3 (1) IN GENERAL.—A school-based health center  
4 may provide services to students in more than 1  
5 school if the school district or other supervising  
6 State entity determined that capacity and geo-  
7 graphic location make such provision of services ap-  
8 propriate.

9 (2) ENROLLMENT.—Upon the enrollment of a  
10 student in a school with a school-based health cen-  
11 ter, the center will provide the student with the op-  
12 portunity to enroll, after parental consent, to receive  
13 health care from the center.

14 (3) REIMBURSEMENT FOR SERVICES.—

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

20 (B) USE OF FUNDS.—Amounts received  
21 from a third party payer under subparagraph  
22 (A) shall be allocated to the school-based health  
23 center that provided the care for which the re-  
24 imbursement was provided for use by that cen-

1           ter for providing additional health care items  
2           and services.

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

11 **TITLE III—BETTER HEALTH FOR**  
12 **OLDER AND DISABLED AMER-**  
13 **ICANS**

14 **SEC. 301. COORDINATION OF SUPPLEMENTAL COVERAGE**  
15 **UNDER THE MEDICAID PROGRAM FOR EL-**  
16 **DERLY AND DISABLED INDIVIDUALS.**

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

19           (1) takes into account the special health care  
20 needs of elderly and disabled individuals who are eli-  
21 gible for medical assistance under State Medicaid  
22 programs, particularly with respect to institutional-  
23 ized care or home and community-based services;  
24 and

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

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

11                  (B) does not supplant the individual’s cov-  
12                  erage under a HAPI plan; and

13                  (C) ensures that the individual receives  
14                  any items or services that are not available  
15                  under the HAPI plan in which the individual is  
16                  enrolled but that the individual would have re-  
17                  ceived under the Medicaid program of the State  
18                  in which the individual resides if the Healthy  
19                  Americans Act had not been enacted.

20           (b) DEFINITIONS.—In this section—

21                   (1) the term “institutionalized care” means the  
22                   health care provided under the Medicaid plan of the  
23                   State of residence of an elderly or disabled individual  
24                   who is a patient in a hospital, nursing facility, inter-  
25                   mediate care facility for the mentally retarded, or an

1 institution for mental diseases (as such terms are  
2 defined for purposes of such plan); and

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

## 11 **TITLE IV—HEALTHIER**

### 12 **MEDICARE**

#### 13 **Subtitle A—Authority To Adjust** 14 **Amount of Part B Premium To** 15 **Reward Positive Health Behav-** 16 **ior**

##### 17 **SEC. 401. AUTHORITY TO ADJUST AMOUNT OF MEDICARE**

##### 18 **PART B PREMIUM TO REWARD POSITIVE**

##### 19 **HEALTH BEHAVIOR.**

20 Section 1839 of the Social Security Act (42 U.S.C.  
21 1395r) is amended—

22 (1) in subsection (a)(2), by striking “and (i)”  
23 and inserting “(i), and (j)”; and

24 (2) by adding at the end the following new sub-  
25 section:

1       “(j)(1) With respect to the monthly premium amount  
2 for months after December 2008, the Secretary may ad-  
3 just (under procedures established by the Secretary) the  
4 amount of such premium for an individual based on  
5 whether or not the individual participates in certain  
6 healthy behaviors, such as weight management, exercise,  
7 nutrition counseling, refraining from tobacco use, desig-  
8 nating a health home, and other behaviors determined ap-  
9 propriate by the Secretary.

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

17       **Subtitle B—Promoting Primary**  
18       **Care for Medicare Beneficiaries**

19       **SEC. 411. PRIMARY CARE SERVICES MANAGEMENT PAY-**  
20       **MENT.**

21       Title XVIII of the Social Security Act (42 U.S.C.  
22 1395 et seq.) is amended by inserting after section 1807  
23 the following new section:

1 **“SEC. 1807A. PRIMARY CARE MANAGEMENT PAYMENT FOR**  
2 **COORDINATING CARE.**

3 “(a) PAYMENT.—

4 “(1) IN GENERAL.—Not later than January 1,  
5 2008, the Secretary, subject to paragraph (2), shall  
6 establish procedures for providing primary care and  
7 participating providers with a management fee (as  
8 determined appropriate by the Secretary, in con-  
9 sultation with the Medicare Payment Advisory Com-  
10 mission established under section 1805) that reflects  
11 the amount of time spent with a Medicare bene-  
12 ficiary, and the family of such beneficiary, providing  
13 chronic care disease management services or other  
14 services in assisting in coordinating care.

15 “(2) REQUIREMENT FOR DESIGNATION AS  
16 HEALTH HOME.—The management fee under para-  
17 graph (1) shall not be provided to a primary care  
18 provider with respect to a Medicare beneficiary un-  
19 less the provider has been designated (under proce-  
20 dures established by the Secretary) as the health  
21 home by the beneficiary.

22 “(b) DEFINITIONS.—In this section:

23 “(1) HEALTH HOME.—The term ‘health home’  
24 means a health care provider that a Medicare bene-  
25 ficiary has designated to monitor the health and  
26 health care of the beneficiary.



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

5           “(3) PRIMARY CARE PROVIDER.—

6                   “(A) IN GENERAL.—The term ‘primary  
7                   care provider’ means a primary care physician  
8                   (as defined in subparagraph (B), a nurse prac-  
9                   titioner (as defined in section 1861aa(5)(A)), or  
10                  a physician assistant (as so defined).

11                   “(B) PRIMARY CARE PHYSICIAN.—In sub-  
12                  paragraph (A), the term ‘primary care physi-  
13                  cian’ means a physician, such as a family prac-  
14                  titioner or internist, who is chosen by an indi-  
15                  vidual to provide continuous medical care, who  
16                  is able to give a wide range of care, including  
17                  prevention and treatment, and who can refer  
18                  the individual to a specialist.”.

## 19       **Subtitle C—Chronic Care Disease** 20                               **Management**

### 21       **SEC. 421. CHRONIC CARE DISEASE MANAGEMENT.**

22           Title XVIII of the Social Security Act (42 U.S.C.  
23       1395 et seq.), as amended by section 411, is amended by  
24       inserting after section 1807A the following new section:

1 **“SEC. 1807B. CHRONIC CARE DISEASE MANAGEMENT PRO-**  
2 **GRAM.**

3 “(a) ESTABLISHMENT.—

4 “(1) IN GENERAL.—Not later than January 1,  
5 2008, the Secretary shall develop and implement a  
6 chronic care disease management program (in this  
7 section referred to as the ‘program’). The program  
8 shall be designed to provide chronic care disease  
9 management to all Medicare beneficiaries with re-  
10 spect to at least the 5 most prevalent diseases within  
11 the population of such beneficiaries (as determined  
12 by the Secretary).

13 “(2) DEVELOPMENT.—In developing and imple-  
14 menting the program under paragraph (1), the Sec-  
15 retary shall—

16 “(A) take into consideration—

17 “(i) the results of chronic care im-  
18 provement programs conducted under sec-  
19 tion 1807, including the independent eval-  
20 uations of such programs conducted under  
21 section 1807(b)(5) and any outcomes re-  
22 ports submitted under section  
23 1807(e)(4)(A); and

24 “(ii) the results of the payments to  
25 primary care providers under section  
26 1807A; and

1           “(B) consult individuals with expertise in  
2           chronic care disease management.

3           “(b) IDENTIFICATION AND ENROLLMENT.—The Sec-  
4           retary shall establish procedures for identifying and enroll-  
5           ing Medicare beneficiaries who may benefit from participa-  
6           tion in the program.

7           “(c) CHRONIC CARE DISEASE MANAGEMENT PAY-  
8           MENT FOR NON-PRIMARY CARE PHYSICIANS.—

9           “(1) IN GENERAL.—Under the program, a non-  
10          primary care physician shall receive a chronic care  
11          disease management payment if the physician serves  
12          the Medicare beneficiary by assuring the beneficiary  
13          receives appropriate and comprehensive care, includ-  
14          ing referral of the individual to specialists, and as-  
15          suring the beneficiary receives preventive services.

16          “(2) AMOUNT OF PAYMENT.—The amount of  
17          the management payment under the program shall  
18          be an amount determined appropriate by the Sec-  
19          retary, in consultation with the Medicare Payment  
20          Advisory Commission established under section  
21          1805. Such amount shall reflect the amount of time  
22          spent with a Medicare beneficiary, and the family of  
23          such beneficiary, providing chronic care disease man-  
24          agement services.

25          “(d) DEFINITIONS.—In this section:

1           “(1) **MEDICARE BENEFICIARY.**—The term  
2           ‘Medicare beneficiary’ means an individual who is  
3           entitled to, or enrolled for, benefits under part A,  
4           enrolled under part B, or both.

5           “(2) **NON-PRIMARY CARE PHYSICIAN.**—The  
6           term ‘non-primary care physician’ means a physician  
7           who—

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

10                   “(B) provides chronic care disease manage-  
11                   ment services to a Medicare beneficiary under  
12                   the program.”.

13 **SEC. 422. CHRONIC CARE EDUCATION CENTERS.**

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

16           (b) **PURPOSE.**—The Chronic Care Education Centers  
17           established under subsection (a) shall serve as clearing-  
18           houses for information on health care providers who have  
19           expertise in the management of chronic disease.

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

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

1           (2) additional information determined appro-  
2           priate by the Secretary.

3           **Subtitle D—Improving Quality in**  
4           **Hospitals for All Patients**

5           **SEC. 431. IMPROVING QUALITY IN HOSPITALS FOR ALL PA-**  
6           **TIENTS.**

7           (a) IMPROVING HEALTHCARE QUALITY FOR ALL PA-  
8           TIENTS.—

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

12                 (A) in subparagraph (U), by striking  
13                 “and” at the end;

14                 (B) in subparagraph (V), by striking the  
15                 period at the end and inserting “, and”; and

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

18                         “(W) in the case of hospitals, to demonstrate to  
19                         accrediting bodies measurable improvement in qual-  
20                         ity control with respect to all patients and to have  
21                         in place quality control programs that are directed  
22                         at care for all patients and that include—

23                                 “(i) rapid response teams that can assist  
24                                 patients with unstable vital signs;

1           “(ii) heart attack treatments with proven  
2 reliability;

3           “(iii) procedures that reduce medication  
4 errors;

5           “(iv) aggressive infection prevention, with  
6 special focus on surgeries and infections with  
7 the highest death rates;

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

11           “(vi) such other elements as the Secretary  
12 determines appropriate.”.

13           (2) EFFECTIVE DATE.—The amendments made  
14 by paragraph (1) shall apply to hospitals as of the  
15 date that is 4 years after the date of enactment of  
16 this Act.

17           (b) PANEL OF INDEPENDENT EXPERTS.—Beginning  
18 not later than the date that is 4 years after the date of  
19 enactment of this Act, in order to ensure that hospitals  
20 practice state-of-the-art quality control, the Secretary  
21 shall convene a panel of independent experts to update the  
22 measures of quality control and the types of quality con-  
23 trol programs, including the elements of such programs,  
24 required under section 1866(a)(1)(W) of the Social Secu-

1 rity Act, as added by subsection (a), not less frequently  
2 than on an annual basis.

### 3 **Subtitle E—Additional Provisions**

#### 4 **SEC. 441. ADDITIONAL COST INFORMATION.**

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

8 “(4) ADDITIONAL COST INFORMATION.—A con-  
9 tract under this section shall require a Medicare Ad-  
10 vantage Organization to aggregate claims informa-  
11 tion into episodes of care and to provide such infor-  
12 mation to the Secretary so that costs for specific  
13 hospitals and physicians may be measured and com-  
14 pared. The Secretary shall make such information  
15 public on an annual basis.”.

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

#### 19 **SEC. 442. REDUCING MEDICARE PAPERWORK AND REGU-** 20 **LATORY BURDENS.**

21 Not later than 18 months after the date of enactment  
22 of this Act, the Secretary shall provide to Congress a plan  
23 for reducing regulations and paperwork in the Medicare  
24 program under title XVIII of the Social Security Act (42  
25 U.S.C. 1395 et seq.). Such plan shall focus initially on

1 regulations that do not directly enhance the quality of pa-  
2 tient care provided under such program.

3 **TITLE V—STATE HEALTH HELP**  
4 **AGENCIES**

5 **SEC. 501. ESTABLISHMENT.**

6 As a condition of receiving payment under section  
7 503, a State shall, not later than the date that is 4 years  
8 after the date of enactment of this Act, establish or des-  
9 ignate a State agency, to be known as the State “Health  
10 Help Agency” (referred to in this Act as a “HHA”) to—

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

13 (2) carry out the functions described in section  
14 502.

15 **SEC. 502. RESPONSIBILITIES AND AUTHORITIES.**

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

20 (1) educate residents about responsibility for in-  
21 dividual health and the health of children;

22 (2) upon request, distribute information to cov-  
23 ered individuals regarding the availability of wellness  
24 programs;



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

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

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

10           (1) providing standardized, unbiased informa-  
11           tion on HAPI plans and supplemental health insur-  
12           ance options;

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

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

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

1           (5) establish procedures for default enrollment  
2 of uninsured individuals into low-cost HAPI plans  
3 for individuals or families who do not enroll, are not  
4 covered under a health plan offered through a pro-  
5 gram described in paragraphs (1)(A) of section  
6 102(a), and are not described in paragraph (1)(B)  
7 of such section;

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

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

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

20           (9) provide prospective enrollees with a com-  
21 parative document that describes all the HAPI plans  
22 in which the individual may enroll; and

23           (10) to assist consumers in choosing a HAPI  
24 plan, publish information that includes loss ratios,  
25 outcome data regarding wellness programs, disease

1 detection and chronic care management programs  
2 categorized by health insurance issuer, and other  
3 data as the HHA determines appropriate.

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

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

10 (2) obtaining necessary information about in-  
11 come from individuals and Federal and State agen-  
12 cies;

13 (3) making eligibility determinations on an indi-  
14 vidual basis and informing individuals of such deter-  
15 minations;

16 (4) establishing a process by which an indi-  
17 vidual may appeal an eligibility determination;

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

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

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

4           (d) PREMIUM RATING RULES.—Each HHA shall en-  
5 sure that the premium payments for each HAPI plan are  
6 determined in accordance with the rating rules described  
7 in section 111(d).

8           (e) EMPOWERMENT OF INDIVIDUALS TO MAKE  
9 HEALTH CARE DECISIONS.—Each HHA shall, upon en-  
10 rollment of an individual in a HAPI plan, provide such  
11 individual with information regarding—

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

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

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

21           (4) applicable State forms on health proxies,  
22 advanced directives, living wills, and other such doc-  
23 umentation.

24           (f) DETERMINATION OF PLAN COVERAGE AREAS.—  
25 Each HHA shall establish, and may revise, HAPI plan

1 coverage areas for the State in which the HHA is located.  
2 The service area of a HAPI plan shall consist of an entire  
3 coverage area established under the preceding sentence.

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

8 (h) TRANSITION FROM MEDICAID AND SCHIP; CO-  
9 ORDINATION OF SUPPLEMENTAL MEDICAL ASSISTANCE  
10 FOR ELDERLY AND DISABLED MEDICAID ELIGIBLES.—  
11 Each HHA shall work with the Secretary to ensure that  
12 the requirements of section 301 of this Act, section 1941  
13 of the Social Security Act (as added by section 673(a) of  
14 this Act), and subsections (a) and (b) of section 1940 of  
15 the Social Security Act (as added by section 311 of this  
16 Act) are met.

17 **SEC. 503. APPROPRIATIONS FOR TRANSITION TO STATE**  
18 **HEALTH HELP AGENCIES.**

19 (a) APPROPRIATION.—There is authorized to be ap-  
20 propriated and there is appropriated, for each of the 4  
21 full fiscal years immediately following the date of enact-  
22 ment of this Act, such sums as may be necessary for the  
23 purpose of enabling each State to carry out the purposes  
24 of this title. The sums made available under this section  
25 shall be used for making payments to States that have

1 submitted, and had approved by the Secretary, an HHA  
2 plan under this section.

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

5 (1) the establishment of an HHA within such  
6 State by the date that is 4 years after the date of  
7 enactment of this Act;

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

11 (3) the compliance by the State of the require-  
12 ments described under section 631.

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

1                   **TITLE VI—SHARED**  
2                   **RESPONSIBILITIES**  
3                   **Subtitle A—Individual**  
4                   **Responsibilities**

5   **SEC. 601. INDIVIDUAL RESPONSIBILITY TO ENSURE HAPI**  
6                   **PLAN COVERAGE.**

7           (a) **OPEN SEASON.**—An adult individual, on behalf  
8 of such individual and the dependent children of such indi-  
9 vidual, shall—

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

13                   (2) submit necessary documentation to the ap-  
14 plicable HHA so that such HHA may determine in-  
15 dividual eligibility for premium and personal respon-  
16 sibility contribution subsidies.

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

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

22                   (1) submit any required monthly premium pay-  
23 ments;

24                   (2) submit any personal responsibility contribu-  
25 tions as required; and

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

3 **Subtitle B—Employer**  
4 **Responsibilities**

5 **SEC. 611. HEALTH CARE RESPONSIBILITY PAYMENTS.**

6 (a) PAYMENT REQUIREMENTS.—

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

10 **“CHAPTER 24A—HEALTH CARE**  
11 **RESPONSIBILITY PAYMENTS**

“SUBCHAPTER A—EMPLOYER SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER B—INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER C—GENERAL PROVISIONS

12 **“Subchapter A—Employer Shared**  
13 **Responsibility Payments**

“Sec. 3411. Payment requirement.

“Sec. 3412. Instrumentalities of the United States.

14 **“SEC. 3411. PAYMENT REQUIREMENT.**

15 “(a) EMPLOYER SHARED RESPONSIBILITY PAY-  
16 MENTS.—Every employer shall pay an employer shared re-  
17 sponsibility payment for each calendar year in an amount  
18 equal to the product of—

19 “(1) the number of full-time equivalent employ-  
20 ees employed by the employer during the preceding  
21 calendar year, multiplied by



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

3           “(b) APPLICABLE PERCENTAGE.—For purposes of  
 4 subsection (a)(2)—

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

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

7           “(2) APPLICABLE PERCENTAGE FOR CERTAIN  
 8           NON-REVENUE PRODUCING ENTITIES.—In the case  
 9           of an employer which is a nonprofit entity, a State  
 10          or local government, or any other type of entity for  
 11          which the Secretary determines that calculating revenue per employee is not appropriate, the applicable  
 12          percentage shall be—

14                   “(A) in the case of a large employer, 17  
 15                   percent, and

16                   “(B) in the case of a small employer, 2  
 17                   percent.

18           “(3) ADDITIONAL RATE FOR CERTAIN SMALL  
 19           EMPLOYERS.—

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

7           “(B) MAXIMUM ADDITIONAL RATE.—The  
8           increase in the applicable percentage deter-  
9           mined under this paragraph shall not exceed 15  
10          percent.

11          “(4) REVENUE PER EMPLOYEE NATIONAL PER-  
12          CENTILE RANK.—At the beginning of each calendar  
13          year, the Secretary, in consultation with the Sec-  
14          retary of Labor, shall publish a table, based on sam-  
15          pling of employers, to be used in determining the na-  
16          tional percentile for revenue per employee amounts  
17          for the preceding calendar year.

18          “(5) INCREASED TRANSITIONAL RATES FOR  
19          LARGE EMPLOYERS.—In the case of any employer  
20          who did not provide health insurance coverage for  
21          employees on the day before the date of enactment  
22          of the Healthy Americans Act, the table contained in  
23          paragraph (1) shall be applied by substituting ‘28%’  
24          for ‘23%’ and by substituting ‘30%’ for ‘25%’ with

1       respect to each of the first 4 calendar years to which  
2       this section applies.

3       “(c) TEMPORARY ADDITIONAL PAYMENT FOR CER-  
4 TAIN EMPLOYERS.—In the case of the first 4 calendar  
5 years to which this section applies—

6               “(1) IN GENERAL.—In the case of any employer  
7       who provided health insurance coverage for employ-  
8       ees on the day before the date of enactment of the  
9       Healthy Americans Act, the employer shared respon-  
10      sibility payment shall be increased by an amount  
11      equal to the excess of—

12               “(A) 100 percent of the designated em-  
13      ployee health insurance premium amount of  
14      such employer, over

15               “(B) the employee salary investment  
16      amount.

17               “(2) EMPLOYEE SALARY INVESTMENT  
18      AMOUNT.—For purposes of this subsection—

19               “(A) IN GENERAL.—The term ‘employee  
20      salary investment amount’ means the lesser  
21      of—

22               “(i) the excess of the amount of aver-  
23      age yearly wages paid to all employees for  
24      such year over the amount of average year-  
25      ly wages paid to such employee for the

1           year before the first year this section ap-  
2           plies, or

3           “(ii) the designated employee health  
4           insurance premium amount of such em-  
5           ployer.

6           “(B) NONDISCRIMINATION RULES.—No  
7           amount paid by an employer shall be treated as  
8           an employee salary investment amount unless  
9           such amount is distributed to all employees on  
10          a basis that is proportional to the amount of  
11          wages paid to such employee before such dis-  
12          tribution.

13          “(C) NOTICE REQUIREMENT.—No amount  
14          paid by an employer shall be treated as an em-  
15          ployee salary investment amount unless the em-  
16          ployer gives each employee notice of the amount  
17          of the designated employee health insurance  
18          premium amount paid by the employer with re-  
19          spect to the employee.

20          “(D) TREATMENT OF AMOUNT.—An em-  
21          ployee salary investment amount shall not be  
22          treated as income or otherwise taken into ac-  
23          count for purposes of determining any individ-  
24          ual’s eligibility for benefits or assistance under  
25          any governmental assistance program.

1           “(3) EMPLOYER SHARED RESPONSIBILITY  
2 CREDIT.—The Secretary may provide a credit to pri-  
3 vate employers who provided health insurance bene-  
4 fits greater than the 80th percentile of the national  
5 average in the 4 years prior to enactment of the  
6 Healthy Americans Act, if such employer can dem-  
7 onstrate the benefits provided encouraged prevention  
8 and wellness activities as defined in this Act, and  
9 that the employer continues to provide wellness pro-  
10 grams.

11           “(4) SPECIAL RULE FOR SELF-INSURED EM-  
12 PLOYERS.—In the case of any employer who pro-  
13 vided health care coverage for employees through  
14 self-insurance, ‘average HAPI plan premium amount  
15 for the first year this section applies’ shall be sub-  
16 stituted for ‘designated employee health insurance  
17 premium amount of such employer’ in paragraphs  
18 (1)(A) and (2)(A)(ii).

19           “(5) REGULATIONS.—The Secretary may estab-  
20 lish such rules and regulations as necessary to carry  
21 out the purposes of this subsection.

22           “(d) TRANSITION RATE FOR EMPLOYERS NOT PRE-  
23 VIOUSLY PROVIDING HEALTH INSURANCE.—In the case  
24 of any employer who did not provide health insurance to

1 employees on the day before the date of enactment of the  
2 Healthy Americans Act—

3 “(1) the employer shared responsibility pay-  
4 ment for the first year this section applies shall be  
5 an amount equal  $\frac{1}{3}$  of the amount otherwise re-  
6 quired under this section (determined without regard  
7 to this subsection), and

8 “(2) the employer shared responsibility pay-  
9 ment for the second year this section applies shall be  
10 an amount equal  $\frac{2}{3}$  of the amount otherwise re-  
11 quired under this section (determined without regard  
12 to this subsection).

13 **“SEC. 3412. INSTRUMENTALITIES OF THE UNITED STATES.**

14 “Notwithstanding any other provision of law (wheth-  
15 er enacted before or after the enactment of this section)  
16 which grants to any instrumentality of the United States  
17 an exemption from taxation, such instrumentality shall  
18 not be exempt from the payment required by section 3411  
19 unless such provision of law grants a specific exemption,  
20 by reference to section 3111 from the payment required  
21 by such section.

22 **“Subchapter B—Individual Shared**  
23 **Responsibility Payments**

“Sec. 3421. Amount of payment.

“Sec. 3422. Deduction of tax from wages.

1 **“SEC. 3421. AMOUNT OF PAYMENT.**

2 “(a) IN GENERAL.—Every individual shall pay an in-  
3 dividual shared responsibility payment in an amount equal  
4 to the HAPI plan premium amount of such individual.

5 “(b) EXCEPTION.—This section shall not apply to  
6 any individual—

7 “(1) who is covered under a HAPI plan of an-  
8 other individual, or

9 “(2) who provides such documentation as re-  
10 quired by the Secretary demonstrating that such in-  
11 dividual has paid such HAPI plan premium amount,  
12 but only for the period with respect to which such  
13 amount is shown to be paid.

14 **“SEC. 3422. DEDUCTION OF INDIVIDUAL SHARED RESPON-**  
15 **SIBILITY PAYMENT FROM WAGES.**

16 “(a) IN GENERAL.—The individual shared responsi-  
17 bility payment imposed by section 3421 shall be collected  
18 by the employer by deducting the amount of the payment  
19 from the wages as and when paid.

20 “(b) NONDEDUCTIBILITY BY EMPLOYER.—The indi-  
21 vidual shared responsibility payment deducted and with-  
22 held by the employer under subsection (a) shall not be al-  
23 lowed as a deduction to the employer in computing taxable  
24 income under subtitle A.

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

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

### 3 **“Subchapter C—General Provisions**

“Sec. 3431. Definitions and special rules.

“Sec. 3432. Labor contracts.

#### 4 **“SEC. 3431. DEFINITIONS AND SPECIAL RULES.**

5 “(a) DEFINITIONS.—For purposes of this chapter—

6 “(1) AVERAGE HAPI PLAN PREMIUM  
 7 AMOUNT.—The term ‘average HAPI plan premium  
 8 amount’ means the national average yearly premium  
 9 for HAPI plans with standard coverage (as deter-  
 10 mined under section 103(b) of the Healthy Ameri-  
 11 cans Act), determined without regard to differing  
 12 classes of coverage.

13 “(2) DESIGNATED EMPLOYEE HEALTH INSUR-  
 14 ANCE PREMIUM AMOUNT.—The term ‘designated  
 15 employee health insurance premium amount’ means  
 16 the greater of—

17 “(A) the yearly premium paid by an em-  
 18 ployer for health insurance coverage for employ-  
 19 ees for the most recent calendar year ending be-  
 20 fore the date of enactment of the Healthy  
 21 Americans Act, or

22 “(B) the yearly premium paid by an em-  
 23 ployer for health insurance coverage for employ-



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

3           “(3) EMPLOYER.—

4                   “(A) IN GENERAL.—The term ‘employer’  
5           has the meaning given such term under section  
6           3401(d).

7                   “(B) AGGREGATION RULES.—For purposes  
8           of this chapter, all persons treated as a single  
9           employer under subsection (a) or (b) of section  
10          52 shall be treated as 1 person.

11          “(4) EMPLOYMENT.—The term ‘employment’  
12          has the meaning given such term under section  
13          3121(b).

14          “(5) FULL-TIME EQUIVALENT EMPLOYEE.—  
15          The term ‘full-time equivalent employee’ means the  
16          equivalent number of full-time employees of an em-  
17          ployer determined for any year under the following  
18          formula:

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

22                   “(B) The quotient of—

23                           “(i) the sum of the average weekly  
24                           hours worked during such year for each

1 employee of the employer (including com-  
2 mon law employees) who—

3 “(I) was employed by such em-  
4 ployer during such year for more than  
5 3 months, and

6 “(II) is not a full-time employee,  
7 divided by

8 “(ii) 40.

9 “(6) FULL-TIME EMPLOYEE.—The term ‘full-  
10 time employee’ means an employee (including a com-  
11 mon law employee) who during an average workweek  
12 performs, or can reasonably be expected to perform,  
13 at least 40 hours of work. The Secretary may pre-  
14 scribe alternative rules for determining full-time  
15 equivalent employees in occupations or industries not  
16 using a standard workweek.

17 “(7) HAPI PLAN.—The term ‘HAPI plan’ has  
18 the meaning given such term under section 3 of the  
19 Healthy Americans Act.

20 “(8) HAPI PLAN PREMIUM AMOUNT.—The  
21 term ‘HAPI plan premium amount’ means, with re-  
22 spect to any individual, the monthly premium for the  
23 HAPI plan under which such individual is enrolled,  
24 determined after taking into account any subsidy

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

3 “(9) LARGE EMPLOYER.—The term ‘large em-  
4 ployer’ means, with respect to any year, an employer  
5 who employs an average of over 200 full-time equiv-  
6 alent employees during such year.

7 “(10) REVENUE PER EMPLOYEE.—The term  
8 ‘revenue per employee’ means, with respect to any  
9 employer for any year, the gross receipts of the em-  
10 ployer for such year divided by the number of full-  
11 time equivalent employees employed by such em-  
12 ployer for such year.

13 “(11) SMALL EMPLOYER.—The term ‘small em-  
14 ployer’ means, with respect to any year, an employer  
15 who employs an average of 200 or fewer full-time  
16 equivalent employees during such year.

17 “(12) WAGES.—The term ‘wages’ has the  
18 meaning given such term under section 3401(a).

19 “(b) SPECIAL RULES.—

20 “(1) SPECIAL RULE FOR SELF-EMPLOYED INDI-  
21 VIDUALS.—For purposes of this chapter, a self-em-  
22 ployed individual (as defined by section  
23 401(c)(1)(B)) shall be treated as both a full-time  
24 equivalent employee and as an employer.

1           “(2) TREATMENT OF PAYMENTS.—For pur-  
2 poses of this title, the payments required by sections  
3 3411 and 3421 shall be treated as a tax imposed by  
4 such sections, respectively.

5           “(3) OTHER SPECIAL RULES.—For purposes of  
6 this chapter, rules similar to rules under the fol-  
7 lowing provisions shall apply:

8           “(A) Section 3122 (relating to Federal  
9 service).

10           “(B) Section 3123 (relating to deductions  
11 as constructive payments).

12           “(C) Section 3125 (relating to returns in  
13 the case of governmental employees in States,  
14 Guam, American Samoa, and the District of  
15 Columbia).

16           “(D) Section 3126 (relating to return and  
17 payment by government employer).

18           “(E) Section 3127 (relating to exemption  
19 for employers and their employees where both  
20 are members of religious faiths opposed to par-  
21 ticipation in social security act programs).

22 **“SEC. 3432. LABOR CONTRACTS.**

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

1 any qualified collective bargaining employer before the  
2 earlier of—

3 “(1) January 1 of the first year which is more  
4 than 9 years after the date of the enactment of this  
5 chapter, or

6 “(2) the date the collective bargaining agree-  
7 ment expires.

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

9 “(1) QUALIFIED COLLECTIVE BARGAINING EM-  
10 PLOYER.—The term ‘qualified collective bargaining  
11 employer’ means an employer who provides health  
12 insurance to employees under the terms of a collec-  
13 tive bargaining agreement which is entered into be-  
14 fore the date of the enactment of this chapter.

15 “(2) QUALIFIED COLLECTIVE BARGAINING EM-  
16 PLOYEE.—The term ‘qualified collective bargaining  
17 employee’ means an employee of a qualified collec-  
18 tive bargaining employer who is covered by a collec-  
19 tive bargaining agreement governing the employee’s  
20 health insurance.”.

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

“CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS”.

1 (b) COLLECTION OF INDIVIDUAL SHARED RESPONSIBI-  
2 BILITY PAYMENTS THROUGH ESTIMATED TAXES.—Sec-  
3 tion 6654 of the Internal Revenue Code of 1986 (relating  
4 to failure by individual to pay estimated tax) is amended—

5 (1) in subsection (a), by striking “and the tax  
6 under chapter 2” and inserting “, the tax under  
7 chapter 2, and the individual shared responsibility  
8 payment required under subchapter B of chapter  
9 24A”, and

10 (2) in subsection (f)—

11 (A) by striking “minus” at the end of  
12 paragraph (2) and inserting “plus”,

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

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

17 “(3) the individual shared responsibility pay-  
18 ment required under subchapter B of chapter 24A,  
19 minus

20 “(4) the amount withheld as an individual  
21 shared responsibility payment under section 3422,  
22 minus”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to calendar years beginning at  
25 least 4 years after the date of the enactment of this Act.

1 **SEC. 612. DISTRIBUTION OF INDIVIDUAL RESPONSIBILITY**

2 **PAYMENTS TO HHAS.**

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

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

13 **Subtitle C—Insurer**  
 14 **Responsibilities**

15 **SEC. 621. INSURER RESPONSIBILITIES.**

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

19 (b) REQUIREMENTS.—A health insurance issuer of-  
 20 fering a HAPI plan in a State shall—

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

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

1        requirements of the health insurance issuers and other  
2        relevant requirements;

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

8            (4) ensure enrollees have the opportunity to  
9        designate a health home as described in section  
10       111(b) and make public how many enrollees per pol-  
11       icy have designated a health home;

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

15           (6) create and implement an electronic medical  
16       record for each covered individual, unless the indi-  
17       vidual submits a notification to the issuer that the  
18       individual declines to have such a record;

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

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



1           (9) use standardized common claims forms and  
2 uniform billing practices as provided for under sub-  
3 section (c);

4           (10) require that hospitals, as a condition of re-  
5 ceiving payment, send bills that are in an amount  
6 more than \$5,000 to the covered individual (without  
7 regard to whether the covered individual is respon-  
8 sible for full or partial payment of the bill) and pro-  
9 vide the individual the contact information of a per-  
10 son who can discuss the bill with the individual;

11           (11) provide incentives such as premium dis-  
12 counts—

13                 (A) for parents, if a covered child partici-  
14 pates in wellness activities and the health of  
15 such child improves; and

16                 (B) for adults covered by a plan to partici-  
17 pate in prevention, wellness and chronic disease  
18 management programs;

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

1           (13) work with the Agency for Healthcare Re-  
2           search and Quality, medical experts, and patient  
3           groups to make information on high quality afford-  
4           able health providers available to all Americans with-  
5           in 4 years of the date of enactment of this Act  
6           through a website searchable by zip code;

7           (14) provide to the HHA of each State in which  
8           the issuer offers a HAPI plan, detailed information  
9           on the HAPI plans offered by such issuer, using  
10          standardized language as required by the HHA, so  
11          that the HHA may compile a document that com-  
12          pares the HAPI plans for use by prospective enroll-  
13          ees;

14          (15) pay to the HHA of each State in which  
15          the issuer seeks to offer a HAPI plan the amount  
16          of the administrative fee assessed by the HHA  
17          under section 502(c)(5) to enter the HHA system of  
18          that State; and

19          (16) provide for prompt payment of providers  
20          for claims received in accordance with State law, but  
21          in no case later than 45 days after the date of re-  
22          ceipt of a claim that has no defect or impropriety or  
23          particular circumstance requiring special treatment  
24          that prevents timely payment from being made on  
25          the claim under the plan.

1 (c) UNIFORM BILLING PRACTICES.—

2 (1) IN GENERAL.—A health insurance issuer of-  
3 fering a HAPI plan in a State shall not receive sub-  
4 sidy payments from the applicable State HHA un-  
5 less such issuer agrees to use standardized common  
6 claim forms prescribed by the applicable State HHA  
7 consistent with paragraph (2) and to provide a copy  
8 of such form to the insured.

9 (2) CONTENTS OF CLAIM FORM.—Each com-  
10 mon claims form shall show—

11 (A) the cost of the entire episode of care  
12 provided to the insured;

13 (B) the percentage of the cost covered by  
14 the issuer; and

15 (C) the percentage of the cost paid by the  
16 insured.

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

19 (d) CHRONIC CARE PROGRAMS OFFERED BY  
20 ISSUERS.—

21 (1) IN GENERAL.—A health insurance issuer of-  
22 fering a HAPI plan in a State shall provide a chron-  
23 ic care program to provide early identification and  
24 management of chronic diseases.

1           (2) DETERMINATION OF CHRONIC CARE PRO-  
2           GRAM.—Each State HHA shall determine what con-  
3           stitutes a chronic care program under this sub-  
4           section and whether to collect and report financial  
5           information related to chronic care programs.

6           (3) UNIFORM CLINICAL PERFORMANCE STAND-  
7           ARDS.—Each chronic care program offered by a  
8           health insurance issuer shall use a uniform set of  
9           clinical performance standards prescribed by the  
10          HHA of the State in which the issuer offers a HAPI  
11          plan (in consultation with the State Medicare quality  
12          improvement organizations and patient and physi-  
13          cian organizations) which should include encourage-  
14          ment that the issuers not require personal responsi-  
15          bility contributions for clinically-needed services to  
16          treat or manage a covered individual’s chronic dis-  
17          ease, particularly if the individual is taking an active  
18          management role in working with their provider to  
19          manage any such disease.

20          (4) REPORTING BY ISSUERS.—Seven years after  
21          the date of enactment of this Act and on an annual  
22          basis thereafter, each health insurance issuer shall  
23          report to the applicable State Insurance Commis-  
24          sioner, State Secretary of Health or other state enti-  
25          ty selected by the State HHA, the chronic care man-

1       agement performance of the issuer as measured by  
2       the uniform clinical performance standards described  
3       in paragraph (3). The issuer shall make such per-  
4       formance public in a manner accessible to the public.

5       (e) PRIVATE INSURANCE COMPANY LOSS RATIO.—

6             (1) IN GENERAL.—The Secretary, in consulta-  
7       tion with consumer and patient organizations, the  
8       National Association of Insurance Commissioners,  
9       and health insurance issuers (including health main-  
10      tenance organizations) shall establish a loss ratio for  
11      issuers of HAPI plans.

12            (2) DETERMINATION OF LOSS RATIO.—In de-  
13      termining the loss ratio, administrative costs shall be  
14      defined as expenses consisting of all actual, allow-  
15      able, allocable, and reasonable expenses incurred in  
16      the adjudication of subscriber benefit claims or in-  
17      curred in the health insurance issuer’s overall oper-  
18      ation of the business.

19            (3) ADMINISTRATIVE EXPENSES.—

20                (A) IN GENERAL.—Unless otherwise deter-  
21      mined by an agreement between a State HHA  
22      and a health insurance issuer, the administra-  
23      tive expenses of an issuer shall—

24                    (i) include all taxes (excluding pre-  
25                    mium taxes) reinsurance premiums, med-

1 ical and dental consultants used in the ad-  
 2 judication process, concurrent or managed  
 3 care review when not billed by a health  
 4 care provider and other forms of utilization  
 5 review, the cost of maintaining eligibility  
 6 files, legal expenses incurred in the litiga-  
 7 tion of benefit payments, and bank charges  
 8 for letters of credit; and

9 (ii) not include the cost of personnel,  
 10 equipment, and facilities directly used in  
 11 the delivery of health care services (benefit  
 12 costs), payments to HHAs for establish-  
 13 ment and administration of HHAs, and  
 14 the cost of overseeing chronic disease man-  
 15 agement programs and wellness programs.

## 16 **Subtitle D—State Responsibilities**

### 17 **SEC. 631. STATE RESPONSIBILITIES.**

18 (a) GENERAL REQUIREMENTS.—As a condition of re-  
 19 ceiving payment under section 503, each State shall—

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

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

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

25 and

1 (B) comply with the requirements of this  
2 Act;

3 (3) ensure that health insurance issuers offer-  
4 ing a HAPI plan in such State comply with the re-  
5 quirements described in section 621;

6 (4) ensure that HAPI plans offer premium dis-  
7 counts and incentives for participation in wellness  
8 programs;

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

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

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

17 (B) fair marketing practices for health in-  
18 surance issuers;

19 (C) grievances and appeals for covered in-  
20 dividuals; and

21 (D) patient protection;

22 (7) ensure that providers receiving payment  
23 from the State HHA, when appropriate, provide in-  
24 formation to patients seeking treatment on the dif-  
25 ferent treatment options, the costs of these treat-

1 ment options, and any comparative effectiveness in-  
2 formation available through the research on com-  
3 parative effectiveness conducted under the amend-  
4 ments made by title VIII; and

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

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

8 (1) collect and exchange data with Federal and  
9 other public agencies as necessary to maintain a  
10 database containing information on the health insur-  
11 ance enrollment status of all State residents;

12 (2) implement methods to check enrollment sta-  
13 tus and enroll individuals in HAPI plans, such as  
14 through the Department of Motor Vehicles of the  
15 State, the enrollment of children in elementary and  
16 secondary schools, the voter registration authority of  
17 the State, and other checkpoints determined appro-  
18 priate by the State;

19 (3) implement mechanisms, which may not in-  
20 clude revocation or ineligibility for coverage under a  
21 HAPI plan, to enforce the responsibility of each  
22 adult individual to purchase HAPI plan coverage for  
23 such individual and any dependent children of such  
24 individual; and



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

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

11           (1) in the case of the first State fiscal year for  
12          which such a report is submitted, 100 percent of the  
13          total amount of the State share of expenditures for  
14          such services under all public health programs oper-  
15          ated in the State that are funded in whole or in part  
16          with State expenditures (including the Medicaid pro-  
17          gram) for the most recent State fiscal year ending  
18          before January 1 of the first calendar year in which  
19          HAPI coverage begins under this Act; and

20           (2) in the case of any subsequent State fiscal  
21          year for which such a report is submitted, the  
22          amount applicable under this subsection for the pre-  
23          ceding State fiscal year increased by the percentage  
24          change, if any, in the consumer price index for all

1 urban consumers over the previous Federal fiscal  
2 year.

3 **SEC. 632. EMPOWERING STATES TO INNOVATE THROUGH**  
4 **WAIVERS.**

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

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

10 (1) the legislature of such State enacts legisla-  
11 tion, or the State through a publically approved bal-  
12 lot measure approves a plan, to provide health care  
13 coverage to it's residents that is at least as com-  
14 prehensive as the coverage required under a HAPI  
15 plan; and

16 (2) the State submits to the Secretary an appli-  
17 cation at such time, in such manner, and containing  
18 such information as the Secretary may require, in-  
19 cluding a comprehensive description of the State leg-  
20 islation or plan for implementing the State-based  
21 health plan.

22 (c) DETERMINATIONS BY SECRETARY.—

23 (1) IN GENERAL.—Not later than 180 days  
24 after the receipt of an application from a State  
25 under subsection (b)(2), the Secretary shall make a

1 determination with respect to the granting of a waiver  
2 under this section to such State.

3 (2) GRANTING OF WAIVER.—If the Secretary  
4 determines that a waiver should be granted under  
5 this section, the Secretary shall notify the State in-  
6 volved of such determination and the terms and ef-  
7 fectiveness of such waiver.

8 (3) REFUSAL TO GRANT WAIVER.—If the Sec-  
9 retary refuses to grant a waiver under this section,  
10 the Secretary shall—

11 (A) notify the State involved of such deter-  
12 mination, and the reasons therefore; and

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

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

20 **Subtitle E—Federal Fallback**  
21 **Guarantee Responsibility**

22 **SEC. 641. FEDERAL GUARANTEE OF ACCESS TO COVERAGE.**

23 (a) FEDERAL GUARANTEE.—

24 (1) IN GENERAL.—If a State does not establish  
25 an HHA in compliance with title V by the date that

1 is 4 years after the date of enactment of this Act,  
2 the Secretary shall ensure that each individual has  
3 available, consistent with paragraph (2), a choice of  
4 enrollment in at least 2 HAPI plans in the coverage  
5 area in which the individual resides. In any such  
6 case in which such plans are not available, the indi-  
7 vidual shall be given the opportunity to enroll in a  
8 fallback HAPI plan.

9 (2) REQUIREMENT FOR DIFFERENT PLAN  
10 SPONSORS.—The requirement in paragraph (1) is  
11 not satisfied with respect to a coverage area if only  
12 1 entity offers all the HAPI plans in the area.

13 (b) CONTRACTS.—

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

19 (2) COMPETITIVE PROCEDURES.—Competitive  
20 procedures (as defined in section 4(5) of the Office  
21 of Federal Procurement Policy Act (41 U.S.C.  
22 403(5))) shall be used to enter into a contract under  
23 this subsection.

1 (c) FALLBACK HAPI PLAN.—For purposes of this  
2 section, the term “fallback HAPI plan” means a HAPI  
3 plan that—

4 (1) meets the requirements described in section  
5 111(b) and does not provide actuarially equivalent  
6 coverage described in section 111(c); and

7 (2) meets such other requirements as the Sec-  
8 retary may specify.

## 9 **Subtitle F—Federal Financing** 10 **Responsibilities**

### 11 **SEC. 651. APPROPRIATION FOR SUBSIDY PAYMENTS.**

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

### 16 **SEC. 652. RECAPTURE OF MEDICARE AND 90 PERCENT OF** 17 **MEDICAID FEDERAL DSH FUNDS TO** 18 **STRENGTHEN MEDICARE AND ENSURE CON-** 19 **TINUED SUPPORT FOR PUBLIC HEALTH PRO-** 20 **GRAMS.**

21 (a) RECAPTURE OF MEDICARE DSH FUNDS.—

22 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) of  
23 the Social Security Act (42 U.S.C.  
24 1395ww(d)(5)(F)(i)) is amended by inserting “and  
25 before January 1 of the first calendar year in which

1 coverage under a HAPI plan begins under the  
2 Healthy Americans Act,” after “May 1, 1986,”.

3 (2) SAVINGS TO PART A TRUST FUND.—The  
4 savings to the Federal Hospital Insurance Trust  
5 Fund by reason of the amendment made by para-  
6 graph (1) shall be used to strengthen the financial  
7 solvency of such Trust Fund.

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

10 (1) HEALTHY AMERICANS PUBLIC HEALTH  
11 TRUST FUND.—Subchapter A of chapter 98 of the  
12 Internal Revenue Code of 1986 (relating to trust  
13 fund code) is amended by adding at the end the fol-  
14 lowing new section:

15 **“SEC. 9511. HEALTHY AMERICANS PUBLIC HEALTH TRUST**  
16 **FUND.**

17 “(a) CREATION OF TRUST FUND.—There is estab-  
18 lished in the Treasury of the United States a trust fund  
19 to be known as the ‘Healthy Americans Public Health  
20 Trust Fund’, consisting of any amount appropriated or  
21 credited to the Trust Fund as provided in this section or  
22 section 9602(b).

23 “(b) TRANSFER TO TRUST FUND OF 90 PERCENT  
24 OF MEDICAID DSH FUNDS.—There are hereby appro-

1 priated to the Healthy Americans Public Health Trust  
2 Fund the following amounts:

3           “(1) In the case of the second, third, and  
4           fourth quarters of the first fiscal year in which cov-  
5           erage under a HAPI plan begins under the Healthy  
6           Americans Act, an amount equal to 90 percent of  
7           the amount that would otherwise have been appro-  
8           priated for the purpose of making payments to  
9           States under section 1903(a) of the Social Security  
10          Act for the Federal share of disproportionate share  
11          hospital payments made under section 1923 of such  
12          Act for such quarters of that fiscal year but for sub-  
13          sections (c)(2) and (d)(2)(D) of section 1941 of the  
14          such Act, as determined by the Secretary of Health  
15          and Human Services.

16          “(2) In the case of each succeeding fiscal year,  
17          an amount equal to 90 percent of the amount that  
18          would otherwise have been appropriated for the pur-  
19          pose of making payments to States under section  
20          1903(a) of the Social Security Act for the Federal  
21          share of disproportionate share hospital payments  
22          made under section 1923 of such Act for that fiscal  
23          year but for subsections (c)(1) and (d)(2)(D) of sec-  
24          tion 1941 of such Act, as determined by the Sec-  
25          retary of Health and Human Services, taking into

1 account the percentage change, if any, in the con-  
2 sumer price index for all urban consumers (U.S. city  
3 average) for the preceding fiscal year.

4 “(c) EXPENDITURES FROM TRUST FUND.—With re-  
5 spect to each fiscal year for which transfers are made  
6 under subsection (b), amounts in the Healthy Americans  
7 Public Health Trust Fund shall be available for that fiscal  
8 year for the following purposes:

9 “(1) PROVIDING PREMIUM AND PERSONAL RE-  
10 SPONSIBILITY CONTRIBUTION SUBSIDIES.—For  
11 making appropriations authorized under section 651  
12 of the Healthy Americans Act for providing pre-  
13 mium and personal responsibility contribution sub-  
14 sidies in accordance with section 122 of such Act.

15 “(2) REDUCING THE FEDERAL BUDGET DEF-  
16 ICIT.—The Secretary shall transfer any amounts in  
17 the Trust Fund that are not expended as of Sep-  
18 tember 30 of a fiscal year for a purpose described  
19 in paragraph (1) to the general revenues account of  
20 the Treasury.”.

21 (2) CLERICAL AMENDMENT.—The table of sec-  
22 tions for such subchapter is amended by adding at  
23 the end the following new item:

“Sec. 9511. Healthy Americans Public Health Trust Fund.”.



1 **Subtitle G—Tax Treatment of**  
2 **Health Care Coverage Under**  
3 **Healthy Americans Program;**  
4 **Termination of Coverage Under**  
5 **Other Governmental Programs**  
6 **and Transition Rules for Med-**  
7 **icaid and SCHIP**

8 **PART 1—TAX TREATMENT OF HEALTH CARE COV-**  
9 **ERAGE UNDER HEALTHY AMERICANS PRO-**  
10 **GRAM**

11 **SEC. 661. LIMITED EMPLOYEE INCOME AND PAYROLL TAX**  
12 **EXCLUSION FOR EMPLOYER SHARED RE-**  
13 **SPONSIBILITY PAYMENTS, HISTORIC RE-**  
14 **TIREE HEALTH CONTRIBUTIONS, AND TRAN-**  
15 **SITIONAL COVERAGE CONTRIBUTIONS.**

16 (a) INCOME TAX EXCLUSION.—

17 (1) IN GENERAL.—Subsection (a) of section  
18 106 of the Internal Revenue Code of 1986 (relating  
19 to contributions by employer to accident and health  
20 plans) is amended to read as follows:

21 “(a) GENERAL RULE.—Gross income of an individual  
22 does not include—

23 “(1) if such individual is an employee, shared  
24 responsibility payments made by an employer under  
25 section 3411,

1           “(2) if such individual is a former employee be-  
2 fore the first calendar year beginning 4 years after  
3 the date of the enactment of the Healthy Americans  
4 Act, employer-provided coverage under an accident  
5 or health plan,

6           “(3) if such individual is a qualified collective  
7 bargaining employee under an accident or health  
8 plan in effect on January 1 of the first calendar year  
9 beginning 4 years after the date of the enactment of  
10 the Healthy Americans Act, employer-provided cov-  
11 erage under such plan during any transition period  
12 described in section 3432, and

13           “(4) employer-provided coverage for qualified  
14 long-term care services (as defined in section  
15 7702B(c)).”.

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

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

20           “(8) TERMINATION.—This subsection shall not  
21 apply to contributions made in any calendar year be-  
22 ginning at least 4 years after the date of the enact-  
23 ment of the Healthy Americans Act.”,

24                   (B) by inserting “and before the first cal-  
25 endar year beginning 4 years after the date of

1 the enactment of the Healthy Americans Act,”  
2 after “January 1, 1997,” in subsection (c)(1),  
3 and

4 (C) by striking “shall be treated as em-  
5 ployer-provided coverage for medical expenses  
6 under an accident or health plan” in subsection  
7 (d)(1) and inserting “shall not be included in  
8 such employee’s gross income”.

9 (b) PAYROLL TAXES.—

10 (1) IN GENERAL.—Section 3121(a) (defining  
11 wages) is amended by adding at the end the fol-  
12 lowing new sentence: “In the case of any calendar  
13 year beginning at least 4 years after the date of the  
14 enactment of the Healthy Americans Act, para-  
15 graphs (2) and (3) shall apply to payments on ac-  
16 count of sickness only if such payments are de-  
17 scribed in section 106(a).”.

18 (2) RAILROAD RETIREMENT.—Section  
19 3231(e)(1) (defining wages) is amended by adding  
20 at the end the following new sentence: “In the case  
21 of any calendar year beginning at least 4 years after  
22 the date of the enactment of the Healthy Americans  
23 Act, this paragraph shall apply to payments on ac-  
24 count of sickness only if such payments are de-  
25 scribed in section 106(a).”.



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

3 “(o) QUALIFIED HEALTH CARE FRINGE.—For pur-  
4 poses of this section, the term ‘qualified health care fringe’  
5 means—

6 “(1) any wellness program described in section  
7 131 of the Healthy Americans Act, and

8 “(2) any on-site first aid coverage for employ-  
9 ees.”.

10 (2) NONDISCRIMINATORY TREATMENT.—Sec-  
11 tion 132(j)(1) of such Code (relating to exclusions  
12 under subsection (a)(1) and (2) apply to highly com-  
13 pensated employees only if no discrimination) is  
14 amended—

15 (A) by striking “Paragraphs (1) and (2) of  
16 subsection (a)” and inserting “Paragraphs (1),  
17 (2), and (9) of subsection (a)”, and

18 (B) by striking “SUBSECTION (a)(1) AND”  
19 in the heading and inserting “SUBSECTIONS  
20 (a)(1), (2), AND”.

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to calendar years beginning at  
23 least 4 years after the date of the enactment of the  
24 Healthy Americans Act.

1 **SEC. 663. LIMITED EMPLOYER DEDUCTION FOR EMPLOYER**  
2 **SHARED RESPONSIBILITY PAYMENTS, HIS-**  
3 **TORIC RETIREE HEALTH CONTRIBUTIONS,**  
4 **AND OTHER HEALTH CARE EXPENSES.**

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

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

12 “(1) any shared responsibility payment made  
13 under section 3411,

14 “(2) any accident or health plan coverage for  
15 individuals who are former employees before the first  
16 calendar year beginning 4 years after the date of the  
17 enactment of the Healthy Americans Act,

18 “(3) any accident or health plan in effect on  
19 January 1 of the first calendar year beginning 4  
20 years after the date of the enactment of the Healthy  
21 Americans Act with respect to coverage for qualified  
22 collective bargaining employees during a transition  
23 period described in section 3432,

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

1           “(5) any accident or health plan which con-  
2           stitutes on-site first aid coverage for employees, and

3           “(6) any accident or health plan which is a  
4           qualified long-term care insurance contract.”.

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

8           (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to calendar years beginning at  
10 least 4 years after the date of the enactment of the  
11 Healthy Americans Act.

12 **SEC. 664. REFUNDABLE CREDIT FOR INDIVIDUAL SHARED**  
13 **RESPONSIBILITY PAYMENTS.**

14           (a) IN GENERAL.—Subpart C of part IV of sub-  
15 chapter A of chapter 1 of the Internal Revenue Code of  
16 1986 is amended by redesignating section 36 as section  
17 37 and by inserting after section 35 the following new sec-  
18 tion:

19 **“SEC. 36. REFUNDABLE CREDIT FOR INDIVIDUAL SHARED**  
20 **RESPONSIBILITY PAYMENTS.**

21           “(a) IN GENERAL.—In the case of an individual, if  
22 the taxpayer has gross income for the taxable year exceed-  
23 ing 100 percent of the poverty line (adjusted for the size  
24 of the family involved) for the calendar year in which such  
25 taxable year begins and is enrolled in a HAPI plan under

1 the Healthy Americans Act, there shall be allowed as a  
2 credit against the tax imposed by this chapter an amount  
3 equal to the applicable fraction times, in the case of—

4           “(1) coverage of an individual, \$1,810,

5           “(2) coverage of a married couple or domestic  
6 partnership (as determined by a State) without de-  
7 pendent children, \$3,615,

8           “(3) coverage of an unmarried individual with  
9 1 or more dependent children, \$2,585, plus \$600 for  
10 each dependent child, and

11           “(4) coverage of a married couple or domestic  
12 partnership (as determined by a State) with 1 or  
13 more dependent children, \$4,565, plus \$600 for each  
14 dependent child.

15           “(b) APPLICABLE FRACTION.—For purposes of sub-  
16 section (a), the applicable fraction is the fraction (not to  
17 exceed 1)—

18           “(1) the numerator of which is the gross in-  
19 come of the taxpayer for the taxable year expressed  
20 as a percentage of the poverty line (adjusted for the  
21 size of the family involved) minus such poverty line  
22 for the calendar year in which such taxable year be-  
23 gins, and



1           “(2) the denominator of which is 400 percent of  
2 the poverty line (adjusted for the size of the family  
3 involved) minus such poverty line.

4           “(c) PHASEOUT OF CREDIT AMOUNT.—

5           “(1) IN GENERAL.—The amount otherwise de-  
6 termined under subsection (a) for any taxable year  
7 shall be reduced by the amount determined under  
8 paragraph (2).

9           “(2) AMOUNT OF REDUCTION.—The amount  
10 determined under this paragraph shall be the  
11 amount which bears the same ratio to the amount  
12 determined under subsection (a) as—

13           “(A) the excess of the taxpayer’s modified  
14 adjusted gross income for such taxable year,  
15 over \$62,500 (twice such amount in the case of  
16 a joint return), bears to

17           “(B) \$62,500 (twice such amount in the  
18 case of a joint return).

19           Any amount determined under this paragraph which  
20 is not a multiple of \$50 shall be rounded to the next  
21 lowest \$50.

22           “(d) INFLATION ADJUSTMENT.—In the case of any  
23 taxable year beginning in a calendar year after 2009, each  
24 dollar amount contained in subsection (a) and subpara-

1 graphs (A) and (B) of subsection (c)(2) shall be increased  
2 by an amount equal to—

3 “(1) such dollar amount, multiplied by

4 “(2) the cost-of-living adjustment determined  
5 under section 1(f)(3) for the calendar year in which  
6 the taxable year begins, determined by substituting  
7 ‘calendar year 2008’ for ‘calendar year 1992’ in sub-  
8 paragraph (B) thereof.

9 Any increase determined under the preceding sentence  
10 shall be rounded to the nearest multiple of \$50.

11 “(e) DETERMINATION OF MODIFIED ADJUSTED  
12 GROSS INCOME.—

13 “(1) IN GENERAL.—For purposes of this sec-  
14 tion, the term ‘modified adjusted gross income’  
15 means adjusted gross income—

16 “(A) determined without regard to this  
17 section and sections 86, 135, 137, 199, 221,  
18 222, 911, 931, and 933, and

19 “(B) increased by—

20 “(i) the amount of interest received or  
21 accrued during the taxable year which is  
22 exempt from tax under this title, and

23 “(ii) the amount of any social security  
24 benefits (as defined in section 86(d)) re-  
25 ceived or accrued during the taxable year.

1           “(2) POVERTY LINE.—For purposes of this  
2 paragraph, the term ‘poverty line’ has the meaning  
3 given such term in section 673(2) of the Community  
4 Health Services Block Grant Act (42 U.S.C.  
5 9902(2)), including any revision required by such  
6 section.”.

7           (b) CONFORMING AMENDMENTS.—

8           (1) Paragraph (2) of section 1324(b) of title  
9 31, United States Code, is amended by inserting “or  
10 36” after “section 35”.

11           (2) The table of sections for subpart C of part  
12 IV of subchapter A of chapter 1 of the Internal Rev-  
13 enue Code of 1986 is amended by striking the last  
14 item and inserting the following new items:

“Sec. 36. Refundable credit for individual shared responsibility payments.

“Sec. 37. Overpayments of tax.”.

15           (c) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to payments made in calendar  
17 years beginning at least 4 years after the date of the en-  
18 actment of this Act.

19 **SEC. 665. MODIFICATION OF OTHER TAX INCENTIVES TO**  
20 **COMPLEMENT HEALTHY AMERICANS PRO-**  
21 **GRAM.**

22           (a) TERMINATION OF CREDIT FOR HEALTH INSUR-  
23 ANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35 of  
24 the Internal Revenue Code of 1986 (relating to health in-

1 surance costs of eligible individuals) is amended by adding  
2 at the end the following new subsection:

3 “(h) TERMINATION.—This section shall not apply to  
4 payments made in any calendar year beginning at least  
5 4 years after the date of the enactment of the Healthy  
6 Americans Act.”.

7 (b) TERMINATION OF HEALTH CARE EXPENSE RE-  
8 IMBURSEMENT UNDER CAFETERIA PLANS.—

9 (1) IN GENERAL.—Section 125 of the Internal  
10 Revenue Code of 1986 (relating to cafeteria plans)  
11 is amended by redesignating subsection (h) as sub-  
12 section (i) and by inserting after subsection (g) the  
13 following new subsection:

14 “(h) TERMINATION.—This section shall not apply to  
15 health benefits coverage in any calendar year beginning  
16 at least 4 years after the date of the enactment of the  
17 Healthy Americans Act.”.

18 (2) LONG-TERM CARE ALLOWED UNDER CAFE-  
19 TERIA PLANS.—

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

23 (B) EFFECTIVE DATE.—The amendment  
24 made by this paragraph shall apply to contracts  
25 issued with respect to any calendar year begin-

1           ning at least 4 years after the date of the en-  
2           actment of this Act.

3           (c) TERMINATION OF ARCHER MSA CONTRIBU-  
4 TIONS.—Section 220 of the Internal Revenue Code of  
5 1986 (relating to Archer MSAs) is amended—

6           (1) by inserting “and made before the first cal-  
7           endar year beginning 4 years after the date of the  
8           enactment of the Healthy Americans Act” after “in  
9           cash” in subsection (d)(1)(A)(i), and

10           (2) by adding at the end the following new sub-  
11           section:

12           “(k) TERMINATION.—This section shall not apply to  
13 contributions made in any calendar year beginning at least  
14 4 years after the date of the enactment of the Healthy  
15 Americans Act.”.

16           (d) HEALTH SAVINGS ACCOUNTS ALLOWED IN CON-  
17 JUNCTION WITH HIGH DEDUCTIBLE HAPI PLANS.—

18           (1) IN GENERAL.—Section 223 of the Internal  
19 Revenue Code of 1986 (relating to health savings ac-  
20 counts) is amended—

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

24           (B) by striking “The term ‘high deductible  
25           health plan’ means a health plan” in subsection

1 (c)(2)(A) and inserting “The term ‘qualified  
2 high deductible health plan’ means a HAPI  
3 plan under the Healthy Americans Act”,

4 (C) by striking subparagraphs (B) and (C)  
5 of subsection (c)(2) and by redesignating sub-  
6 paragraph (D) of subsection (c)(2) as subpara-  
7 graph (B), and

8 (D) by striking “HIGH” in the heading for  
9 paragraph (2) of subsection (c) and inserting  
10 “QUALIFIED HIGH”.

11 (2) EFFECTIVE DATE.—The amendments made  
12 by this subsection shall apply to payments made in  
13 calendar years beginning at least 4 years after the  
14 date of the enactment of this Act.

15 **SEC. 666. TERMINATION OF CERTAIN EMPLOYER INCEN-**  
16 **TIVES WHEN REPLACED BY LOWER HEALTH**  
17 **CARE COSTS.**

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

22 **“SEC. 7875. TERMINATION OF CERTAIN PROVISIONS.**

23 “The following provisions shall not apply to taxable  
24 years beginning (or transactions in the case of sections  
25 referred to in paragraph (3)) in any calendar year begin-

1 ning at least 4 years after the date of the enactment of  
2 the Healthy Americans Act:

3 “(1) Section 199 (relating to income attrib-  
4 utable to domestic production activities).

5 “(2) Section 501(c)(9) (relating to tax-exempt  
6 status of voluntary employees’ beneficiary associa-  
7 tions).

8 “(3) Sections 861(a)(6), 862(a)(6), 863(b)(2),  
9 863(b)(3), and 865(b) (relating to inventory prop-  
10 erty sales source rule exception).”.

11 (b) DEFERRAL OF ACTIVE INCOME OF CONTROLLED  
12 FOREIGN CORPORATIONS.—Section 952 of the Internal  
13 Revenue Code of 1986 (relating to subpart F income de-  
14 fined) is amended by adding at the end the following new  
15 subsection:

16 “(e) SPECIAL APPLICATION OF SUBPART.—

17 “(1) IN GENERAL.—For taxable years begin-  
18 ning in any calendar year beginning at least 4 years  
19 after the date of the enactment of the Healthy  
20 Americans Act, notwithstanding any other provision  
21 of this subpart, the term ‘subpart F income’ means,  
22 in the case of any controlled foreign corporation, the  
23 income of such corporation derived from any foreign  
24 country.

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

4           (c) CONFORMING AMENDMENT.—The table of sec-  
5           tions for subchapter C of chapter 90 of the Internal Rev-  
6           enue Code of 1986 is amended by adding at the end the  
7           following new item:

          “Sec. 7875. Termination of certain provisions.”.

8   **PART 2—TERMINATION OF COVERAGE UNDER**  
9           **OTHER GOVERNMENTAL PROGRAMS AND**  
10          **TRANSITION RULES FOR MEDICAID AND**  
11          **SCHIP**

12   **SEC. 671. GROUP AND INDIVIDUAL HEALTH PLAN REQUIRE-**  
13          **MENTS NOT APPLICABLE TO HAPI PLANS.**

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

20          (b) INTERNAL REVENUE CODE OF 1986.—Section  
21          5000 of the Internal Revenue Code of 1986 (relating to  
22          certain group health plans) is amended by adding at the  
23          end the following new subsection:

24               “(e) HAPI PLANS.—For purposes of this section, the  
25          terms ‘group health plan’ and ‘large group health plan’



1 shall not include any HAPI plan under the Healthy Amer-  
2 icans Act.”.

3 (c) PUBLIC HEALTH SERVICE ACT.—Section  
4 2791(b)(5) of the Public Health Service Act (42 U.S.C.  
5 300gg–91(b)(5)) is amended by adding at the end the fol-  
6 lowing new sentence: “Such term shall not include health  
7 insurance coverage offered to individuals through a HAPI  
8 plan under the Healthy Americans Act.”.

9 **SEC. 672. FEDERAL EMPLOYEES HEALTH BENEFITS PLAN.**

10 (a) IN GENERAL.—Chapter 89 of title 5, United  
11 States Code, is amended by adding at the end the fol-  
12 lowing new section:

13 **“§ 8915. Termination**

14 “No contract shall be entered into under this chapter  
15 or chapters 89A and 89B with respect to any coverage  
16 period occurring in any calendar year beginning at least  
17 4 years after the date of the enactment of the Healthy  
18 Americans Act.”.

19 (b) CONFORMING AMENDMENT.—The table of sec-  
20 tions for such chapter 89 is amended by adding at the  
21 end the following new item:

“8915. Termination.”.

22 **SEC. 673. MEDICAID AND SCHIP.**

23 (a) IN GENERAL.—Title XIX of the Social Security  
24 Act, as amended by section 311, is amended by adding  
25 at the end the following new section:

1 “TRANSITION TO COVERAGE UNDER HAPI PLANS; RE-  
2 REQUIREMENT TO PROVIDE SUPPLEMENTAL COV-  
3 ERAGE; TERMINATION OF UNNECESSARY PROVISIONS  
4 “SEC. 1941. (a) TRANSITION AND SUPPLEMENTAL  
5 COVERAGE REQUIREMENTS.—The Secretary shall provide  
6 technical assistance to States and health insurance issuers  
7 of HAPI plans to ensure that individuals receiving medical  
8 assistance under State Medicaid plans under this title or  
9 child health assistance under child health plans under title  
10 XXI are—

11 “(1) informed of—

12 “(A) the guarantee of private coverage for  
13 essential services for all Americans established  
14 by the Healthy Americans Act; and

15 “(B) each individual’s personal responsi-  
16 bility—

17 “(i) for health care prevention;

18 “(ii) to enroll (or to be enrolled on  
19 their behalf) in a HAPI plan through the  
20 applicable State HHA during an open en-  
21 rollment period; and

22 “(iii) to submit necessary documenta-  
23 tion to their State HHA so that the HHA  
24 may determine the individual’s eligibility

1           for premium and personal responsibility  
2           contribution subsidies;

3           “(2) provided with appropriate assistance in  
4           transitioning from receiving medical assistance  
5           under State Medicaid plans or child health assist-  
6           ance under child health plans for their primary  
7           health coverage to obtaining such coverage through  
8           enrollment in HAPI plans in a manner that ensures  
9           continuation of coverage for such individuals; and

10          “(3) notwithstanding any other provision of this  
11          title, after December 31 of the last calendar year  
12          ending before the first calendar year in which cov-  
13          erage under a HAPI plan begins in accordance with  
14          the Healthy Americans Act, provided with medical  
15          assistance that consists of supplemental coverage  
16          that meets the requirements of sections 202 and 301  
17          of such Act.

18          “(b) MAINTENANCE OF MEDICARE COST-SHAR-  
19          ING.—For each month beginning after the last month of  
20          the last calendar year ending before the first calendar year  
21          in which coverage under a HAPI plan begins in accord-  
22          ance with the Healthy Americans Act—

23                 “(1) a State shall continue to provide medical  
24                 assistance for medicare cost-sharing to individuals

1 described in section 1902(a)(10)(E) as if the  
2 Healthy Americans Act had not been enacted; and

3 “(2) the Secretary shall continue to reimburse  
4 the State for the provision of such medical assist-  
5 ance.

6 “(c) CONTINUED SUPPORT FOR DSH EXPENDI-  
7 TURES.—

8 “(1) IN GENERAL.—Notwithstanding any other  
9 provision of this title, with respect to each fiscal year  
10 that begins after the first calendar year in which  
11 coverage under a HAPI plan begins in accordance  
12 with the Healthy Americans Act, the DSH allotment  
13 for each State otherwise applicable under section  
14 1923(f) for that fiscal year shall be reduced by 90  
15 percent and no payment shall be made under section  
16 1903(a) to a State with respect to any payment ad-  
17 justment made under section 1923 for hospitals in  
18 the State for quarters in the fiscal year in excess of  
19 the reduced DSH allotment for the State applicable  
20 for such year.

21 “(2) SPECIAL RULE FOR LAST 3 QUARTERS OF  
22 FIRST FISCAL YEAR IN WHICH COVERAGE UNDER A  
23 HAPI PLAN BEGINS.—With respect to the first fiscal  
24 year in which coverage under a HAPI plan begins  
25 in accordance with the Healthy Americans Act, the

1 Secretary shall reduce the DSH allotment for each  
2 State that is otherwise applicable under section  
3 1923(f) for that fiscal year so that each such DSH  
4 allotment reflects a 90 percent reduction in the allot-  
5 ment for the second, third, and fourth quarters of  
6 that fiscal year.

7 “(d) TERMINATION OF ALL FEDERAL PAYMENTS  
8 UNDER THIS TITLE OTHER THAN FOR MEDICARE COST-  
9 SHARING OR SUPPLEMENTAL MEDICAL ASSISTANCE.—  
10 Notwithstanding any other provision of this title:

11 “(1) no individual other than an individual to  
12 which section 202 or 301 of the Healthy Americans  
13 Act applies is entitled to medical assistance under a  
14 State plan approved under this title for any item or  
15 service furnished after December 31 of the last cal-  
16 endar year ending before the first calendar year in  
17 which coverage under a HAPI plan begins in accord-  
18 ance with such Act;

19 “(2) no payment shall be made to a State  
20 under section 1903(a) for any item or service fur-  
21 nished after that date or for any other sums ex-  
22 pended by a State for which a payment would have  
23 been made under such section, other than for the  
24 Federal medical assistance percentage of the total

1 amount expended by a State for each fiscal year  
2 quarter beginning after that date for providing—

3 “(A) medical assistance for the mainte-  
4 nance of medicare cost-sharing in accordance  
5 with subsection (b);

6 “(B) medical assistance for individuals who  
7 are eligible for supplemental medical assistance  
8 under this title after such date in accordance  
9 with section 202 or 301 of the Healthy Ameri-  
10 cans Act; and

11 “(C) payment adjustments under section  
12 1923 for hospitals in the State that do not ex-  
13 ceed the reduced DSH allotment for the State  
14 determined under subsection (c)”.

15 (b) APPLICATION TO SCHIP.—

16 (1) APPLICATION OF TRANSITION REQUIRE-  
17 MENTS.—Section 2107(e)(1) of the Social Security  
18 Act (42 U.S.C. 1397gg(e)(1)) is amended by adding  
19 at the end the following:

20 “(E) Section 1941(a) (relating to transi-  
21 tion to coverage under HAPI plans and, in the  
22 case of paragraph (3) of such section, the re-  
23 quirement to provide supplemental medical as-  
24 sistance for targeted low-income children who  
25 are provided child health assistance as optional

1 targeted low-income children under title  
2 XIX).”.

3 (2) TERMINATION.—Title XXI of the Social Se-  
4 curity Act is amended by adding at the end the fol-  
5 lowing new section:

6 “TERMINATION  
7 “SEC. 2111. Notwithstanding any other provision of  
8 this title, no payment shall be made to a State under sec-  
9 tion 2105(a) with respect to child health assistance for  
10 any item or service furnished after December 31 of the  
11 last calendar year ending before the first calendar year  
12 in which coverage under a HAPI plan begins in accord-  
13 ance with the Healthy Americans Act.”.

14 **TITLE VII—PURCHASING**  
15 **HEALTH SERVICES AND**  
16 **PRODUCTS THAT ARE MOST**  
17 **EFFECTIVE**

18 **SEC. 701. ONE TIME DISALLOWANCE OF DEDUCTION FOR**  
19 **ADVERTISING AND PROMOTIONAL EXPENSES**  
20 **FOR CERTAIN PRESCRIPTION PHARMA-**  
21 **CEUTICALS.**

22 (a) IN GENERAL.—Part IX of subchapter B of chap-  
23 ter 1 of subtitle A of the Internal Revenue Code of 1986  
24 (relating to items not deductible) is amended by adding  
25 at the end the following new section:

1 **“SEC. 280I. ONE TIME DISALLOWANCE OF DEDUCTION FOR**  
2 **CERTAIN PRESCRIPTION PHARMACEUTICALS**  
3 **ADVERTISING AND PROMOTIONAL EX-**  
4 **PENSES.**

5 “(a) IN GENERAL.—No deduction shall be allowed  
6 under this chapter for expenses relating to advertising or  
7 promoting the sale and use of prescription pharma-  
8 ceuticals other than drugs for rare diseases or conditions  
9 (within the meaning of section 45C) for any taxable year  
10 which includes any portion of—

11 “(1) the 3-year period which begins on the date  
12 of a new drug application approval with respect to  
13 such a pharmaceutical, unless the manufacturer of  
14 such pharmaceutical demonstrates to the satisfaction  
15 of the Secretary that such pharmaceutical is subject  
16 to a comparison effectiveness study, including over-  
17 the-counter medication (if appropriate), or

18 “(2) the 1-year period which ends with the  
19 availability of a generic drug substitute, unless such  
20 advertising or promotion includes a statement that  
21 a lower cost alternative may soon be available and  
22 includes the chemical name of such alternative.

23 “(b) ADVERTISING OR PROMOTING.—For purposes of  
24 this section, the term ‘advertising or promoting’ includes  
25 direct-to-consumer advertising and any activity designed  
26 to promote the use of a prescription pharmaceutical di-



1 rected to providers or others who may make decisions  
2 about the use of prescription pharmaceuticals (including  
3 the provision of product samples, free trials, and starter  
4 kits).”.

5 (b) CONFORMING AMENDMENT.—The table of sec-  
6 tions for such part IX is amended by adding after the  
7 item relating to section 280H the following new item:

“Sec. 280I. One time disallowance of deduction for certain prescription phar-  
maceuticals advertising and promotional expenses.”.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to taxable years beginning with  
10 or within calendar years beginning at least 4 years after  
11 the date of the enactment of this Act.

12 **SEC. 702. ENHANCED NEW DRUG AND DEVICE APPROVAL.**

13 (a) IN GENERAL.—

14 (1) NEW DRUGS.—Section 505 of the Federal  
15 Food, Drug, and Cosmetic Act (21 U.S.C. 355) is  
16 amended by adding at the end the following:

17 “(o)(1) The sponsor of a new drug application under  
18 subsection (b) may include as part of such application a  
19 full report of an investigation which has been made to  
20 show, with respect to the new drug that is the subject of  
21 the application—

22 “(A) the population for whom the drug is ap-  
23 propriate; and

1           “(B) the effectiveness of the drug when com-  
2           pared to the effectiveness of drugs on the market as  
3           of the date that the application is submitted.

4           “(2) If a sponsor of a new drug application under  
5           subsection (b) includes in such application the report de-  
6           scribed under paragraph (1) then, notwithstanding any  
7           other provision of law, the Secretary shall apply section  
8           505A(b) to the drug that is the subject of such application  
9           in the same manner as the Secretary applies such section  
10          to a new drug in the pediatric population that is the sub-  
11          ject of a study described in such section.

12          “(3) If a sponsor of a new drug application under  
13          subsection (b) does not include in such application the re-  
14          port described under paragraph (1) then, notwithstanding  
15          any other provision of law, the Secretary shall require  
16          that—

17                 “(A) all promotional material with respect to  
18                 such drug include the following disclosure: ‘This  
19                 drug has not been proven to be more effective than  
20                 other drugs on the market for any condition or ill-  
21                 ness mentioned in this advertisement.’; and

22                 “(B) such disclosure—

23                         “(i) appears at the beginning and end of  
24                         any audio and visual promotional material;

1           “(ii) constitutes not less than 20 percent of  
2           the time of any audio and visual promotional  
3           material; and

4           “(iii)(I) in any promotional material, in-  
5           cludes a clear and conspicuous printed state-  
6           ment that is larger than other print used in  
7           such promotional material; and

8           “(II) in any audio and visual promotional  
9           material, includes such statement in audio as  
10          well as visual format.”.

11          (2) NEW DEVICES.—Section 515(c) of the Fed-  
12          eral Food, Drug, and Cosmetic Act (21 U.S.C.  
13          360e) is amended by adding at the end the fol-  
14          lowing:

15          “(5)(A) A person that files a report seeking pre-  
16          market approval under this subsection may include as part  
17          of such report a full description of an investigation which  
18          has been made to show, with respect to the device that  
19          is the subject of the report—

20                 “(i) the population for whom the device is ap-  
21                 propriate; and

22                 “(ii) the effectiveness of the device when com-  
23                 pared to the effectiveness of devices on the market  
24                 as of the date that the report is submitted.

1           “(B) If a person that files a report seeking premarket  
2 approval under this subsection includes in such report the  
3 description referred to under subparagraph (A), then the  
4 Secretary shall certify to the Director of the United States  
5 Patent and Trademark Office that such person included  
6 such description in such report so that the Director may  
7 extend the patent with respect to such device under section  
8 702(b) of the Healthy Americans Act.

9           “(C) If a person that files a report seeking premarket  
10 approval under this subsection does not include in such  
11 report the description referred to under subparagraph (A)  
12 then, notwithstanding any other provision of law, the Sec-  
13 retary shall require that—

14                 “(i) all promotional material with respect to  
15 such device include the following disclosure: ‘This  
16 device has not been proven to be more effective than  
17 other devices on the market for any condition or ill-  
18 ness mentioned in this advertisement.’; and

19                 “(ii) such disclosure—

20                         “(I) appears at the beginning and end of  
21 any audio and visual promotional material;

22                         “(II) constitutes not less than 20 percent  
23 of the time of any audio and visual promotional  
24 material; and

1           “(III)(aa) in any promotional material, in-  
2           cludes a clear and conspicuous printed state-  
3           ment that is larger than other print used in  
4           such promotional material; and

5           “(bb) in any audio and visual promotional  
6           material, includes such statement in audio as  
7           well as visual format.”.

8           (b) EXTENSION OF DEVICE PATENTS.—If the Direc-  
9           tor of the United States Patent and Trademark Office re-  
10          ceives a certification from the Secretary pursuant to sec-  
11          tion 515(c)(5) of the Federal Food, Drug, and Cosmetic  
12          Act (as added under subsection (a)), the Director shall  
13          extend, for a period of 2 years, the patent in effect with  
14          respect to such device under title 35 of the United States  
15          Code.

16          (c) EFFECTIVE DATE.—This section shall apply to  
17          new drug applications filed under section 505(b) of the  
18          Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)  
19          and to applications for premarket approval of devices  
20          under section 515 of such Act (21 U.S.C. 350e) 180 days  
21          after the date of enactment of this Act.

1 **SEC. 703. MEDICAL SCHOOLS AND FINDING WHAT WORKS**  
2 **IN HEALTH CARE.**

3 Part B of title IX of the Public Health Service Act  
4 (42 U.S.C. 299b et seq.) is amended by adding at the end  
5 the following:

6 **“SEC. 918. MEDICAL SCHOOLS AND FINDING WHAT WORKS**  
7 **IN HEALTH CARE.**

8 “(a) ESTABLISHMENT OF WEBSITE.—Not later than  
9 1 year after the date of enactment of the Healthy Ameri-  
10 cans Act, the Agency shall establish an Internet website—

11 “(1) on which researchers at medical schools  
12 and other institutions may post the results of their  
13 research concerning evidence-informed best practices  
14 for improving the quality and efficiency of care; and

15 “(2) that—

16 “(A) includes a description on how to im-  
17 plement such best practices; and

18 “(B) clearly identifies the funding source  
19 for the research.

20 “(b) PILOT PROGRAM.—

21 “(1) ESTABLISHMENT.—Using the information  
22 about evidence-informed best practices from the  
23 website under subsection (a) and other sources, the  
24 Agency, through the National Research Training  
25 Program and in consultation with medical schools,  
26 shall develop a pilot program to establish methods

1 by which medical school curricula and training may  
2 be updated regularly to reflect best practices to im-  
3 prove quality and efficiency in medical practice.

4 “(2) APPLICATION TO PARTICIPATE.—To par-  
5 ticipate in the pilot program, an entity shall—

6 “(A) be an accredited medical school; and

7 “(B) submit an application at such time,  
8 in such manner, and containing such informa-  
9 tion as the Secretary may require.

10 “(3) PARTICIPANTS.—The Secretary shall en-  
11 sure that not less than 28 medical schools shall be  
12 included in the pilot program.

13 “(4) DURATION; PUBLICATION OF RESULTS.—  
14 The Agency shall—

15 “(A) operate the pilot program for 3 years;

16 and

17 “(B) not later than 180 days after the  
18 date of the completion of the pilot program,  
19 publish and make public the results of the pilot  
20 program; and

21 “(C) include, as part of the published re-  
22 sults under subparagraph (B), recommenda-  
23 tions on how to assure that all medical school  
24 curricula is updated on a regular basis to re-

1           flect best practices to improve quality and effi-  
2           ciency in medical practice.”.

3 **SEC. 704. FINDING AFFORDABLE HEALTH CARE PRO-**  
4                                   **VIDERS NEARBY.**

5           (a) IN GENERAL.—Not later than 2 years after the  
6 date of enactment of this Act, the Secretary, in consulta-  
7 tion with each HHA and health insurance issuers that  
8 offer a HAPI plan, shall establish an Internet website to  
9 assist covered individuals with locating health care pro-  
10 viders in their State of residence who provide affordable,  
11 high-quality health care services.

12           (b) QUALITY OF CARE STANDARD.—To develop the  
13 information displayed on the website with respect to the  
14 quality of care of a health care provider, the Secretary  
15 shall—

16                   (1) on the date of establishment of the website,  
17 use information on the performance of providers in  
18 quality initiatives under the Medicare program, in-  
19 cluding demonstration projects, reporting initiatives,  
20 and pay for performance efforts; and

21                   (2) not later than 3 years after the date of es-  
22 tablishment of the website, in addition to the infor-  
23 mation used under paragraph (1), use quality of  
24 care standards developed in consultation with, and



1 similar to standards used by, Medicare quality im-  
 2 provement organizations of each State.

3 (c) AFFORDABILITY STANDARD.—Not later than 2  
 4 years after the date of enactment of this Act, the Sec-  
 5 retary shall, in consultation with health insurance issuers  
 6 that offer a HAPI plan, develop guidelines by which each  
 7 health care provider reports to the Secretary with respect  
 8 to the affordability of services by such provider. The Sec-  
 9 retary shall ensure that such guidelines—

10 (1) on the date of establishment of such guide-  
 11 lines, provide for the reporting of affordability of  
 12 primary care services; and

13 (2) by a date that is no later than 3 years after  
 14 the date of enactment of this Act, provide for the re-  
 15 porting of other services.

## 16 **TITLE VIII—ENHANCED HEALTH** 17 **CARE VALUE**

### 18 **SEC. 801. SHORT TITLE.**

19 This title may be cited as the “Enhanced Health Care  
 20 Value for All Act of 2007”.

### 21 **SEC. 802. RESEARCH ON COMPARATIVE EFFECTIVENESS** 22 **OF HEALTH CARE ITEMS AND SERVICES.**

23 (a) EXPANSION OF SCOPE OF RESEARCH.—Sub-  
 24 section (a) of section 1013 of the Medicare Prescription

1 Drug, Improvement, and Modernization Act of 2003 (Pub-  
2 lic Law 108–173) is amended—

3 (1) in paragraph (1)—

4 (A) in subparagraph (A)—

5 (i) by striking “programs established  
6 under titles XVIII, XIX, and XXI of the  
7 Social Security Act” and inserting “Fed-  
8 eral health care programs (as defined in  
9 subparagraph (C))”;

10 (ii) by striking “shall conduct and  
11 support research” and inserting “shall con-  
12 duct and support research, which may in-  
13 clude clinical research,”;

14 (iii) in clause (i), by striking “and” at  
15 the end;

16 (iv) in clause (ii), by striking the pe-  
17 riod at the end and inserting “; and”;

18 (v) by adding at the end the following:

19 “(iii) gaps in current research which  
20 may necessitate research beyond system-  
21 atic reviews of existing evidence.”;

22 (B) by adding at the end the following new  
23 subparagraph:

24 “(C) FEDERAL HEALTH CARE PROGRAMS  
25 DEFINED.—For purposes of this section, the

1 term ‘Federal health care program’ means each  
2 of the following:

3 “(i) Any program established under  
4 title XVIII, XIX, or XXI of the Social Se-  
5 curity Act.

6 “(ii) The Federal employees health  
7 benefits program under chapter 89 of title  
8 5, United States Code.

9 “(iii) A health program operated  
10 under title 38, United States Code, by the  
11 Department of Veterans Affairs.

12 “(iv) The TRICARE program under  
13 chapter 55 of title 10, United States Code.

14 “(v) A medical care program of the  
15 Indian Health Service or of a tribal organi-  
16 zation.

17 “(vi) A HAPI plan under the Healthy  
18 Americans Act.”;

19 (2) in paragraph (2)—

20 (A) in subparagraph (C)(i), by striking  
21 “the programs established” and inserting “Fed-  
22 eral health care programs, including the pro-  
23 grams established”;

24 (B) in subparagraph (C)(ii), by striking  
25 “and” at the end;

1 (C) in subparagraph (C)(iii), by striking  
2 the period at the end and inserting “; and”;

3 (D) by inserting after subparagraph (C)  
4 the following:

5 “(iv) shall provide for edu-  
6 cation to physicians, other health  
7 care providers, and the public  
8 (including patients and con-  
9 sumers) about the information on  
10 comparative effectiveness that is  
11 available as a result of research  
12 funded under this section.”; and

13 (E) by adding at the end the following:

14 “(D) COMPARATIVE EFFECTIVENESS ADVI-  
15 SORY BOARD.—

16 “(i) IN GENERAL.—Effective as of the  
17 date of the enactment of the Enhanced  
18 Health Care Value for All Act of 2007, the  
19 stakeholder group consulted for purposes  
20 of subparagraph (C)(1) shall be known as  
21 the Comparative Effectiveness Advisory  
22 Board. Any reference in a law, map, regu-  
23 lation, document, paper, or other record of  
24 the United States to such stakeholder  
25 group shall be deemed to be a reference to

1 the Comparative Effectiveness Advisory  
2 Board.

3 “(ii) COMPOSITION OF BOARD.—The  
4 members of the Comparative Effectiveness  
5 Advisory Board shall consist of—

6 “(I) the Director of the Agency  
7 for Healthcare Research and Quality;  
8 and

9 “(II) up to 14 additional mem-  
10 bers who shall represent broad con-  
11 stituencies of stakeholders including  
12 clinicians, patients, researchers, third-  
13 party payers, consumers of Federal  
14 and State beneficiary programs, and  
15 health care industry professionals.

16 “(iii) APPOINTMENT; TERMS.—The  
17 Comptroller General of the United States  
18 shall appoint the members of the Compara-  
19 tive Effectiveness Advisory Board. Each  
20 member shall be appointed for a term of 2  
21 years. The members appointed for the first  
22 term following the date of the enactment  
23 of the Enhanced Health Care Value for All  
24 Act of 2007 shall be appointed not later  
25 than 90 days after such date of enactment.

1 Any member serving on the Advisory  
2 Board as of the date of the enactment of  
3 the Enhanced Health Care Value for All  
4 Act of 2007 may continue serving  
5 through the end of the member's term.

6 “(iv) CONFLICTS OF INTEREST.—In  
7 appointing the members of the Compara-  
8 tive Effectiveness Advisory Board (and the  
9 members of any panel that reports to the  
10 Board), the Comptroller General of the  
11 United States shall take into consideration  
12 any financial conflicts of interest.

13 “(E) ADDITIONAL AUTHORITIES.—In addi-  
14 tion to any authorities vested in the Compara-  
15 tive Effectiveness Advisory Board as of the day  
16 before the date of the enactment of the En-  
17 hanced Health Care Value for All Act of 2007,  
18 the Comparative Effectiveness Advisory Board  
19 shall have the following authorities:

20 “(i) To provide input on research pri-  
21 orities.

22 “(ii) To recommend how to organize  
23 research funded under this section taking  
24 into consideration the full range of appro-  
25 priate methodologies, including randomized

1 control trials, practical clinical trials, ob-  
2 servation studies, and synthesis of existing  
3 research.

4 “(iii) To make recommendations on  
5 how findings resulting from research fund-  
6 ed under this section should be described,  
7 presented, and disseminated.

8 “(iv) To make recommendations to  
9 the Congress and the Secretary, not later  
10 than 2 years after the date of the enact-  
11 ment of the Enhanced Health Care Value  
12 for All Act of 2007, regarding the estab-  
13 lishment of one or more federally-funded  
14 research and development centers.

15 “(v) To identify, consistent with sub-  
16 paragraph (C)(i), highest priorities (such  
17 as treatments that are highly utilized or  
18 are for high-cost, chronic illnesses) for re-  
19 search, demonstrations, and evaluations to  
20 support and improve Federal health care  
21 programs.

22 “(vi) To ensure that such priorities  
23 are in accordance with the principles de-  
24 scribed in subparagraph (F).

1           “(vii) To establish a clinical peer re-  
2 view advisory panel (comprised of meth-  
3 odologists, health service researchers, and  
4 medical experts) for each such priority to  
5 advise the Secretary on validating the  
6 science and methods used to conduct com-  
7 parative effectiveness studies.

8           “(F) PRINCIPLES.—Research conducted or  
9 supported under this section shall be in accord-  
10 ance with the following principles:

11           “(i) INDEPENDENCE.—The setting of  
12 the agenda and use of the research shall be  
13 insulated from inappropriate political or  
14 stakeholder influence.

15           “(ii) SCIENTIFIC CREDIBILITY.—The  
16 methods for conducting the research shall  
17 be scientifically based.

18           “(iii) TRANSPARENCY.—All aspects of  
19 the prioritization of research, the conduct  
20 of the research, and any recommendations  
21 based on the research shall be carried out  
22 in a transparent manner.

23           “(iv) INCLUSION OF INPUT FROM  
24 STAKEHOLDERS.—Patients, providers,  
25 health care consumer representatives,



1 health industry representatives, and law-  
2 makers shall be consulted regarding prior-  
3 ities and dissemination of the research.”;

4 (3) in paragraph (3)(C), by adding at the end  
5 the following:

6 “(iii) UPDATES.—The Secretary shall  
7 make available and disseminate updated  
8 evaluations, syntheses, and findings under  
9 this subparagraph not less than every 6  
10 months.”; and

11 (4) in paragraph (4)(A), by striking “the pro-  
12 grams established under titles XVIII, XIX, and XXI  
13 of the Social Security Act” and inserting “the Fed-  
14 eral health care programs”.

15 (b) REPORTS TO CONGRESS.—Such section is further  
16 amended—

17 (1) by redesignating subsection (e) as sub-  
18 section (f); and

19 (2) by inserting after subsection (d) the fol-  
20 lowing:

21 “(e) REPORTS.—Not later than 1 year after the date  
22 of the enactment of the Enhanced Health Care Value for  
23 All Act of 2007, and annually thereafter, the Secretary,  
24 in consultation with the Comparative Effectiveness Advi-  
25 sory Board, shall submit to Congress a report on the ac-

1 tivities conducted under this section. The report submitted  
2 under this subsection in 2012 shall include a description  
3 of the total activities conducted under this section since  
4 the date of the enactment of the Enhanced Health Care  
5 Value for All Act of 2007, including—

6 “(1) an evaluation of the return on the invest-  
7 ment in the program conducted under this section,  
8 including the overall cost of the program, the sci-  
9 entific knowledge created through the program, and  
10 the ways in which such knowledge has been used;

11 “(2) an evaluation of any backlog of unfunded  
12 research projects; and

13 “(3) an assessment of—

14 “(A) how the program is working;

15 “(B) the governance structure of the pro-  
16 gram;

17 “(C) the ability of the program to include  
18 public comment and patient perspectives in pri-  
19 ority setting; and

20 “(D) the ability of the program to dissemi-  
21 nate findings and conclusions.”.

22 **SEC. 803. HEALTH CARE COMPARATIVE EFFECTIVENESS**  
23 **RESEARCH TRUST FUND; FINANCING FOR**  
24 **TRUST FUND.**

25 (a) ESTABLISHMENT OF TRUST FUND.—

1           (1) IN GENERAL.—Subchapter A of chapter 98  
2           of the Internal Revenue Code of 1986 (relating to  
3           trust fund code) is amended by adding at the end  
4           the following new section:

5   **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**  
6                           **RESEARCH TRUST FUND.**

7           “(a) CREATION OF TRUST FUND.—There is estab-  
8           lished in the Treasury of the United States a trust fund  
9           to be known as the ‘Health Care Comparative Effective-  
10          ness Research Trust Fund’ (hereinafter in this section re-  
11          ferred to as the ‘Trust Fund’), consisting of such amounts  
12          as may be appropriated or credited to such Trust Fund  
13          as provided in this section and section 9602(b).

14          “(b) TRANSFERS TO FUND.—There are hereby ap-  
15          propriated to the Trust Fund the following:

16                 “(1) Amounts equivalent to the net revenues re-  
17                 ceived in the Treasury from the fees imposed under  
18                 subchapter B of chapter 34 (relating to fees on  
19                 health insurance and self-insured plans).

20                 “(2) Subject to subsection (c)(2), for each fiscal  
21                 year beginning with fiscal year 2008, amounts deter-  
22                 mined by the Secretary of Health and Human Serv-  
23                 ices to be equivalent to fair share amount deter-  
24                 mined under subsection (c) multiplied by the average  
25                 number of individuals entitled to benefits under part

1       A, or enrolled under part B, of title XVIII of the So-  
2       cial Security Act during such fiscal year.

3       The amounts appropriated under paragraph (2) shall be  
4       transferred from the Federal Hospital Insurance Trust  
5       Fund (established under section 1817 of the Social Secu-  
6       rity Act) and from the Federal Supplementary Medical In-  
7       surance Trust Fund (established under section 1841 of  
8       such Act), and from the Medicare Prescription Drug Ac-  
9       count within such Trust Fund, in proportion (as estimated  
10      by the Secretary) to the total expenditures during such  
11      fiscal year that are made under title XVIII of such Act  
12      from the respective trust fund or account.

13       “(c) FAIR SHARE AMOUNT.—

14           “(1) IN GENERAL.—The Secretary of Health  
15           and Human Services shall compute for each fiscal  
16           year (beginning with fiscal year 2008) a fair share  
17           amount under this subsection that is an amount  
18           that, when applied under this section and subchapter  
19           B of chapter 34 of the Internal Revenue Code of  
20           1986, will result in revenues to the Trust Fund (tak-  
21           ing into account any outstanding balance in the  
22           Trust Fund) for the fiscal year as follows:

23                   “(A) for fiscal year 2008, \$100,000,000;

24                   “(B) for fiscal year 2009, \$200,000,000;

25                   and

1           “(C) for each of fiscal years 2010 through  
2           2012, \$900,000,000.

3           “(2) LIMITATION ON MEDICARE FUNDING.—In  
4           no case shall the amount transferred under sub-  
5           section (b)(2) for any fiscal year exceed  
6           \$200,000,000.

7           “(d) EXPENDITURES FROM FUND.—Amounts in the  
8           Trust Fund are available to the Secretary of Health and  
9           Human Services for carrying out section 1013 of the  
10          Medicare Prescription Drug, Improvement, and Mod-  
11          ernization Act of 2003.

12          “(e) NET REVENUES.—For purposes of this section,  
13          the term ‘net revenues’ means the amount estimated by  
14          the Secretary based on the excess of—

15                 “(1) the fees received in the Treasury under  
16                 subchapter B of chapter 34, over

17                 “(2) the decrease in the tax imposed by chapter  
18                 1 resulting from the fees imposed by such sub-  
19                 chapter.”.

20                 (2) CLERICAL AMENDMENT.—The table of sec-  
21                 tions for such subchapter A is amended by adding  
22                 at the end thereof the following new item:

          “Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.”.

23                 (b) FINANCING FOR FUND FROM FEES ON INSURED  
24                 AND SELF-INSURED HEALTH PLANS.—

1           (1) GENERAL RULE.—Chapter 34 of the Inter-  
2           nal Revenue Code of 1986 is amended by adding at  
3           the end the following new subchapter:

4           **“Subchapter B—Insured Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Definitions and special rules.

5           **“SEC. 4375. HEALTH INSURANCE.**

6           “(a) IMPOSITION OF FEE.—There is hereby imposed  
7           on each specified health insurance policy for each policy  
8           year a fee equal to the fair share amount determined  
9           under section 9511(c)(1) multiplied by the average num-  
10          ber of lives covered under the policy.

11          “(b) LIABILITY FOR FEE.—The fee imposed by sub-  
12          section (a) shall be paid by the issuer of the policy.

13          “(c) SPECIFIED HEALTH INSURANCE POLICY.—For  
14          purposes of this section—

15                 “(1) IN GENERAL.—Except as otherwise pro-  
16                 vided in this section, the term ‘specified health in-  
17                 surance policy’ means any accident or health insur-  
18                 ance policy issued with respect to individuals resid-  
19                 ing in the United States.

20                 “(2) EXEMPTION OF CERTAIN POLICIES.—The  
21                 term ‘specified health insurance policy’ does not in-  
22                 clude any insurance policy if substantially all of the  
23                 coverage provided under such policy relates to—

1           “(A) liabilities incurred under workers’  
2           compensation laws,

3           “(B) tort liabilities,

4           “(C) liabilities relating to ownership or use  
5           of property,

6           “(D) credit insurance,

7           “(E) medicare supplemental coverage, or

8           “(F) such other similar liabilities as the  
9           Secretary may specify by regulations.

10           “(3) TREATMENT OF PREPAID HEALTH COV-  
11           ERAGE ARRANGEMENTS.—

12           “(A) IN GENERAL.—In the case of any ar-  
13           rangement described in subparagraph (B)—

14                   “(i) such arrangement shall be treated  
15                   as a specified health insurance policy, and

16                   “(ii) the person referred to in such  
17                   subparagraph shall be treated as the  
18                   issuer.

19           “(B) DESCRIPTION OF ARRANGEMENTS.—

20           An arrangement is described in this subpara-  
21           graph if under such arrangement fixed pay-  
22           ments or premiums are received as consider-  
23           ation for any person’s agreement to provide or  
24           arrange for the provision of accident or health  
25           coverage to residents of the United States, re-

1            regardless of how such coverage is provided or ar-  
2            ranged to be provided.

3    **“SEC. 4376. DEFINITIONS AND SPECIAL RULES.**

4            “(a) DEFINITIONS.—For purposes of this sub-  
5 chapter—

6            “(1) ACCIDENT AND HEALTH COVERAGE.—The  
7 term ‘accident and health coverage’ means any cov-  
8 erage which, if provided by an insurance policy,  
9 would cause such policy to be a specified health in-  
10 surance policy (as defined in section 4375(c)).

11           “(2) INSURANCE POLICY.—The term ‘insurance  
12 policy’ means any policy or other instrument where-  
13 by a contract of insurance is issued, renewed, or ex-  
14 tended.

15           “(3) UNITED STATES.—The term ‘United  
16 States’ includes any possession of the United States.

17           “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

18           “(1) IN GENERAL.—For purposes of this sub-  
19 chapter—

20           “(A) the term ‘person’ includes any gov-  
21 ernmental entity, and

22           “(B) notwithstanding any other law or rule  
23 of law, governmental entities shall not be ex-  
24 empt from the fees imposed by this subchapter  
25 except as provided in paragraph (2).



1           “(2) TREATMENT OF EXEMPT GOVERNMENTAL  
2 PROGRAMS.—In the case of an exempt governmental  
3 program, no fee shall be imposed under section 4375  
4 or section 4376 on any covered life under such pro-  
5 gram.

6           “(3) EXEMPT GOVERNMENTAL PROGRAM DE-  
7 FINED.—For purposes of this subchapter, the term  
8 ‘exempt governmental program’ means—

9                   “(A) any insurance program established  
10 under title XVIII of the Social Security Act,

11                   “(B) the medical assistance program es-  
12 tablished by title XIX or XXI of the Social Se-  
13 curity Act,

14                   “(C) any program established by Federal  
15 law for providing medical care (other than  
16 through insurance policies) to individuals (or  
17 the spouses and dependents thereof) by reason  
18 of such individuals being—

19                           “(i) members of the Armed Forces of  
20 the United States, or

21                           “(ii) veterans, and

22                   “(D) any program established by Federal  
23 law for providing medical care (other than  
24 through insurance policies) to members of In-

1           dian tribes (as defined in section 4(d) of the In-  
2           dian Health Care Improvement Act).

3           “(c) TREATMENT AS TAX.—For purposes of subtitle  
4 F, the fees imposed by this subchapter shall be treated  
5 as if they were taxes.

6           “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
7 standing any other provision of law, no amount collected  
8 under this subchapter shall be covered over to any posses-  
9 sion of the United States.”

10           (2) CLERICAL AMENDMENT.—Chapter 34 of  
11 such Code is amended by striking the chapter head-  
12 ing and inserting the following:

13           **“CHAPTER 34—TAXES ON CERTAIN**  
14           **INSURANCE POLICIES**

          “SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

          “SUBCHAPTER B. INSURED HEALTH PLANS

15           **“Subchapter A—Policies Issued By Foreign**  
16           **Insurers”.**

17           (3) EFFECTIVE DATE.—The amendments made  
18 by this section shall apply with respect to policies  
19 and plans for portions or policy or plan years begin-  
20 ning on or after October 1, 2007.

21           **SEC. 804. COORDINATION OF HEALTH SERVICES RE-**  
22           **SEARCH.**

23           (a) ESTABLISHMENT.—The Secretary of Health and  
24 Human Services shall establish a permanent council (in

1 this section referred to as the “Council”) for the purpose  
2 of assisting the offices and agencies of the Department  
3 of Health and Human Services, the Department of Vet-  
4 erans Affairs, the Department of Defense, and any other  
5 department or agency to coordinate the conduct or sup-  
6 port of health services research. Such coordination shall  
7 include advising each such office and agency—

8           (1) on clarifying its policies regarding public ac-  
9           cess to data resulting from research conducted or  
10           supported by the office or agency, including the pro-  
11           vision of reasons for not permitting any such data  
12           to be publicly disclosed;

13           (2) on making such policies, as clarified, pub-  
14           licly available; and

15           (3) on updating the publicly available versions  
16           of such policies to reflect any subsequent modifica-  
17           tions;

18           (b) MEMBERSHIP.—

19           (1) NUMBER AND APPOINTMENT.—The Council  
20           shall be composed of 20 members. One member shall  
21           be the Director of the Agency for Healthcare Re-  
22           search and Quality. The Director shall appoint the  
23           other members not later than 30 days after the en-  
24           actment of this Act.

25           (2) QUALIFICATIONS.—

1 (A) IN GENERAL.—The members of the  
2 Council shall include one senior official from  
3 each of the following agencies:

4 (i) The Veterans Health Administra-  
5 tion.

6 (ii) The Department of Defense Mili-  
7 tary Health Care System.

8 (iii) The Centers for Disease Control  
9 and Prevention.

10 (iv) The National Center for Health  
11 Statistics.

12 (v) The National Institutes of Health.

13 (vi) The Center for Medicare & Med-  
14 icaid Services.

15 (vii) The Federal Employees Health  
16 Benefits Program.

17 (B) NATIONAL, PHILANTHROPIC FOUNDA-  
18 TIONS.—The members of the Council shall in-  
19 clude 4 senior leaders from major national,  
20 philanthropic foundations that fund and use  
21 health services research.

22 (C) STAKEHOLDERS.—The remaining  
23 members of the Council shall be representatives  
24 of other stakeholders in health services re-  
25 search, including private purchasers, health

1 plans, hospitals and other health facilities, and  
2 health consumer groups.

3 (D) PERIOD OF APPOINTMENT.—Members  
4 of the Council shall be appointed for the life of  
5 the Council. Any vacancies shall not affect the  
6 power and duties of the Council and shall be  
7 filled in the same manner as the original ap-  
8 pointment.

9 (c) LEADERSHIP.—The Secretary of Health and  
10 Human Services shall appoint the chair of the Council.  
11 Not later than 15 days after the date on which all mem-  
12 bers of the Council have been appointed under section  
13 (b)(1), the Council chair shall designate a co-chair of the  
14 Council. The co-chair shall be the leader of a national  
15 foundation that funds health services research.

16 (d) SUBCOMMITTEES.—The Council may establish  
17 subcommittees to assist in carrying out its duties.

18 (e) DUTIES.—

19 (1) PUBLIC MEETINGS.—Not later than 120  
20 days after the designation of a co-chairperson under  
21 subsection (c), the Council shall hold public meetings  
22 with producers and users of health services research  
23 to examine—

24 (A) the major infrastructure challenges  
25 facing the field of health services research;

1 (B) the field's research priorities over the  
2 next 5 years;

3 (C) the current portfolio of health services  
4 research being funded;

5 (D) ways to stimulate innovation in the  
6 field of health services research; and

7 (E) ways in which the field of health serv-  
8 ices research might help to transform the health  
9 care system by 2020.

10 (2) ADDITIONAL MEETINGS.—The Council may  
11 hold additional public meetings on subjects other  
12 than those listed in the paragraph (1) so long as the  
13 meetings are determined to be necessary by the  
14 Council in carrying out its duties. Additional meet-  
15 ings are not required to be completed within the  
16 time period specified in paragraph (1).

17 (3) DEVELOP A STRATEGIC PLAN.—Not later  
18 than 2 years after the meetings described in para-  
19 graph (1) and (2) are completed, the Council shall  
20 prepare and make public through the Internet and  
21 other channels a strategic plan for the field of health  
22 services research, which plan shall include the fol-  
23 lowing:

1 (A) A health services research agenda to  
2 address the Nation's evolving health care prior-  
3 ities.

4 (B) A plan for addressing the infrastruc-  
5 ture needs of the field of health services re-  
6 search, including professional development for  
7 the next generation of researchers and improved  
8 methods and data.

9 (C) A plan for fostering innovation in the  
10 field of health services research.

11 (D) A uniform definition of health services  
12 research and standard research categories to be  
13 used across the funders of health services re-  
14 search in developing research budgets and re-  
15 porting research expenditures.

16 (f) ANNUAL REPORT.—Not later than 1 year after  
17 the publication of the Council's strategic plan under sub-  
18 section (e)(3), and annually thereafter, the Council shall  
19 report to the Congress on, and make public a detailed de-  
20 scription of, the following:

21 (1) The Council's progress in implementing the  
22 strategic plan.

23 (2) Organizational expenditures in health serv-  
24 ices research by the Federal agencies specified in  
25 subsection (b)(2)(A) according to the uniform defini-

1       tion and standard research categories developed by  
2       the Council.

3       (g) **DETAIL OF EMPLOYEES.**—Each Federal agency  
4 represented on the Council may, on a non-reimbursable  
5 basis, detail one employee to the Council. Each such detail  
6 shall last no more than 2 years. Any detail of an employee  
7 shall be without interruption or loss of civil services status  
8 or privilege.

9       (h) **CONTRACTING.**—The Director of the Agency for  
10 Healthcare Research and Quality may contract with an  
11 outside entity to assist the Council in holding public meet-  
12 ings, developing the strategic plan for the field of health  
13 services research, and fulfilling annual reporting require-  
14 ments.

15 **TITLE IX—CONTAINING MED-**  
16 **ICAL COSTS AND GETTING**  
17 **MORE VALUE FOR THE**  
18 **HEALTH CARE DOLLAR**

19 **SEC. 901. COST-CONTAINMENT RESULTS OF THE HEALTHY**  
20 **AMERICANS ACT.**

21       Congress finds that the Healthy Americans Act will  
22 result in the following:

23           (1) Private insurance companies will be forced  
24       to hold down costs and will slow the rate of growth



1 because they are required to offer standardized  
2 Healthy American Private Insurance plans.

3 (2) Administrative savings will be derived from  
4 decoupling employers from the health care infra-  
5 structure and reducing employers' and insurers' ad-  
6 ministrative costs.

7 (3) Private insurance companies will implement  
8 uniform billing and common claims forms.

9 (4) Congress will reclaim Medicare and Med-  
10 icaid disproportionate share hospital (DSH) pay-  
11 ments because previously uninsured persons will go  
12 to providers on an outpatient basis instead of an  
13 emergency department.

14 (5) State and local governments will save  
15 money on programs they operated for the uninsured  
16 before enactment of this Act.

17 (6) The Federal Government will save money  
18 on Federal tax subsidies that reward inefficient care  
19 and are regressive.

20 (7) The Federal Government and the private  
21 sector will save money if the Food and Drug Admin-  
22 istration determines whether products provide new  
23 value.

24 (8) Reducing medical errors will save the gov-  
25 ernment and the private sector money.

1           (9) Requiring hospitals to send large bills to pa-  
2           tients for their review will reduce errors in medical  
3           billing and force major providers to be more cost  
4           conscious.

5           (10) Requiring insurers to reimburse for quality  
6           and cost effective services will hold down private sec-  
7           tor costs.

8           (11) Reduction of Medicare's restriction on bar-  
9           gaining power for prescription drugs will reduce  
10          costs for sole source drugs and other medications.

11          (12) Establishment of electronic medical  
12          records by insurers will create savings.

13          (13) Publication of cost and quality data will  
14          enable people to look up by zip code affordable high-  
15          quality providers.

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