

110TH CONGRESS  
1ST SESSION

# S. 334

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

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IN THE SENATE OF THE UNITED STATES

JANUARY 18, 2007

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

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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.—

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

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Subtitle B—Standards for Healthy Americans Private Insurance Coverage

- Sec. 111. Healthy Americans Private Insurance plans.  
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- Sec. 311. New, automatic Medicaid option for State choices for long-term care program.  
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Sec. 441. Improving quality in hospitals for all patients.

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Sec. 454. Clearinghouse.

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Subtitle E—Federal Fallback Guarantee Responsibility

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- 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.

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- Sec. 661. Limited employee income and payroll tax exclusion for employer shared responsibility payments, historic retiree health contributions, and transitional coverage contributions.  
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- Sec. 801. Cost-containment results of the Healthy Americans Act.

**1 SEC. 2. FINDINGS.**

**2** Congress makes the following findings:

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

4           (2) American health care provides primarily  
5           “sick care” and does not do enough to prevent  
6           chronic illnesses like heart disease, stroke, and dia-  
7           betes. This results in significantly higher health  
8           costs for all Americans.

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

12          (4) Personal responsibility for one’s health  
13          should include purchasing one’s own private health  
14          care coverage.

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

20          (6) Financing this guarantee should be a  
21          shared responsibility between individuals, the Gov-  
22          ernment, and employers.

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

1           (8) This guarantee must include easier access  
2 to understandable information about the quality,  
3 cost, and effectiveness of health care providers, prod-  
4 ucts, and services.

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

11 **SEC. 3. DEFINITIONS.**

12 In this Act:

13           (1) ADULT INDIVIDUAL.—The term “adult indi-  
14 vidual” means an individual who—

15                   (A) is—

16                           (i) age 19 or older;

17                           (ii) a resident of a State;

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

19                                   (II) an alien with permanent resi-  
20 dence;

21                           (iv) not a dependent child; and

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

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

4 (2) ALIEN WITH PERMANENT RESIDENCE.—  
5 The term “alien with permanent residence” has the  
6 meaning given the term “qualified alien” in section  
7 431 of the Personal Responsibility and Work Oppor-  
8 tunity Reconciliation Act of 1996 (8 U.S.C. 1641).

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

12 (4) DEPENDENT CHILD.—The term “dependent  
13 child” has the meaning given the term “qualifying  
14 child” in section 152(c) of the Internal Revenue  
15 Code of 1986.

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

19 (6) HHA.—The term “HHA” means the  
20 Health Help Agency of a State as described under  
21 title V.

22 (7) HEALTH INSURANCE ISSUER.—The term  
23 “health insurance issuer” means an insurance com-  
24 pany, insurance service, or insurance organization  
25 (including a health maintenance organization, as de-

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

7            (8) HEALTH MAINTENANCE ORGANIZATION.—  
8        The term “health maintenance organization”  
9        means—

10            (A) a federally qualified health mainte-  
11            nance organization (as defined in section  
12            1301(a)),

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

15            (C) a similar organization regulated under  
16            State law for solvency in the same manner and  
17            to the same extent as such a health mainte-  
18            nance organization.

19            (9) PERSONAL RESPONSIBILITY CONTRIBU-  
20        TION.—The term “personal responsibility contribu-  
21        tion” means a payment made by a covered individual  
22        to a health care provider or a health insurance  
23        issuer with respect to the provision of health care  
24        services under a HAPI plan, not including any  
25        health insurance premium payment.



1           (10) QUALIFIED COLLECTIVE BARGAINING  
2 AGREEMENT.—

3           (A) IN GENERAL.—The term “qualified  
4 collective bargaining agreement” means an  
5 agreement between a qualified collective bar-  
6 gaining employer and an employee organization  
7 that represents the employees of such employer  
8 that is in effect until the date that is the earlier  
9 of—

10           (i) January 1 of the first year which  
11 is more than 7 years after the date of en-  
12 actment of this Act, or

13           (ii) the date the collective bargaining  
14 agreement expires.

15           (B) QUALIFIED COLLECTIVE BARGAINING  
16 EMPLOYER.—The term “qualified collective bar-  
17 gaining employer” means an employer who pro-  
18 vides health insurance to employees under the  
19 terms of a collective bargaining agreement  
20 which is entered into before the date of the en-  
21 actment of this Act.

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

24           (12) STATE.—The term “State” means each of  
25 the several States of the United States, the District

1 of Columbia, the Commonwealth of Puerto Rico, the  
 2 Virgin Islands, American Samoa, Guam, the Com-  
 3 monwealth of the Northern Mariana Islands, and  
 4 other territories of the United States.

5 (13) STATE OF RESIDENCE.—The term “State  
 6 of residence”, with respect to an individual, means  
 7 the State in which the individual has primary resi-  
 8 dence.

9 **TITLE I—HEALTHY AMERICANS**  
 10 **PRIVATE INSURANCE PLANS**  
 11 **Subtitle A—Guaranteed Private**  
 12 **Coverage**

13 **SEC. 101. GUARANTEE OF HEALTHY AMERICANS PRIVATE**  
 14 **INSURANCE COVERAGE.**

15 Not later than the date that is 2 years after the date  
 16 of enactment of this Act, each adult individual shall have  
 17 the opportunity to purchase a Healthy Americans Private  
 18 Insurance plan that meets the requirements of subtitle B,  
 19 (referred to in this Act as “HAPI plan”) for such indi-  
 20 vidual and the dependent children of such individual.

21 **SEC. 102. INDIVIDUAL RESPONSIBILITY TO ENROLL IN A**  
 22 **HEALTHY AMERICANS PRIVATE INSURANCE**  
 23 **PLAN.**

24 (a) INDIVIDUAL RESPONSIBILITY.—

1           (1) ADULT INDIVIDUALS.—Each adult indi-  
2           vidual shall have the responsibility to enroll in a  
3           HAPI plan offered through the HHA of the adult  
4           individual’s State of residence, unless the adult indi-  
5           vidual—

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

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

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

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

15                           (iv) a qualified collective bargaining  
16                           agreement;

17                           (v) the Department of Veterans Af-  
18                           fairs; or

19                           (vi) the Indian Health Service; or

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

1           (2) DEPENDENT CHILDREN.—Each adult indi-  
 2           vidual shall have the responsibility to enroll each de-  
 3           pendent child of the adult individual in a HAPI plan  
 4           offered through the HHA of the adult individual’s  
 5           State of residence, unless the adult individual—

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

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

11           (3) VERIFICATION OF RELIGIOUS EXCEPTION.—  
 12           Each State shall develop guidelines for determining  
 13           and verifying the individuals who qualify for the ex-  
 14           ception under paragraph (1)(B).

15           (b) PENALTY FOR FAILURE TO PURCHASE COV-  
 16           ERAGE.—

17                   (1) PENALTY.—

18                   (A) IN GENERAL.—In the case of an indi-  
 19           vidual described in subparagraph (B), such in-  
 20           dividual shall be subject to a late enrollment  
 21           penalty in an amount determined under sub-  
 22           paragraph (C).

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

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

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

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

11 (C) AMOUNT OF PENALTY.—

12 (i) IN GENERAL.—The amount deter-  
 13 mined under this subparagraph for an in-  
 14 dividual is an amount equal to the sum  
 15 of—

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

24 (II) 15 percent of the amount de-  
 25 termined under subclause (I).

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

8 (I) was covered under a HAPI  
9 plan or a health plan offered through  
10 a program described in paragraph  
11 (1)(A) of section 102(a) for any por-  
12 tion of such month; or

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

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

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

1 individual’s State of residence under procedures  
2 established by the State.

3 (E) APPLICABLE DATE.—In this para-  
4 graph, the term “applicable date” means the  
5 earlier of—

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

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

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

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

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

4 **Subtitle B—Standards for Healthy**  
 5 **Americans Private Insurance**  
 6 **Coverage**

7 **SEC. 111. HEALTHY AMERICANS PRIVATE INSURANCE**  
 8 **PLANS.**

9 (a) OPTIONS.—A State HHA—

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

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

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

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



1 description of the standardized benefits, items,  
 2 or services required under the plan under this  
 3 section (and consistent with the manner in  
 4 which such items are displayed by medigap poli-  
 5 cies) and that enables a consumer to identify  
 6 such additional benefits, items, and services and  
 7 the cost associated with such; and

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

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

15 (b) STANDARDIZED COVERAGE REQUIREMENTS FOR  
 16 HAPI PLANS.—

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

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

1 including coverage of an initial primary care as-  
2 sessment and annual physical examinations;

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

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

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

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

22 (F) provide benefits for comprehensive dis-  
23 ease prevention, early detection, disease man-  
24 agement, and chronic condition management

1 that meets minimum standards developed by  
2 the Secretary;

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

13 (i) preventive items or services; and

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

17 (H) comply with the requirements of sec-  
18 tion 112.

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

24 (3) COVERAGE FOR FAMILY PLANNING.—

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

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

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

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

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

1 (A) shall include coverage for—

2 (i) preventive items and services (in-  
3 cluding well baby care and well child care  
4 and appropriate immunizations) and dis-  
5 ease management services;

6 (ii) inpatient and outpatient hospital  
7 services;

8 (iii) physicians' surgical and medical  
9 services; and

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

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

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

19 (d) PREMIUMS AND RATING REQUIREMENTS.—

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

23 (A) Coverage of an individual.

1 (B) Coverage of a married couple or do-  
2 mestic partnership (as determined by a State)  
3 without dependent children.

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

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

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

18 (3) REWARDS.—A State shall permit a health  
19 insurance issuer to provide premium discounts and  
20 other incentives to enrollees based on the partici-  
21 pation of such enrollees in wellness, chronic disease  
22 management, and other programs designed to im-  
23 prove the health of the enrollees.

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

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

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

6       **SEC. 112. SPECIFIC COVERAGE REQUIREMENTS.**

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

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

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

1           (3) provide for the guaranteed renewability of  
2 coverage in a manner similar to that provided for  
3 under section 2712 of the Public Health Service Act  
4 (42 U.S.C. 300gg-12), as such section existed on  
5 the day before the date of enactment of this Act, ex-  
6 cept that the prohibition on market reentry provided  
7 for under such section shall be deemed to be 2 years;

8           (4) prohibit discrimination against individual  
9 enrollees and prospective enrollees based on health  
10 status in a manner similar to that provided for  
11 under section 2702 of the Public Health Service Act  
12 (42 U.S.C. 300gg-1), as such section existed on the  
13 day before the date of enactment of this Act;

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

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



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

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

10 (b) GENETIC NONDISCRIMINATION.—

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

19           (2) PROHIBITION ON GENETIC INFORMATION IN  
20 SETTING PREMIUM RATES.—A HAPI plan shall not  
21 adjust premium or personal responsibility contribu-  
22 tion amounts for an individual on the basis of ge-  
23 netic information concerning the individual or a fam-  
24 ily member of the individual (including information

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

3 (3) GENETIC TESTING.—

4 (A) LIMITATION ON REQUESTING OR RE-  
5 QUIRING GENETIC TESTING.—A HAPI plan  
6 shall not request or require an individual or a  
7 family member of such individual to undergo a  
8 genetic test.

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

11 (i) limit the authority of a health care  
12 professional who is providing health care  
13 services with respect to an individual to re-  
14 quest that such individual or a family  
15 member of such individual undergo a ge-  
16 netic test;

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

25 or

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

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

8 **SEC. 113. UPDATING HEALTHY AMERICANS PRIVATE IN-**  
9 **SURANCE PLAN REQUIREMENTS.**

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

16 (b) COMPOSITION.—

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

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

22 (B) at least 1 such member shall be an  
23 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) ACTION BY SECRETARY.—Not later than Decem-  
18 ber 31 of the second full calendar year following the date  
19 of enactment of this Act, and each December 31 there-  
20 after, the Advisory Committee shall provide to Congress  
21 and the Secretary a report that—

22 (1) describes any recommendations for modi-  
23 fications to the benefits, items, and services that are  
24 required to be covered under a HAPI plan; and

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

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

9           **Subtitle C—Eligibility for Premium**  
10           **and Personal Responsibility**  
11           **Contribution Subsidies**

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

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

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

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

1 greater than 100 percent of the poverty line, as ap-  
2 plicable to a family of the size involved, but below  
3 the applicable percentage of the poverty line, as ap-  
4 plicable to a family of the size involved, the covered  
5 individual is entitled under this section to an in-  
6 come-related premium subsidy equal to the basic  
7 premium subsidy amount reduced by the amount de-  
8 termined under paragraph (2).

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

13 (A) the excess of—

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

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

19 (B) the excess of—

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

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

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

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

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

10          (2) the weighted average of the premium for  
11          HAPI plans of the same class of coverage (as de-  
12          scribed in section 111(d)(1)) as the individual’s in  
13          the applicable coverage area.

14          (d) CHANGE IN STATUS NOTIFICATION.—

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



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

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

9   **SEC. 122. ELIGIBILITY FOR PERSONAL RESPONSIBILITY**  
10                                   **CONTRIBUTION SUBSIDIES.**

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

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

1 of any personal responsibility contributions applicable to  
2 such individual.

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

4 (a) DETERMINATION OF MODIFIED ADJUSTED  
5 GROSS INCOME.—

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

10 (A) determined without regard to sections  
11 86, 135, 137, 199, 221, 222, 911, 931, and  
12 933 of such Code; and

13 (B) increased by—

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

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

21 (2) TAXABLE YEAR TO BE USED TO DETER-  
22 MINE MODIFIED ADJUSTED GROSS INCOME.—In ap-  
23 plying this subtitle to determine an individual’s an-  
24 nual premiums, the covered individual’s modified ad-  
25 justed gross income shall be such income determined

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

4 (b) POVERTY LINE.—In this subtitle, the term “pov-  
5 erty line” has the meaning given such term in section  
6 673(2) of the Community Health Services Block Grant  
7 Act (42 U.S.C. 9902(2)), including any revision required  
8 by such section.

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

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

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

1 eligibility for status in the United States or adjust the sta-  
2 tus of an alien in the United States if the alien owes—

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

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

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

## 14           **Subtitle D—Wellness Programs**

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

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

24           (b) DISCOUNTS.—

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

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

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

13                   (B) the wellness program meets the re-  
14 quirements of this subsection.

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

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

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

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

1 (D) permits any enrollee for whom it is un-  
2 reasonably difficult to meet the initial program  
3 standard for participation due to a medical con-  
4 dition (or for whom it is medically inadvisable  
5 to attempt) an opportunity to meet a reason-  
6 able alternative participation standard—

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

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

14 (ii) the availability of which is dis-  
15 closed in the original documents relating to  
16 participation in the program;

17 (E) applies procedures for determining  
18 whether an enrollee is participating in a mean-  
19 ingful manner in the program, including proce-  
20 dures to determine if such participation is re-  
21 sulting in lifestyle changes that are indicative of  
22 an improved health outcome or outcomes; and

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

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

5           (4) AVAILABILITY OF DISCOUNTS.—

6           (A) OFFERING OF ENROLLMENT.—A  
7           HAPI plan shall provide enrollees with the op-  
8           portunity to participate in a wellness program  
9           (for purposes of qualifying for premium dis-  
10          counts) at least once each year.

11          (B) DETERMINATIONS.—Determinations  
12          with respect to the successful participation by  
13          an enrollee in a wellness program for purposes  
14          of qualifying for discounts shall be made by the  
15          HAPI plan based on a retrospective review of  
16          the scope of activities of the enrollee under the  
17          program. The HAPI plan may require a min-  
18          imum level of successful participation in such a  
19          program prior to applying any premium dis-  
20          count.

21          (C) PARTICIPATION IN MULTIPLE PRO-  
22          GRAMS.—An enrollee may participate in mul-  
23          tiple wellness programs to reach the maximum  
24          premium discount permitted by the HAPI plan  
25          under applicable State law.





1 fied adjusted gross income that is below 300 percent of  
 2 the poverty line as applicable to a family of the size in-  
 3 volved, who is not otherwise eligible for coverage as a de-  
 4 pendent under a HAPI plan maintained by his or her par-  
 5 ents, is covered under a HAPI plan provided through the  
 6 State HHA.

7 (c) POLICIES AND PROCEDURES.—The Secretary  
 8 shall develop policies and procedures to be applied by the  
 9 States to identify children described in subsection (a) and  
 10 to provide such children with coverage under a HAPI plan.  
 11 States shall determine, in consultation with health insur-  
 12 ance issuers, a separate class of coverage to assure afford-  
 13 able child coverage.

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

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

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

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

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

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

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

20 (b) DEFINITION.—In this section, the term “child”,  
21 in addition to the meaning given that term under section  
22 201(d), includes any individual who would be considered  
23 a child under the Medicaid program of the State in which  
24 the individual resides.

## 1           **Subtitle B—Service Providers**

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

3           (a) IN GENERAL.—To ensure that children have ac-  
4   cess to health care in their communities, and that such  
5   care is provided to such children for no cost or on a reim-  
6   bursable basis, a HAPI plan shall ensure that health care  
7   items and services may be obtained by such children from,  
8   at a minimum, the providers described in subsection (b)  
9   if available in the area involved.

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

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

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

16               (3) A federally qualified health center.

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

19               (5) An Indian health service facility.

### 20   **SEC. 212. USE OF, AND GRANTS FOR, SCHOOL-BASED** 21                               **HEALTH CENTERS.**

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

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

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

3           (3) is administered by a community-based orga-  
4           nization including a hospital, public health depart-  
5           ment, community health center, or nonprofit health  
6           care agency;

7           (4) at a minimum, provides to school-aged chil-  
8           dren—

9                   (A) primary health care services, including  
10                   comprehensive health assessments, and diag-  
11                   nosis and treatment of minor, acute, and chron-  
12                   ic medical conditions and Healthy Start bene-  
13                   fits;

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

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

22                   (D) services through the use of a qualified  
23                   and appropriately credentialed individual, in-  
24                   cluding a nurse practitioner or physician assist-

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

3 (E) by not later than January 1, 2010, an  
4 electronic medical record relating to the indi-  
5 vidual; and

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

11 (b) ACCESS TO SCHOOL-BASED HEALTH CEN-  
12 TERS.—

13 (1) IN GENERAL.—A school-based health center  
14 may provide services to students in more than 1  
15 school if the school district or other supervising  
16 State entity determined that capacity and geo-  
17 graphic location make such provision of services ap-  
18 propriate.

19 (2) ENROLLMENT.—Upon the enrollment of a  
20 student in a school with a school-based health cen-  
21 ter, the center will provide the student with the op-  
22 portunity to enroll, after parental consent, to receive  
23 health care from the center.

24 (3) REIMBURSEMENT FOR SERVICES.—

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

6           (B) USE OF FUNDS.—Amounts received  
7 from a third party payer under subparagraph  
8 (A) shall be allocated to the school-based health  
9 center that provided the care for which the re-  
10 imbursement was provided for use by that cen-  
11 ter for providing additional health care items  
12 and services.

13       (c) DEVELOPMENTAL GRANTS.—

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

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

23           (3) SELECTION CRITERIA.—In awarding grants  
24 under this subsection, the Secretary shall give pri-  
25 ority to—

1           (A) an applicant that will use amounts  
2           under the grant to establish a school-based  
3           health center in a medically underserved area,  
4           or an area for which there are extended dis-  
5           tances between the school involved and appro-  
6           priate providers of care for school-aged children  
7           in the geographic area involved;

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

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

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

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

9 (e) AUTHORIZATION OF APPROPRIATIONS.—There is  
 10 authorized to be appropriated, such sums as may be nec-  
 11 essary for each fiscal year to carry out this section.

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

15 **Subtitle A—Assurance of**  
 16 **Supplemental Medicaid Coverage**

17 **SEC. 301. COORDINATION OF SUPPLEMENTAL COVERAGE**

18 **UNDER THE MEDICAID PROGRAM FOR EL-**

19 **DERLY AND DISABLED INDIVIDUALS.**

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

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



1        ized care or home and community-based services;  
2        and

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

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

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

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

22        (b) DEFINITIONS.—In this section—

23            (1) the term “institutionalized care” means the  
24        health care provided under the Medicaid plan of the  
25        State of residence of an elderly or disabled individual

1 who is a patient in a hospital, nursing facility, inter-  
 2 mediate care facility for the mentally retarded, or an  
 3 institution for mental diseases (as such terms are  
 4 defined for purposes of such plan); and

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

13 **Subtitle B—Empowering Individ-**  
 14 **uals and States To Improve**  
 15 **Long-Term Care Choices**

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

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

21 “STATE CHOICES FOR LONG-TERM CARE PROGRAM

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

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

3 “(b) PROGRAM REQUIREMENTS.—A program estab-  
4 lished under the authority of this section shall satisfy the  
5 following requirements:

6 “(1) INDIVIDUALIZED BENEFIT PACKAGE.—  
7 Each individual enrolled in the program shall be pro-  
8 vided with long-term care coverage consisting of  
9 medical assistance for long-term care services that  
10 are provided according to the specific needs of the  
11 individual and that best reflect the individual’s needs  
12 and preferences, based on a clinical assessment of  
13 the individual.

14 “(2) PERSONAL CASE MANAGERS.—Each indi-  
15 vidual enrolled in the program shall be provided with  
16 a personal case manager who shall assist the indi-  
17 vidual in—

18 “(A) determining the individual’s needs  
19 and preferences for the long-term care services  
20 that are contained within the individual’s ben-  
21 efit package, including the selection of the serv-  
22 ice providers for such services;

23 “(B) identifying community resources that  
24 are available to provide support for the indi-  
25 vidual; and

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

4           “(3) INFORMED CHOICE.—The program shall  
5           have procedures to ensure that each individual that  
6           is likely to satisfy the eligibility criteria established  
7           for the program under paragraph (6) who is dis-  
8           charged from a hospital or who resides in a nursing  
9           facility, intermediate care facility for the mentally  
10          retarded, or institution for mental diseases and who  
11          requires long-term care services is informed of the  
12          options available to the individual under the pro-  
13          gram for obtaining such services.

14          “(4) SELF-DIRECTED OPTION.—The program  
15          shall provide an individual enrolled in the program  
16          with the option to elect to plan and purchase the  
17          long-term care services that are contained in the in-  
18          dividual’s benefit package under the direction and  
19          control of the individual (or the individual’s author-  
20          ized representative), subject to an individualized  
21          budget developed for, and with the involvement of,  
22          the individual (or the individual’s authorized rep-  
23          resentative).

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

1 program shall provide an individual enrolled in the  
2 program who, because of the individual's mental or  
3 physical condition, requires a level of care for long  
4 term care services that is above a level of care for  
5 such services that can appropriately be provided  
6 solely through home and community-based providers  
7 (as defined by the State and approved by the Sec-  
8 retary), with equal access to long-term care services  
9 provided through institutional facilities and long-  
10 term care services provided through home and com-  
11 munity-based providers.

12 “(6) ELIGIBILITY; PRIORITIZATION OF NEED.—  
13 The program shall apply eligibility criteria for indi-  
14 viduals desiring to enroll in the program that is es-  
15 tablished by the State and approved by the Sec-  
16 retary. The eligibility criteria established by the  
17 State shall—

18 “(A) require that an individual enrolled in  
19 the program—

20 “(i) be eligible for medical assistance  
21 under the State plan (or under a statewide  
22 waiver of such plan) for nursing facility  
23 services, services in an intermediate care  
24 facility for the mentally retarded, services  
25 in an institution for mental diseases, or

1 services provided under a home and com-  
2 munity-based waiver approved for the  
3 State; and

4 “(ii) satisfy such other criteria as the  
5 State shall establish; and

6 “(B) be based on a strategy for prioritizing  
7 and allocating expenditures so that those indi-  
8 viduals with the highest level of need for long-  
9 term care services are assured of receiving such  
10 services through an institutional facility or  
11 through a home and community-based provider,  
12 based on the individual’s needs and preferences.

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

16 “(1) AGREEMENT TO LIMIT FEDERAL EXPENDI-  
17 TURES.—

18 “(A) IN GENERAL.—The State agrees to  
19 an aggregate limit for a 5-year period for Fed-  
20 eral payments under section 1903(a) for ex-  
21 penditures for medical assistance for long-term  
22 care services under the State plan and adminis-  
23 trative expenditures related to the provision of  
24 such assistance.

1           “(B) CALCULATION OF AGGREGATE  
2           LIMIT.—The 5-year aggregate limit applicable  
3           to a State under subparagraph (A) shall be de-  
4           termined by the State and the Secretary based  
5           on the following:

6                   “(i) HISTORICAL AND PROJECTED  
7                   CASELOADS.—The historical and projected  
8                   State caseloads (determined for a 5-year  
9                   period, respectively) of individuals receiving  
10                  nursing facility services, services in an in-  
11                  termediate care facility for the mentally re-  
12                  tarded, services in an institution for men-  
13                  tal diseases, or services provided under a  
14                  home and community-based waiver ap-  
15                  proved for the State under the State plan,  
16                  based on data from the Secretary, the Bu-  
17                  reau of the Census, the Commissioner of  
18                  Social Security, and such other sources as  
19                  the Secretary may approve.

20                   “(ii) HISTORICAL AND PROJECTED  
21                   EXPENDITURES.—The historical and pro-  
22                   jected expenditures (determined for a 5-  
23                   year period, respectively) for the services  
24                   identified in clause (i). Projected expendi-  
25                   tures shall be determined without regard to

1           the program established under this section  
2           and shall take into account the percentage  
3           change (if any) in the medical care compo-  
4           nent of the consumer price index for all  
5           urban consumers (U.S. city average) for  
6           each year of the period.

7           “(C) RULE OF CONSTRUCTION.—Nothing  
8           in this paragraph shall be construed as affect-  
9           ing the requirement for a State to incur State  
10          expenditures for medical assistance for long-  
11          term care services in order to be paid the Fed-  
12          eral medical assistance percentage determined  
13          for the State for such expenditures (not to ex-  
14          ceed the aggregate 5-year limit on Federal pay-  
15          ments for such expenditures applicable under  
16          subparagraph (A)).

17          “(2) PLAN FOR CAPACITY BUILDING AND  
18          SKILLS ENHANCEMENT.—The State establishes a  
19          plan for building the capacity of the long-term care  
20          services system within the State, particularly with  
21          respect to the delivery of home and community-  
22          based services, and for enhancing the skill levels of  
23          the caregivers for individuals eligible for medical as-  
24          sistance for such services under the State plan.



1           “(3) DEDICATION OF PROGRAM SAVINGS FOR  
2 PREVENTION OR EARLY INTERVENTION SERVICES.—

3 The State agrees that for each fiscal year in which  
4 the program is operated, the State will expend an  
5 amount equal to the State share of the expenditures  
6 that the State would have made under the State  
7 plan for providing medical assistance for long-term  
8 care services for individuals enrolled in the program  
9 but for the operation of such program, for the provi-  
10 sion of prevention or early intervention services for  
11 nonenrolled individuals residing in the State who re-  
12 quire a level of long-term care services that is below  
13 the level that individuals enrolled in the program re-  
14 quire (regardless of whether such nonenrolled indi-  
15 viduals are eligible for medical assistance under the  
16 State plan).

17           “(d) OPTION TO OPERATE PROGRAM THROUGH A  
18 MANAGED CARE PLAN.—A State may operate a program  
19 under this section through an arrangement on a capitated  
20 basis with a medicaid managed care organization (as de-  
21 fined in section 1903(m)(1)(A)).

22           “(e) INDEPENDENT EVALUATION AND REPORT.—

23           “(1) IN GENERAL.—The Secretary shall con-  
24 tract with a nongovernmental organization or aca-

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

3               “(A) the quality of the long-term care serv-  
4               ices provided under the program;

5               “(B) the cost-effectiveness of such services;

6               “(C) consumer satisfaction; and

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

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

14              “(f) DEFINITION OF LONG-TERM CARE SERVICES.—  
15              For purposes of this section, the term ‘long-term care  
16              services’ has the meaning given such term by a State es-  
17              tablishing and operating a program under this section,  
18              subject to approval by the Secretary.”.

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

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

24              (a) QUALIFIED LONG-TERM CARE INSURANCE CON-  
25              TRACT MUST SATISFY QUALIFIED LONG-TERM CARE

1 PLAN REQUIREMENTS.—Section 7702B(b)(1)(A) (defin-  
 2 ing qualified long-term care insurance contract) is amend-  
 3 ed by inserting “through a qualified long-term care plan”  
 4 after “qualified long-term care services”.

5 (b) QUALIFIED LONG-TERM CARE PLAN.—Section  
 6 7702B is amended by adding at the end the following new  
 7 subsection:

8 “(h) QUALIFIED LONG-TERM CARE PLAN.—For pur-  
 9 poses of this section—

10 “(1) IN GENERAL.—The term ‘qualified long-  
 11 term care plan’ means an insurance plan that meets  
 12 the standards and requirements set forth in para-  
 13 graph (2) (including the 2009 NAIC Model Regula-  
 14 tion or 2009 Federal Regulation (as the case may  
 15 be)) on or after the date specified in paragraph (5).

16 “(2) DEVELOPMENT OF STANDARDS AND RE-  
 17 QUIREMENTS FOR QUALIFIED LONG-TERM CARE  
 18 PLANS.—

19 “(A) IN GENERAL.—If, within 9 months  
 20 after the date of the enactment of this sub-  
 21 section, the National Association of Insurance  
 22 Commissioners (in this subsection referred to as  
 23 the ‘Association’) adopts a model regulation (in  
 24 this section referred to as the ‘2009 NAIC  
 25 Model Regulation’) to incorporate—

1           “(i) limitations on the groups or pack-  
2           ages of benefits that may be offered under  
3           a long-term care insurance policy con-  
4           sistent with paragraphs (3) and (4),

5           “(ii) uniform language and definitions  
6           to be used with respect to such benefits,

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

9           “(iv) other standards required by the  
10          Secretary of Health and Human Services

11         paragraph (1) shall be applied in each State, ef-  
12         fective for policies issued to policyholders on  
13         and after the date specified in paragraph (5).

14         “(B) SECRETARIAL RESPONSIBILITY.—If  
15         the Association does not adopt the 2009 NAIC  
16         Model Regulation within the 9-month period  
17         specified in subparagraph (A), the Secretary  
18         shall promulgate, not later than 9 months after  
19         the end of such period, a regulation (in this sec-  
20         tion referred to as the ‘2009 Federal Regula-  
21         tion’) and paragraph (1) shall be applied in  
22         each State, effective for policies issued to pol-  
23         icyholders on and after the date specified in  
24         paragraph (5).

1           “(C) CONSULTATION.—In promulgating  
2 standards and requirements under this para-  
3 graph, the Association or Secretary shall con-  
4 sult with a working group composed of rep-  
5 resentatives of issuers of long-term care insur-  
6 ance policies, consumer groups, long-term care  
7 insurance beneficiaries, and other qualified indi-  
8 viduals. Such representatives shall be selected  
9 in a manner so as to insure balanced represen-  
10 tation among the interested groups.

11           “(3) LIMITATIONS OF GROUPS OR PACKAGES OF  
12 BENEFITS.—The benefits under the 2009 NAIC  
13 Model Regulation or 2009 Federal Regulation shall  
14 provide—

15           “(A) for such groups or packages of bene-  
16 fits as may be appropriate taking into account  
17 the considerations specified in paragraph (4)  
18 and the requirements of the succeeding sub-  
19 paragraphs,

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

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

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

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

6                   “(A) provide for benefits that offer con-  
7                   sumers the ability to purchase the benefits that  
8                   are available in the market as of November 5,  
9                   2008, and

10                   “(B) balance the objectives of—

11                           “(i) simplifying the market to facili-  
12                           tate comparisons among policies,

13                           “(ii) avoiding adverse selection,

14                           “(iii) providing consumer choice,

15                           “(iv) providing market stability, and

16                           “(v) promoting competition.

17           “(5) EFFECTIVE DATE.—

18                   “(A) IN GENERAL.—Subject to subpara-  
19                   graph (B), the date specified in this paragraph  
20                   shall be the date the State adopts the 2009  
21                   NAIC Model Regulation or 2009 Federal Regu-  
22                   lation or 1 year after the date the Association  
23                   or the Secretary first adopts such standards,  
24                   whichever is earlier.

1           “(B) REQUIRED STATE LEGISLATION.—In  
2 the case of a State which the Secretary identi-  
3 fies, in consultation with the Association, as—

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

9           “(ii) having a legislature which is not  
10 scheduled to meet in 2009 in a legislative  
11 session in which such legislation may be  
12 considered,

13 the date specified in this paragraph is the first  
14 day of the first calendar quarter beginning after  
15 the close of the first legislative session of the  
16 State legislature that begins on or after Janu-  
17 ary 1, 2010. For purposes of the preceding sen-  
18 tence, in the case of a State that has a 2-year  
19 legislative session, each year of such session  
20 shall be deemed to be a separate regular session  
21 of the State legislature.”.

22 (c) ADDITIONAL CONSUMER PROTECTIONS.—

23           (1) IN GENERAL.—Section 7702B(g)(1) (relat-  
24 ing to consumer protection provisions) is amended—

1 (A) by striking subparagraph (A) and in-  
2 serting the following new paragraph:

3 “(1) the requirements of the 1993 NAIC model  
4 regulation and model Act described in paragraph (2)  
5 and the 2000 NAIC model regulation and model Act  
6 described in paragraph (5),”

7 (B) by striking “and” at the end of sub-  
8 paragraph (B),

9 (C) by striking the period at the end of  
10 subparagraph (C) and inserting “, and”, and

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

13 “(D) the requirements relating to manda-  
14 tory offer and information under paragraph  
15 (6).”.

16 (2) NAIC MODEL REGULATION AND ACT.—Sec-  
17 tion 7702B(g) is amended—

18 (A) by inserting “1993 NAIC” after “RE-  
19 QUIREMENTS OF” in the heading for paragraph  
20 (2),

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

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



1           “(5) REQUIREMENTS OF 2000 NAIC MODEL REG-  
2           ULATION AND ACT.—

3           “(A) IN GENERAL.—The requirements of  
4           this paragraph are met with respect to any con-  
5           tract if such contract meets—

6           “(i) MODEL REGULATION.—The fol-  
7           lowing requirements of the model regula-  
8           tion:

9           “(I) Section 6A (other than para-  
10           graph (5) thereof) and the require-  
11           ments of section 6B of the model Act  
12           relating to such section 6A.

13           “(II) Section 6B (other than  
14           paragraph (7) thereof).

15           “(III) Sections 6C, 6D, 6E, and  
16           7.

17           “(IV) Section 8 (other than sec-  
18           tions 8F, 8G, 8H, and 8I thereof).

19           “(V) Sections 9, 11, 12, 14, 15,  
20           and 22.

21           “(VI) Section 23, including inac-  
22           curate completion of medical histories  
23           (other than paragraphs (1), (6), and  
24           (9) of section 23C).

25           “(VII) Sections 24 and 25.

1                   “(VIII) The provisions of section  
2                   26 relating to contingent nonforfeiture  
3                   benefits, if the policyholder declines  
4                   the offer of a nonforfeiture provision  
5                   described in paragraph (4).

6                   “(IX) Sections 29 and 30.

7                   “(ii) MODEL ACT.—The following re-  
8                   quirements of the model Act:

9                   “(I) Sections 6C and 6D.

10                   “(II) The provisions of section 8  
11                   relating to contingent nonforfeiture  
12                   benefits.

13                   “(III) Sections 6F, 6G, 6H, 6J,  
14                   6K, and 7.

15                   “(B) DEFINITIONS.—For purposes of this  
16                   paragraph—

17                   “(i) MODEL PROVISIONS.—The terms  
18                   ‘model regulation’ and ‘model Act’ mean  
19                   the long-term care insurance model regula-  
20                   tion, and the long-term care insurance  
21                   model Act, respectively, promulgated by  
22                   the National Association of Insurance  
23                   Commissioners (as adopted as of October  
24                   2000).

1           “(ii) COORDINATION.—Any provision  
 2           of the model regulation or model Act listed  
 3           under clause (i) or (ii) of subparagraph  
 4           (A) shall be treated as including any other  
 5           provision of such regulation or Act nec-  
 6           essary to implement the provision.

7           “(iii) DETERMINATION.—For pur-  
 8           poses of this section and section 4980C,  
 9           the determination of whether any require-  
 10          ment of a model regulation or the model  
 11          Act has been met shall be made by the  
 12          Secretary.”.

13          (d) MANDATORY OFFER AND INFORMATION.—Sec-  
 14          tion 7702B(g), as amended by subsection (c), is amended  
 15          by inserting after paragraph (5) the following new para-  
 16          graph:

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

19                 “(A) MANDATORY OFFER.—Any person  
 20                 who sells a long-term care insurance policy to  
 21                 an individual shall make available for sale to  
 22                 the individual a long-term care insurance policy  
 23                 with only the core group of basic benefits (de-  
 24                 scribed in subsection (h)(3)(B)).

1           “(B) INFORMATION.—Any person who sells  
2           a long-term care insurance policy to an indi-  
3           vidual shall provide the individual, before the  
4           sale of the policy, an outline of coverage which  
5           describes the benefits under the policy. Such  
6           outline shall be on a standard form approved by  
7           the State regulatory program or the Secretary  
8           (as the case may be) consistent with the 2009  
9           NAIC Model Regulation or 2009 Federal Regu-  
10          lation.”.

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

14          “(i) STATE REGULATION OF OUT-OF-STATE CON-  
15          TRACTS.—Nothing in this section shall be construed so as  
16          to affect the right of any State to regulate long-term care  
17          insurance policies which, under the provisions of this sec-  
18          tion, are considered to be issued in another State.”.

19          (f) EFFECTIVE DATE.—The amendments made by  
20          this section shall apply to contracts issued after December  
21          31, 2008.

1                   **TITLE IV—HEALTHIER**  
2                   **MEDICARE**  
3 **Subtitle A—Authority To Adjust**  
4 **Amount of Part B Premium To**  
5 **Reward Positive Health Behav-**  
6 **ior**

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

10           Section 1839 of the Social Security Act (42 U.S.C.  
11 1395r) is amended—

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

14                   (2) by adding at the end the following new sub-  
15           section:

16           “(j)(1) With respect to the monthly premium amount  
17 for months after December 2008, the Secretary may ad-  
18 just (under procedures established by the Secretary) the  
19 amount of such premium for an individual based on  
20 whether or not the individual participates in certain  
21 healthy behaviors, such as weight management, exercise,  
22 nutrition counseling, refraining from tobacco use, desig-  
23 nating a health home, and other behaviors determined ap-  
24 propriate by the Secretary.

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

8       **Subtitle B—Promoting Primary**  
 9       **Care for Medicare Beneficiaries**

10       **SEC. 411. PRIMARY CARE SERVICES MANAGEMENT PAY-**  
 11       **MENT.**

12       Title XVIII of the Social Security Act (42 U.S.C.  
 13 1395 et seq.) is amended by inserting after section 1807  
 14 the following new section:

15       **“SEC. 1807A. PRIMARY CARE MANAGEMENT PAYMENT FOR**  
 16       **COORDINATING CARE.**

17       “(a) PAYMENT.—

18               “(1) IN GENERAL.—Not later than January 1,  
 19 2008, the Secretary, subject to paragraph (2), shall  
 20 establish procedures for providing primary care and  
 21 participating providers with a management fee (as  
 22 determined appropriate by the Secretary, in con-  
 23 sultation with the Medicare Payment Advisory Com-  
 24 mission established under section 1805) that reflects  
 25 the amount of time spent with a Medicare bene-

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

4           “(2) REQUIREMENT FOR DESIGNATION AS  
5       HEALTH HOME.—The management fee under para-  
6       graph (1) shall not be provided to a primary care  
7       provider with respect to a Medicare beneficiary un-  
8       less the provider has been designated (under proce-  
9       dures established by the Secretary) as the health  
10      home by the beneficiary.

11      “(b) DEFINITIONS.—In this section:

12           “(1) HEALTH HOME.—The term ‘health home’  
13      means a health care provider that a Medicare bene-  
14      ficiary has designated to monitor the health and  
15      health care of the beneficiary.

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

20           “(3) PRIMARY CARE PROVIDER.—

21           “(A) IN GENERAL.—The term ‘primary  
22      care provider’ means a primary care physician  
23      (as defined in subparagraph (B), a nurse prac-  
24      titioner (as defined in section 1861aa(5)(A)), or  
25      a physician assistant (as so defined).

1           “(B) PRIMARY CARE PHYSICIAN.—In sub-  
 2           paragraph (A), the term ‘primary care physi-  
 3           cian’ means a physician, such as a family prac-  
 4           titioner or internist, who is chosen by an indi-  
 5           vidual to provide continuous medical care, who  
 6           is able to give a wide range of care, including  
 7           prevention and treatment, and who can refer  
 8           the individual to a specialist.”.

## 9       **Subtitle C—Chronic Care Disease** 10       **Management**

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

12       Title XVIII of the Social Security Act (42 U.S.C.  
 13   1395 et seq.), as amended by section 411, is amended by  
 14   inserting after section 1807A the following new section:

### 15   **“SEC. 1807B. CHRONIC CARE DISEASE MANAGEMENT PRO-** 16       **GRAM.**

17       “(a) ESTABLISHMENT.—

18           “(1) IN GENERAL.—Not later than January 1,  
 19       2008, the Secretary shall develop and implement a  
 20       chronic care disease management program (in this  
 21       section referred to as the ‘program’). The program  
 22       shall be designed to provide chronic care disease  
 23       management to all Medicare beneficiaries with re-  
 24       spect to at least the 5 most prevalent diseases within



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

3 “(2) DEVELOPMENT.—In developing and imple-  
4 menting the program under paragraph (1), the Sec-  
5 retary shall—

6 “(A) take into consideration—

7 “(i) the results of chronic care im-  
8 provement programs conducted under sec-  
9 tion 1807, including the independent eval-  
10 uations of such programs conducted under  
11 section 1807(b)(5) and any outcomes re-  
12 ports submitted under section  
13 1807(e)(4)(A); and

14 “(ii) the results of the payments to  
15 primary care providers under section  
16 1807A; and

17 “(B) consult individuals with expertise in  
18 chronic care disease management.

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

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

1           “(1) IN GENERAL.—Under the program, a non-  
2 primary care physician shall receive a chronic care  
3 disease management payment if the physician serves  
4 the Medicare beneficiary by assuring the beneficiary  
5 receives appropriate and comprehensive care, includ-  
6 ing referral of the individual to specialists, and as-  
7 suring the beneficiary receives preventive services.

8           “(2) AMOUNT OF PAYMENT.—The amount of  
9 the management payment under the program shall  
10 be an amount determined appropriate by the Sec-  
11 retary, in consultation with the Medicare Payment  
12 Advisory Commission established under section  
13 1805. Such amount shall reflect the amount of time  
14 spent with a Medicare beneficiary, and the family of  
15 such beneficiary, providing chronic care disease man-  
16 agement services.

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

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

22           “(2) NON-PRIMARY CARE PHYSICIAN.—The  
23 term ‘non-primary care physician’ means a physician  
24 who—

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

3           “(B) provides chronic care disease manage-  
4           ment services to a Medicare beneficiary under  
5           the program.”.

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

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

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

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

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

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

21 **Subtitle D—Part D Improvements**

22 **SEC. 431. NEGOTIATING FAIR PRICES FOR MEDICARE PRE-**  
23 **SCRIPTION DRUGS.**

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

1 ing subsection (i) (relating to noninterference) and by in-  
2 serting the following:

3 “(i) AUTHORITY TO NEGOTIATE PRICES WITH MAN-  
4 UFACTURERS.—

5 “(1) IN GENERAL.—Subject to paragraph (4),  
6 in order to ensure that beneficiaries enrolled under  
7 prescription drug plans and MA–PD plans pay the  
8 lowest possible price, the Secretary shall have au-  
9 thority similar to that of other Federal entities that  
10 purchase prescription drugs in bulk to negotiate con-  
11 tracts with manufacturers of covered part D drugs,  
12 consistent with the requirements and in furtherance  
13 of the goals of providing quality care and containing  
14 costs under this part.

15 “(2) MANDATORY RESPONSIBILITIES.—The  
16 Secretary shall be required to—

17 “(A) negotiate contracts with manufactur-  
18 ers of covered part D drugs for each fallback  
19 prescription drug plan under subsection (g);  
20 and

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

1           “(3) RULE OF CONSTRUCTION.—Nothing in  
2 paragraph (2) shall be construed to limit the author-  
3 ity of the Secretary under paragraph (1) to the man-  
4 datory responsibilities under paragraph (2).

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

11           “(5) USE OF SAVINGS TO REDUCE COVERAGE  
12 GAP.—The Secretary shall establish a process for  
13 using the savings to the Medicare Prescription Drug  
14 Account through the use of the authority provided  
15 under this subsection (including the mandatory re-  
16 sponsibilities under paragraph (2)) to reduce the  
17 coverage gap under section 1860D–2.”.

18           (b) CONFORMING AMENDMENT.—Section 1860D–  
19 2(b) of the Social Security Act (42 U.S.C. 1395w–102(b))  
20 is amended in the matter preceding paragraph (1) by  
21 striking “For purposes” and inserting “Subject to section  
22 1860D–11(i)(5), for purposes”.

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

1 **SEC. 432. PROCESS FOR INDIVIDUALS ENTERING THE**  
2 **MEDICARE COVERAGE GAP TO SWITCH TO A**  
3 **PLAN THAT PROVIDES COVERAGE IN THE**  
4 **GAP.**

5 (a) PROCESS.—Notwithstanding any other provision  
6 of law, by not later than 30 days after the date of enact-  
7 ment of this Act, the Secretary of Health and Human  
8 Services (in this section referred to as the “Secretary”)  
9 shall establish a process under which an applicable indi-  
10 vidual may terminate enrollment in the prescription drug  
11 plan or the MA–PD plan in which they are enrolled and  
12 enroll in any prescription drug plan or MA–PD plan—

13 (1) that provides some coverage of covered part  
14 D drugs (as defined in subsection (e) of section  
15 1860D–2 of the Social Security Act (42 U.S.C.  
16 1395w–102)) after the individual has reached the  
17 initial coverage limit under the plan but has not  
18 reached the annual out-of-pocket threshold under  
19 subsection (b)(4)(B) of such section; and

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

22 (b) SPECIAL RULE PERMITTING APPLICABLE INDI-  
23 VIDUALS TO ENROLL IN A PRESCRIPTION DRUG PLAN  
24 OUTSIDE OF THE REGION IN WHICH THE INDIVIDUAL  
25 RESIDES.—In the case of an applicable individual who re-  
26 sides in a PDP region under section 1860D–11(a)(2) of

1 the Social Security Act (42 U.S.C. 1395w–111(a)(2)) in  
2 which there is no prescription drug plan available that pro-  
3 vides some coverage of brand name covered part D drugs  
4 (as so defined) after the individual has reached the initial  
5 coverage limit under the plan but before the individual has  
6 reached such annual out-of-pocket threshold, the Sec-  
7 retary shall ensure that the process established under sub-  
8 section (a) permits the individual to enroll in a prescrip-  
9 tion drug plan that provides such coverage but is in an-  
10 other PDP region. The Secretary shall determine the PDP  
11 region in which the individual may enroll in such a pre-  
12 scription drug plan.

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

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

24 (e) DEFINITIONS.—In this section:

1           (1) APPLICABLE INDIVIDUAL.—The term “ap-  
2           plicable individual” means a part D eligible indi-  
3           vidual (as defined in section 1860D–1(a)(3)(A) of  
4           the Social Security Act (42 U.S.C. 1395w–  
5           101(a)(3)(A)) who, with respect to a year—

6                   (A) is enrolled in a prescription drug plan  
7                   or an MA–PD plan that does not provide any  
8                   coverage of covered part D drugs (as so de-  
9                   fined) after the individual has reached the ini-  
10                  tial coverage limit under the plan but has not  
11                  reached such annual out-of-pocket threshold;  
12                  and

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

15           (2) PRESCRIPTION DRUG PLAN; MA–PD PLAN.—

16           The terms “prescription drug plan” and “MA–PD  
17           plan” have the meanings given those terms in sec-  
18           tion 1860D–41(a)(14) of the Social Security Act (42  
19           U.S.C. 1395w–151(a)(14)) and section 1860D–  
20           1(a)(3)(C) of such Act (42 U.S.C. 1395w–  
21           101(a)(3)(C)), respectively.



1     **Subtitle E—Improving Quality in**  
2             **Hospitals for All Patients**

3     **SEC. 441. IMPROVING QUALITY IN HOSPITALS FOR ALL PA-**  
4             **TIENTS.**

5             (a) IMPROVING HEALTHCARE QUALITY FOR ALL PA-  
6     TIENTS.—

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

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

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

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

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

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

23            “(ii) heart attack treatments with proven  
24            reliability;

1           “(iii) procedures that reduce medication  
2 errors;

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

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

9           “(vi) such other elements as the Secretary  
10 determines appropriate.”.

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

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

1           **Subtitle F—End-of-Life Care**  
2                           **Improvements**

3   **SEC. 451. PATIENT EMPOWERMENT AND FOLLOWING A PA-**  
4                           **TIENT’S HEALTH CARE WISHES.**

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

8                   (1) in subparagraph (V), by striking “and” at  
9           the end;

10                   (2) in subparagraph (W), by striking the period  
11           at the end and inserting “, and”; and

12                   (3) by inserting after subparagraph (W) the fol-  
13           lowing new subparagraph:

14                   “(X) to provide each patient with a document  
15           designed to promote patient autonomy by docu-  
16           menting the patient’s treatment preferences (and co-  
17           ordinating these preferences with physician orders)  
18           that at a minimum—

19                           “(i) transfers with the patient from one  
20           setting to another;

21                           “(ii) provides a summary of treatment  
22           preferences in multiple scenarios by the patient  
23           or the patient’s guardian and a physician or  
24           other practitioner’s order for care;

1           “(iii) is easy to read in an emergency situ-  
2           ation;

3           “(iv) reduces repetitive activities in com-  
4           plying with the Patient Self Determination Act;

5           “(v) ensures that the use of the document  
6           is voluntary by the patient or the patient’s  
7           guardian;

8           “(vi) is easily accessible in a patient’s med-  
9           ical chart; and

10           “(vii) does not supplant State health care  
11           proxy, living wills, or other end-of-life care  
12           forms.”.

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

16           **SEC. 452. PERMITTING HOSPICE BENEFICIARIES TO RE-**  
17           **CEIVE CURATIVE CARE.**

18           (a) **IN GENERAL.**—Section 1812 of the Social Secu-  
19           rity Act (42 U.S.C. 1395d) is amended—

20           (1) in subsection (a)(4), by striking “in lieu of  
21           certain other benefits,”; and

22           (2) in subsection (d)—

23           (A) in paragraph (1), by striking “instead  
24           of certain other benefits under this title”; and

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

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

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

11 **SEC. 453. PROVIDING BENEFICIARIES WITH INFORMATION**  
12                           **REGARDING END-OF-LIFE CARE CLEARING-**  
13                           **HOUSE.**

14           Section 1804 of the Social Security Act (42 U.S.C.  
15 1395b–2) is amended—

16           (1) in the heading, by inserting “; END-OF-LIFE  
17           CARE INFORMATION” after “INFORMATION”; and

18           (2) by adding at the end the following new sub-  
19           section:

20           “(d) Not later than 1 year after the date of enact-  
21           ment of the Healthy Americans Act, the Secretary shall  
22           establish procedures to ensure that each individual, at the  
23           time the individual applies for benefits under part A or  
24           enrolls under part B, is provided with contact information

1 for the clearinghouse described in section 454 of such  
2 Act.”.

3 **SEC. 454. CLEARINGHOUSE.**

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

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

21 **Subtitle G—Additional Provisions**

22 **SEC. 461. ADDITIONAL COST INFORMATION.**

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



1 after the date of enactment of this Act, establish or des-  
2 ignate a State agency, to be known as the State “Health  
3 Help Agency” (referred to in this Act as a “HHA”) to—

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

6 (2) carry out the functions described in section  
7 502.

8 **SEC. 502. RESPONSIBILITIES AND AUTHORITIES.**

9 (a) PROMOTION OF PREVENTION AND WELLNESS.—

10 Each HHA shall promote prevention and wellness for all  
11 State residents, including through the implementation of  
12 programs that—

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

15 (2) upon request, distribute information to cov-  
16 ered individuals regarding the availability of wellness  
17 programs;

18 (3) make available to the public, with respect to  
19 each health insurance issuer and each HAPI plan,  
20 the number of covered individuals who have des-  
21 ignated a health home described in section 111(b);  
22 and

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



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

3 (1) providing standardized, unbiased informa-  
4 tion on HAPI plans and supplemental health insur-  
5 ance options;

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

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

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

18 (5) establish procedures for default enrollment  
19 of uninsured individuals into low-cost HAPI plans  
20 for individuals or families who do not enroll, are not  
21 covered under a health plan offered through a pro-  
22 gram described in paragraphs (1)(A) of section  
23 102(a), and are not described in paragraph (1)(B)  
24 of such section;

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

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

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

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

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

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

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

3           (2) obtaining necessary information about in-  
4           come from individuals and Federal and State agen-  
5           cies;

6           (3) making eligibility determinations on an indi-  
7           vidual basis and informing individuals of such deter-  
8           minations;

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

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

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

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

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

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

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

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

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

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

12 (4) applicable State forms on health proxies,  
13 advanced directives, living wills, and other such doc-  
14 umentation.

15 (f) DETERMINATION OF PLAN COVERAGE AREAS.—

16 Each HHA shall establish, and may revise, HAPI plan  
17 coverage areas for the State in which the HHA is located.

18 The service area of a HAPI plan shall consist of an entire  
19 coverage area established under the preceding sentence.

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

24 (h) TRANSITION FROM MEDICAID AND SCHIP; CO-  
25 ORDINATION OF SUPPLEMENTAL MEDICAL ASSISTANCE

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

8 **SEC. 503. APPROPRIATIONS FOR TRANSITION TO STATE**  
9 **HEALTH HELP AGENCIES.**

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

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

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

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

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

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

11                           **TITLE VI—SHARED**  
12                           **RESPONSIBILITIES**  
13                           **Subtitle A—Individual**  
14                           **Responsibilities**

15   **SEC. 601. INDIVIDUAL RESPONSIBILITY TO ENSURE HAPI**  
16                           **PLAN COVERAGE.**

17          (a) OPEN SEASON.—An adult individual, on behalf  
18          of such individual and the dependent children of such indi-  
19          vidual, shall—

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

23               (2) submit necessary documentation to the ap-  
24               plicable HHA so that such HHA may determine in-

1       dividual eligibility for premium and personal respon-  
2       sibility contribution subsidies.

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

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

8           (1) submit any required monthly premium pay-  
9       ments;

10          (2) submit any personal responsibility contribu-  
11       tions as required; and

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

## 14                   **Subtitle B—Employer** 15                   **Responsibilities**

### 16   **SEC. 611. HEALTH CARE RESPONSIBILITY PAYMENTS.**

17       (a) PAYMENT REQUIREMENTS.—

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

### 21                   **“CHAPTER 24A—HEALTH CARE** 22                   **RESPONSIBILITY PAYMENTS**

“SUBCHAPTER A—EMPLOYER SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER B—INDIVIDUAL SHARED RESPONSIBILITY PAYMENTS

“SUBCHAPTER C—GENERAL PROVISIONS

1                   **“Subchapter A—Employer Shared**  
 2                   **Responsibility Payments**

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

3   **“SEC. 3411. PAYMENT REQUIREMENT.**

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

8                   “(1) the number of full-time equivalent employ-  
 9 ees employed by the employer during the preceding  
 10 calendar year, multiplied by

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

13           “(b) APPLICABLE PERCENTAGE.—For purposes of  
 14 subsection (a)(2)—

15                   “(1) IN GENERAL.—The applicable percentage  
 16 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%.

17                   “(2) APPLICABLE PERCENTAGE FOR CERTAIN  
 18 NON-REVENUE PRODUCING ENTITIES.—In the case  
 19 of an employer which is a nonprofit entity, a State



1 or local government, or any other type of entity for  
2 which the Secretary determines that calculating rev-  
3 enue per employee is not appropriate, the applicable  
4 percentage shall be—

5 “(A) in the case of a large employer, 17  
6 percent, and

7 “(B) in the case of a small employer, 2  
8 percent.

9 “(3) ADDITIONAL RATE FOR CERTAIN SMALL  
10 EMPLOYERS.—

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

17 “(B) MAXIMUM ADDITIONAL RATE.—The  
18 increase in the applicable percentage deter-  
19 mined under this paragraph shall not exceed 15  
20 percent.

21 “(4) REVENUE PER EMPLOYEE NATIONAL PER-  
22 CENTILE RANK.—At the beginning of each calendar  
23 year, the Secretary, in consultation with the Sec-  
24 retary of Labor, shall publish a table, based on sam-  
25 pling of employers, to be used in determining the na-

1 tional percentile for revenue per employee amounts  
2 for the preceding calendar year.

3 “(c) TRANSITION RATES.—

4 “(1) TRANSITION RATE FOR EMPLOYERS PRE-  
5 VIOUSLY PROVIDING HEALTH INSURANCE.—

6 “(A) IN GENERAL.—In the case of the first  
7 and second calendar years to which this section  
8 applies, in the case of any employer who pro-  
9 vided health insurance coverage for employees  
10 on the day before the date of enactment of the  
11 Healthy Americans Act, the employer shared  
12 responsibility payment shall be, in lieu of the  
13 amount determined under subsection (a), an  
14 amount equal to—

15 “(i) 100 percent of the designated em-  
16 ployee health insurance premium amount  
17 of such employer, minus

18 “(ii) the employee salary investment  
19 amount.

20 “(B) EMPLOYEE SALARY INVESTMENT  
21 AMOUNT.—For purposes of this paragraph—

22 “(i) IN GENERAL.—The term ‘em-  
23 ployee salary investment amount’ means  
24 the lesser of—

1                   “(I) the excess of the amount of  
2                   average yearly wages paid to all em-  
3                   ployees for such year over the amount  
4                   of average yearly wages paid to such  
5                   employee for the year before the first  
6                   year this section applies, or

7                   “(II) the designated employee  
8                   health insurance premium amount of  
9                   such employer.

10                  “(ii) NONDISCRIMINATION RULES.—  
11                  No amount paid by an employer shall be  
12                  treated as an employee salary investment  
13                  amount unless such amount is distributed  
14                  to all employees on a basis that is propor-  
15                  tional to the amount of wages paid to such  
16                  employee before such distribution.

17                  “(iii) NOTICE REQUIREMENT.—No  
18                  amount paid by an employer shall be treat-  
19                  ed as an employee salary investment  
20                  amount unless the employer gives each em-  
21                  ployee notice of the amount of the des-  
22                  ignated employee health insurance pre-  
23                  mium amount paid by the employer with  
24                  respect to the employee.

1           “(C) EMPLOYER SHARED RESPONSIBILITY  
2 CREDIT.—The Secretary may provide a credit  
3 to private employers who provided health insur-  
4 ance benefits greater than the 80th percentile  
5 of the national average in the 2 years prior to  
6 enactment of this Act, can demonstrate the  
7 benefits provided encouraged prevention and  
8 wellness activities as defined in this Act, and  
9 continue to provide wellness programs

10           “(D) SPECIAL RULE FOR SELF-INSURED  
11 EMPLOYERS.—In the case of any employer who  
12 provided health care coverage for employees  
13 through self-insurance, ‘average HAPI plan  
14 premium amount for the first year this section  
15 applies’ shall be substituted for ‘designated em-  
16 ployee health insurance premium amount of  
17 such employer’ in subparagraphs (A)(i) and  
18 (B)(i)(II).

19           “(E) REGULATIONS.—The Secretary may  
20 establish such rules and regulations as nec-  
21 essary to carry out the purposes of this para-  
22 graph.

23           “(2) TRANSITION RATE FOR OTHER EMPLOY-  
24 ERS.—In the case of any employer who did not pro-  
25 vide health insurance to employees on the day before

1 the date of enactment of the Healthy Americans  
2 Act—

3 “(A) the employer shared responsibility  
4 payment for the first year this section applies  
5 shall be an amount equal  $\frac{1}{3}$  of the amount oth-  
6 erwise required under this section (determined  
7 without regard to this subsection), and

8 “(B) the employer shared responsibility  
9 payment for the second year this section applies  
10 shall be an amount equal  $\frac{2}{3}$  of the amount oth-  
11 erwise required under this section (determined  
12 without regard 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 7 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 2 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 2 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; and

14          (15) paying 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.

19          (c) UNIFORM BILLING PRACTICES.—

20                (1) IN GENERAL.—A health insurance issuer of-  
21                fering a HAPI plan in a State shall not receive sub-  
22                sidy payments from the applicable State HHA un-  
23                less such issuer agrees to use standardized common  
24                claim forms prescribed by the applicable State HHA.

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

3           (d) CHRONIC CARE PROGRAMS OFFERED BY  
4 ISSUERS.—

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

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

14          (3) UNIFORM CLINICAL PERFORMANCE STAND-  
15          ARDS.—Each chronic care program offered by a  
16          health insurance issuer shall use a uniform set of  
17          clinical performance standards prescribed by the  
18          HHA of the State in which the issuer offers a HAPI  
19          plan (in consultation with the State Medicare quality  
20          improvement organizations and patient and physi-  
21          cian organizations) which should include encourage-  
22          ment that the issuers not require personal responsi-  
23          bility contributions for clinically-needed services to  
24          treat or manage a covered individual’s chronic dis-  
25          ease, particularly if the individual is taking an active

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

3 (4) REPORTING BY ISSUERS.—Five years after  
4 the date of enactment of this Act and on an annual  
5 basis thereafter, each health insurance issuer shall  
6 report to the applicable State Insurance Commis-  
7 sioner, State Secretary of Health or other state enti-  
8 ty selected by the State HHA, the chronic care man-  
9 agement performance of the issuer as measured by  
10 the uniform clinical performance standards described  
11 in paragraph (3). The issuer shall make such per-  
12 formance public in a manner accessible to the public.

13 (e) PRIVATE INSURANCE COMPANY LOSS RATIO.—

14 (1) IN GENERAL.—The Secretary, in consulta-  
15 tion with consumer and patient organizations, the  
16 National Association of Insurance Commissioners,  
17 and health insurance issuers (including health main-  
18 tenance organizations) shall establish a loss ratio for  
19 issuers of HAPI plans.

20 (2) DETERMINATION OF LOSS RATIO.—In de-  
21 termining the loss ratio, administrative costs shall be  
22 defined as expenses consisting of all actual, allow-  
23 able, allocable, and reasonable expenses incurred in  
24 the adjudication of subscriber benefit claims or in-

1 curred in the health insurance issuer's overall oper-  
2 ation of the business.

3 (3) ADMINISTRATIVE EXPENSES.—

4 (A) IN GENERAL.—Unless otherwise deter-  
5 mined by an agreement between a State HHA  
6 and a health insurance issuer, the administra-  
7 tive expenses of an issuer shall—

8 (i) include all taxes (excluding pre-  
9 mium taxes) reinsurance premiums, med-  
10 ical and dental consultants used in the ad-  
11 judication process, concurrent or managed  
12 care review when not billed by a health  
13 care provider and other forms of utilization  
14 review, the cost of maintaining eligibility  
15 files, legal expenses incurred in the litiga-  
16 tion of benefit payments, and bank charges  
17 for letters of credit; and

18 (ii) not include the cost of personnel,  
19 equipment, and facilities directly used in  
20 the delivery of health care services (benefit  
21 costs), payments to HHAs for establish-  
22 ment and administration of HHAs, and  
23 the cost of overseeing chronic disease man-  
24 agement programs and wellness programs.

## 1   **Subtitle D—State Responsibilities**

### 2   **SEC. 631. STATE RESPONSIBILITIES.**

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

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

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

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

10          and

11          (B) comply with the requirements of this  
12       Act;

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

16          (4) ensure that HAPI plans offer premium dis-  
17       counts and incentives for participation in wellness  
18       programs;

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

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

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

3 (B) fair marketing practices for health in-  
4 surance issuers;

5 (C) grievances and appeals for covered in-  
6 dividuals; and

7 (D) patient protection;

8 (7) eliminate fictitious group prohibitions; and

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

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

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

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

23 (3) implement mechanisms, which may not in-  
24 clude revocation or ineligibility for coverage under a  
25 HAPI plan, to enforce the responsibility of each

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

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

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

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

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

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

5 **SEC. 632. EMPOWERING STATES TO INNOVATE THROUGH**  
6 **WAIVERS.**

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

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

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

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

24 (c) DETERMINATIONS BY SECRETARY.—



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

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

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

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

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

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

1           **Subtitle E—Federal Fallback**  
2           **Guarantee Responsibility**

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

4           (a) FEDERAL GUARANTEE.—

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

15          (2) REQUIREMENT FOR DIFFERENT PLAN  
16          SPONSORS.—The requirement in paragraph (1) is  
17          not satisfied with respect to a coverage area if only  
18          1 entity offers all the HAPI plans in the area.

19          (b) CONTRACTS.—

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

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

6           (c) FALLBACK HAPI PLAN.—For purposes of this  
7 section, the term “fallback HAPI plan” means a HAPI  
8 plan that—

9           (1) meets the requirements described in section  
10 111(b) and does not provide actuarially equivalent  
11 coverage described in section 111(c); and

12           (2) meets such other requirements as the Sec-  
13 retary may specify.

14           **Subtitle F—Federal Financing**  
15                           **Responsibilities**

16           **SEC. 651. APPROPRIATION FOR SUBSIDY PAYMENTS.**

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

1 **SEC. 652. RECAPTURE OF MEDICARE AND 90 PERCENT OF**  
 2 **MEDICAID FEDERAL DSH FUNDS TO**  
 3 **STRENGTHEN MEDICARE AND ENSURE CON-**  
 4 **TINUED SUPPORT FOR PUBLIC HEALTH PRO-**  
 5 **GRAMS.**

6 (a) RECAPTURE OF MEDICARE DSH FUNDS.—

7 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) of  
 8 the Social Security Act (42 U.S.C.  
 9 1395ww(d)(5)(F)(i)) is amended by inserting “and  
 10 before January 1 of the first calendar year in which  
 11 coverage under a HAPI plan begins under the  
 12 Healthy Americans Act,” after “May 1, 1986,”.

13 (2) SAVINGS TO PART A TRUST FUND.—The  
 14 savings to the Federal Hospital Insurance Trust  
 15 Fund by reason of the amendment made by para-  
 16 graph (1) shall be used to strengthen the financial  
 17 solvency of such Trust Fund.

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

20 (1) HEALTHY AMERICANS PUBLIC HEALTH  
 21 TRUST FUND.—Subchapter A of chapter 98 of the  
 22 Internal Revenue Code of 1986 (relating to trust  
 23 fund code) is amended by adding at the end the fol-  
 24 lowing new section:

1 **“SEC. 9511. HEALTHY AMERICANS PUBLIC HEALTH TRUST**  
2 **FUND.**

3 “(a) CREATION OF TRUST FUND.—There is estab-  
4 lished in the Treasury of the United States a trust fund  
5 to be known as the ‘Healthy Americans Public Health  
6 Trust Fund’, consisting of any amount appropriated or  
7 credited to the Trust Fund as provided in this section or  
8 section 9602(b).

9 “(b) TRANSFER TO TRUST FUND OF 90 PERCENT  
10 OF MEDICAID DSH FUNDS.—There are hereby appro-  
11 priated to the Healthy Americans Public Health Trust  
12 Fund the following amounts:

13 “(1) In the case of the second, third, and  
14 fourth quarters of the first fiscal year in which cov-  
15 erage under a HAPI plan begins under the Healthy  
16 Americans Act, an amount equal to 90 percent of  
17 the amount that would otherwise have been appro-  
18 priated for the purpose of making payments to  
19 States under section 1903(a) of the Social Security  
20 Act for the Federal share of disproportionate share  
21 hospital payments made under section 1923 of such  
22 Act for such quarters of that fiscal year but for sub-  
23 sections (c)(2) and (d)(2)(D) of section 1941 of the  
24 such Act, as determined by the Secretary of Health  
25 and Human Services.

1           “(2) In the case of each succeeding fiscal year,  
2           an amount equal to 90 percent of the amount that  
3           would otherwise have been appropriated for the pur-  
4           pose of making payments to States under section  
5           1903(a) of the Social Security Act for the Federal  
6           share of disproportionate share hospital payments  
7           made under section 1923 of such Act for that fiscal  
8           year but for subsections (c)(1) and (d)(2)(D) of sec-  
9           tion 1941 of such Act, as determined by the Sec-  
10          retary of Health and Human Services, taking into  
11          account the percentage change, if any, in the con-  
12          sumer price index for all urban consumers (U.S. city  
13          average) for the preceding fiscal year.

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

19                 “(1) PROVIDING PREMIUM AND PERSONAL RE-  
20                 SPONSIBILITY CONTRIBUTION SUBSIDIES.—For  
21                 making appropriations authorized under section 651  
22                 of the Healthy Americans Act for providing pre-  
23                 mium and personal responsibility contribution sub-  
24                 sidies in accordance with section 122 of such Act.

1           “(2) MAKING BONUS PAYMENTS TO STATES  
2           FOR IMPLEMENTING MEDICAL MALPRACTICE RE-  
3           FORM.—For making appropriations for bonus pay-  
4           ments to States in accordance with section 802 of  
5           such Act for implementing a State medical mal-  
6           practice reform law that complies with subsection  
7           (b) of such section.

8           “(3) REDUCING THE FEDERAL BUDGET DEF-  
9           ICIT.—The Secretary shall transfer any amounts in  
10          the Trust Fund that are not expended as of Sep-  
11          tember 30 of a fiscal year for a purpose described  
12          in paragraph (1), (2), or (3) to the general revenues  
13          account of the Treasury.”.

14          (2) CLERICAL AMENDMENT.—The table of sec-  
15          tions for such subchapter is amended by adding at  
16          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 I—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 2 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 2 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 2 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 2 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 2 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 2 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           (3) UNEMPLOYMENT.—Section 3306(b) (defin-  
2           ing wages) is amended by adding at the end the fol-  
3           lowing new sentence: “In the case of any calendar  
4           year beginning at least 2 years after the date of the  
5           enactment of the Healthy Americans Act, para-  
6           graphs (2) and (4) shall apply to payments on ac-  
7           count of sickness only if such payments are de-  
8           scribed in section 106(a).”.

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

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

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

21                       “(9) qualified health care fringe.”.

22          (b) QUALIFIED HEALTH CARE FRINGE.—

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

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 (2)” in the heading and inserting “SUB-  
20 SECTIONS (a)(1), (2), AND (9)”.

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

12 **SEC. 664. HEALTH CARE STANDARD DEDUCTION.**

13           (a) IN GENERAL.—Section 62(a) of the Internal Rev-  
14 enue Code of 1986 (defining adjusted gross income) is  
15 amended by inserting after paragraph (20) the following  
16 new paragraph:

17           “(21) INDIVIDUAL SHARED RESPONSIBILITY  
18           PAYMENTS.—

19           “(A) IN GENERAL.—In the case of a tax-  
20           payer with gross income for the taxable year ex-  
21           ceeding 100 percent of the poverty line (ad-  
22           justed for the size of the family involved) for  
23           the calendar year in which such taxable year  
24           begins and who is enrolled in a HAPI plan  
25           under the Healthy Americans Act, the deduc-

1           tion allowable under section 213 by reason of  
2           subsection (d)(1)(D) thereof (determined with-  
3           out regard to any income limitation under sub-  
4           section (a) thereof) in an amount equal to the  
5           lesser of—

6                   “(i) the amount paid under section  
7                   3421 with respect to such plan by such  
8                   taxpayer for such taxable year, or

9                   “(ii) the applicable fraction times, in  
10                  the case of—

11                           “(I) coverage of an individual,  
12                           \$6,025,

13                           “(II) coverage of a married cou-  
14                           ple or domestic partnership (as deter-  
15                           mined by a State) without dependent  
16                           children, \$12,050,

17                           “(III) coverage of an unmarried  
18                           individual with 1 or more dependent  
19                           children, \$8,610, plus \$2,000 for each  
20                           dependent child, and

21                           “(IV) coverage of a married cou-  
22                           ple or domestic partnership (as deter-  
23                           mined by a State) with 1 or more de-  
24                           pendent children, \$15,210, plus  
25                           \$2,000 for each dependent child.

1           “(B) APPLICABLE FRACTION.—For pur-  
2 poses of subparagraph (A)(ii), the applicable  
3 fraction is the fraction (not to exceed 1)—

4           “(i) the numerator of which is the  
5 gross income of the taxpayer for the tax-  
6 able year expressed as a percentage of the  
7 poverty line (adjusted for the size of the  
8 family involved) minus such poverty line  
9 for the calendar year in which such taxable  
10 year begins, and

11           “(ii) the denominator of which is 400  
12 percent of the poverty line (adjusted for  
13 the size of the family involved) minus such  
14 poverty line.

15           “(C) PHASEOUT OF DEDUCTION  
16 AMOUNT.—

17           “(i) IN GENERAL.—The amount oth-  
18 erwise determined under subparagraph (A)  
19 for any taxable year shall be reduced by  
20 the amount determined under clause (ii).

21           “(ii) AMOUNT OF REDUCTION.—The  
22 amount determined under this clause shall  
23 be the amount which bears the same ratio  
24 to the amount determined under subpara-  
25 graph (A) as—



1                   “(I) the excess of the taxpayer’s  
2                   modified adjusted gross income for  
3                   such taxable year, over \$62,500  
4                   (\$125,000 in the case of a joint re-  
5                   turn), bears to

6                   “(II) \$62,500 (\$125,000 in the  
7                   case of a joint return).

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

11                  “(D) INFLATION ADJUSTMENT.—In the  
12                  case of any taxable year beginning in a calendar  
13                  year after 2009, each dollar amount contained  
14                  in subparagraph (A)(ii) and subparagraph  
15                  (C)(ii)(I) shall be increased by an amount equal  
16                  to such dollar amount, multiplied by the cost-  
17                  of-living adjustment determined under section  
18                  1(f)(3) for the calendar year in which the tax-  
19                  able year begins, determined by substituting  
20                  ‘calendar year 2008’ for ‘calendar year 1992’ in  
21                  subparagraph (B) thereof. Any increase deter-  
22                  mined under the preceding sentence shall be  
23                  rounded to the nearest multiple of \$50 (\$1,000  
24                  in the case of the dollar amount contained in  
25                  subparagraph (C)(ii)(I)).

1           “(E) DETERMINATION OF MODIFIED AD-  
2 JUSTED GROSS INCOME.—

3           “(i) IN GENERAL.—For purposes of  
4 this paragraph, the term ‘modified ad-  
5 justed gross income’ means adjusted gross  
6 income—

7           “(ii) determined without regard to  
8 this section and sections 86, 135, 137,  
9 199, 221, 222, 911, 931, and 933, and

10           “(iii) increased by—

11           “(I) the amount of interest re-  
12 ceived or accrued during the taxable  
13 year which is exempt from tax under  
14 this title, and

15           “(II) the amount of any social se-  
16 curity benefits (as defined in section  
17 86(d)) received or accrued during the  
18 taxable year.

19           “(F) POVERTY LINE.—For purposes of  
20 this paragraph, the term ‘poverty line’ has the  
21 meaning given such term in section 673(2) of  
22 the Community Health Services Block Grant  
23 Act (42 U.S.C. 9902(2)), including any revision  
24 required by such section.”.

1 (b) CONFORMING AMENDMENT.—Section  
 2 213(d)(1)(D) of the Internal Revenue Code of 1986 is  
 3 amended by inserting “amounts paid under section 3421  
 4 and” after “including”.

5 (c) EFFECTIVE DATE.—The amendments made by  
 6 this section shall apply to payments made in calendar  
 7 years beginning at least 2 years after the date of the en-  
 8 actment of this Act.

9 **SEC. 665. MODIFICATION OF OTHER TAX INCENTIVES TO**  
 10 **COMPLEMENT HEALTHY AMERICANS PRO-**  
 11 **GRAM.**

12 (a) TERMINATION OF CREDIT FOR HEALTH INSUR-  
 13 ANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35 of  
 14 the Internal Revenue Code of 1986 (relating to health in-  
 15 surance costs of eligible individuals) is amended by adding  
 16 at the end the following new subsection:

17 “(h) TERMINATION.—This section shall not apply to  
 18 payments made in any calendar year beginning at least  
 19 2 years after the date of the enactment of the Healthy  
 20 Americans Act.”.

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

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

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

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

7 (2) LONG-TERM CARE ALLOWED UNDER CAFE-  
8 TERIA PLANS.—

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

12 (B) EFFECTIVE DATE.—The amendment  
13 made by this paragraph shall apply to contracts  
14 issued with respect to any calendar year begin-  
15 ning at least 2 years after the date of the en-  
16 actment of this Act.

17 (c) TERMINATION OF ARCHER MSA CONTRIBU-  
18 TIONS.—Section 220 of the Internal Revenue Code of  
19 1986 (relating to Archer MSAs) is amended—

20 (1) by inserting “and made before the first cal-  
21 endar year beginning 2 years after the date of the  
22 enactment of the Healthy Americans Act” after “in  
23 cash” in subsection (d)(1)(A)(i), and

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

1       “(k) TERMINATION.—This section shall not apply to  
2 contributions made in any calendar year beginning at least  
3 2 years after the date of the enactment of the Healthy  
4 Americans Act.”.

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

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

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

13                   (B) by striking “The term ‘high deductible  
14 health plan’ means a health plan” in subsection  
15 (c)(2)(A) and inserting “The term ‘qualified  
16 high deductible health plan’ means a HAPI  
17 plan under the Healthy Americans Act”,

18                   (C) by striking subparagraphs (B) and (C)  
19 of subsection (c)(2) and by redesignating sub-  
20 paragraph (D) of subsection (c)(2) as subpara-  
21 graph (B), and

22                   (D) by striking “HIGH” in the heading for  
23 paragraph (2) of subsection (c) and inserting  
24 “QUALIFIED HIGH”.

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

5 **SEC. 666. TERMINATION OF CERTAIN EMPLOYER INCEN-**  
6                           **TIVES WHEN REPLACED BY LOWER HEALTH**  
7                           **CARE COSTS.**

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

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

13          “The following provisions shall not apply to taxable  
14          years beginning (or transactions in the case of sections  
15          referred to in paragraph (3)) in any calendar year begin-  
16          ning at least 2 years after the date of the enactment of  
17          the Healthy Americans Act:

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

20                 “(2) Section 501(c)(9) (relating to tax-exempt  
21                 status of voluntary employees’ beneficiary associa-  
22                 tions).

23                 “(3) Sections 861(a)(6), 862(a)(6), 863(b)(2),  
24                 863(b)(3), and 865(b) (relating to inventory prop-  
25                 erty sales source rule exception).”.

1 (b) DEFERRAL OF ACTIVE INCOME OF CONTROLLED  
 2 FOREIGN CORPORATIONS.—Section 952 of the Internal  
 3 Revenue Code of 1986 (relating to subpart F income de-  
 4 fined) is amended by adding at the end the following new  
 5 subsection:

6 “(e) SPECIAL APPLICATION OF SUBPART.—

7 “(1) IN GENERAL.—For taxable years begin-  
 8 ning in any calendar year beginning at least 2 years  
 9 after the date of the enactment of the Healthy  
 10 Americans Act, notwithstanding any other provision  
 11 of this subpart, the term ‘subpart F income’ means,  
 12 in the case of any controlled foreign corporation, the  
 13 income of such corporation derived from any foreign  
 14 country.

15 “(2) APPLICABLE RULES.—Rules similar to the  
 16 rules under the last sentence of subsection (a) and  
 17 subsection (d) shall apply to this subsection.”.

18 (c) CONFORMING AMENDMENT.—The table of sec-  
 19 tions for subchapter C of chapter 90 of the Internal Rev-  
 20 enue Code of 1986 is amended by adding at the end the  
 21 following new item:

“Sec. 7875. Termination of certain provisions.”.

1 **PART II—TERMINATION OF COVERAGE UNDER**  
2 **OTHER GOVERNMENTAL PROGRAMS AND**  
3 **TRANSITION RULES FOR MEDICAID AND**  
4 **SCHIP**

5 **SEC. 671. GROUP AND INDIVIDUAL HEALTH PLAN REQUIRE-**  
6 **MENTS NOT APPLICABLE TO HAPI PLANS.**

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

13 (b) INTERNAL REVENUE CODE OF 1986.—Section  
14 5000 of the Internal Revenue Code of 1986 (relating to  
15 certain group health plans) is amended by adding at the  
16 end the following new subsection:

17 “(e) HAPI PLANS.—For purposes of this section, the  
18 terms ‘group health plan’ and ‘large group health plan’  
19 shall not include any HAPI plan under the Healthy Amer-  
20 icans Act.”.

21 (c) PUBLIC HEALTH SERVICE ACT.—Section  
22 2791(b)(5) of the Public Health Service Act (42 U.S.C.  
23 300gg–91(b)(5)) is amended by adding at the end the fol-  
24 lowing new sentence: “Such term shall not include health  
25 insurance coverage offered to individuals through a HAPI  
26 plan under the Healthy Americans Act.”.



1 **SEC. 672. FEDERAL EMPLOYEES HEALTH BENEFITS PLAN.**

2 (a) IN GENERAL.—Chapter 89 of title 5, United  
3 States Code, is amended by adding at the end the fol-  
4 lowing new section:

5 **“§ 8915. Termination**

6 “No contract shall be entered into under this chapter  
7 or chapters 89A and 89B with respect to any coverage  
8 period occurring in any calendar year beginning at least  
9 2 years after the date of the enactment of the Healthy  
10 Americans Act.”.

11 (b) CONFORMING AMENDMENT.—The table of sec-  
12 tions for such chapter 89 is amended by adding at the  
13 end the following new item:

“8915. Termination.”.

14 **SEC. 673. MEDICAID AND SCHIP.**

15 (a) IN GENERAL.—Title XIX of the Social Security  
16 Act, as amended by section 311, is amended by adding  
17 at the end the following new section:

18 “TRANSITION TO COVERAGE UNDER HAPI PLANS; RE-  
19 QUIREMENT TO PROVIDE SUPPLEMENTAL COV-  
20 ERAGE; TERMINATION OF UNNECESSARY PROVISIONS

21 “SEC. 1941. (a) TRANSITION AND SUPPLEMENTAL  
22 COVERAGE REQUIREMENTS.—The Secretary shall provide  
23 technical assistance to States and health insurance issuers  
24 of HAPI plans to ensure that individuals receiving medical  
25 assistance under State Medicaid plans under this title or

1 child health assistance under child health plans under title  
2 XXI are—

3 “(1) informed of—

4 “(A) the guarantee of private coverage for  
5 essential services for all Americans established  
6 by the Healthy Americans Act; and

7 “(B) each individual’s personal responsi-  
8 bility—

9 “(i) for health care prevention;

10 “(ii) to enroll (or to be enrolled on  
11 their behalf) in a HAPI plan through the  
12 applicable State HHA during an open en-  
13 rollment period; and

14 “(iii) to submit necessary documenta-  
15 tion to their State HHA so that the HHA  
16 may determine the individual’s eligibility  
17 for premium and personal responsibility  
18 contribution subsidies;

19 “(2) provided with appropriate assistance in  
20 transitioning from receiving medical assistance  
21 under State Medicaid plans or child health assist-  
22 ance under child health plans for their primary  
23 health coverage to obtaining such coverage through  
24 enrollment in HAPI plans in a manner that ensures  
25 continuation of coverage for such individuals;

1           “(3) notwithstanding any other provision of this  
2 title, after December 31 of the last calendar year  
3 ending before the first calendar year in which cov-  
4 erage under a HAPI plan begins in accordance with  
5 the Healthy Americans Act, provided with medical  
6 assistance that consists of supplemental coverage  
7 that meets the requirements of sections 202 and 301  
8 of such Act; and

9           “(4) if the State elects to establish a State  
10 Choices for Long-Term Care Program under section  
11 1940 and the individual is likely to be eligible for the  
12 program, informed of the coverage available under  
13 the program and how to enroll.

14           “(b) MAINTENANCE OF MEDICARE COST-SHAR-  
15 ING.—For each month beginning after the last month of  
16 the last calendar year ending before the first calendar year  
17 in which coverage under a HAPI plan begins in accord-  
18 ance with the Healthy Americans Act—

19           “(1) a State shall continue to provide medical  
20 assistance for medicare cost-sharing to individuals  
21 described in section 1902(a)(10)(E) as if the  
22 Healthy Americans Act had not been enacted; and

23           “(2) the Secretary shall continue to reimburse  
24 the State for the provision of such medical assist-  
25 ance.

1       “(c) CONTINUED SUPPORT FOR DSH EXPENDI-  
2 TURES.—

3           “(1) IN GENERAL.—Notwithstanding any other  
4 provision of this title, with respect to each fiscal year  
5 that begins after the first calendar year in which  
6 coverage under a HAPI plan begins in accordance  
7 with the Healthy Americans Act, the DSH allotment  
8 for each State otherwise applicable under section  
9 1923(f) for that fiscal year shall be reduced by 90  
10 percent and no payment shall be made under section  
11 1903(a) to a State with respect to any payment ad-  
12 justment made under section 1923 for hospitals in  
13 the State for quarters in the fiscal year in excess of  
14 the reduced DSH allotment for the State applicable  
15 for such year.

16           “(2) SPECIAL RULE FOR LAST 3 QUARTERS OF  
17 FIRST FISCAL YEAR IN WHICH COVERAGE UNDER A  
18 HAPI PLAN BEGINS.—With respect to the first fiscal  
19 year in which coverage under a HAPI plan begins  
20 in accordance with the Healthy Americans Act, the  
21 Secretary shall reduce the DSH allotment for each  
22 State that is otherwise applicable under section  
23 1923(f) for that fiscal year so that each such DSH  
24 allotment reflects a 90 percent reduction in the allot-

1       ment for the second, third, and fourth quarters of  
2       that fiscal year.

3       “(d) TERMINATION OF ALL FEDERAL PAYMENTS  
4 UNDER THIS TITLE OTHER THAN FOR MEDICARE COST-  
5 SHARING, SUPPLEMENTAL MEDICAL ASSISTANCE, OR A  
6 STATE CHOICES FOR LONG-TERM CARE PROGRAM.—Not-  
7 withstanding any other provision of this title:

8               “(1) no individual other than an individual to  
9       which section 202, 301, or 311 of the Healthy  
10       Americans Act applies is entitled to medical assist-  
11       ance under a State plan approved under this title for  
12       any item or service furnished after December 31 of  
13       the last calendar year ending before the first cal-  
14       endar year in which coverage under a HAPI plan be-  
15       gins in accordance with such Act;

16               “(2) no payment shall be made to a State  
17       under section 1903(a) for any item or service fur-  
18       nished after that date or for any other sums ex-  
19       pended by a State for which a payment would have  
20       been made under such section, other than for the  
21       Federal medical assistance percentage of the total  
22       amount expended by a State for each fiscal year  
23       quarter beginning after that date for providing—

1           “(A) medical assistance for the mainte-  
2 nance of medicare cost-sharing in accordance  
3 with subsection (b);

4           “(B) medical assistance for individuals who  
5 are eligible for supplemental medical assistance  
6 under this title after such date in accordance  
7 with section 202 or 301 of the Healthy Ameri-  
8 cans Act;

9           “(C) payments for expenditures for estab-  
10 lishing and operating a State Choices for Long-  
11 Term Care Program under section 1940 (sub-  
12 ject to the aggregate 5-year limit established  
13 under subsection (c)(1) of such section); and

14           “(D) payment adjustments under section  
15 1923 for hospitals in the State that do not ex-  
16 ceed the reduced DSH allotment for the State  
17 determined under subsection (c)”.

18 (b) APPLICATION TO SCHIP.—

19           (1) APPLICATION OF TRANSITION REQUIRE-  
20 MENTS.—Section 2107(e)(1) of the Social Security  
21 Act (42 U.S.C. 1397gg(e)(1)) is amended by adding  
22 at the end the following:

23           “(E) Section 1941(a) (relating to transi-  
24 tion to coverage under HAPI plans and, in the  
25 case of paragraph (3) of such section, the re-



1 **TITLE VII—PURCHASING**  
 2 **HEALTH SERVICES AND**  
 3 **PRODUCTS THAT ARE MOST**  
 4 **EFFECTIVE**

5 **Subtitle A—Effective Health**  
 6 **Services and Products**

7 **SEC. 701. ONE TIME DISALLOWANCE OF DEDUCTION FOR**  
 8 **ADVERTISING AND PROMOTIONAL EXPENSES**  
 9 **FOR CERTAIN PRESCRIPTION PHARMA-**  
 10 **CEUTICALS.**

11 (a) IN GENERAL.—Part IX of subchapter B of chap-  
 12 ter 1 of subtitle A of the Internal Revenue Code of 1986  
 13 (relating to items not deductible) is amended by adding  
 14 at the end the following new section:

15 **“SEC. 280I. ONE TIME DISALLOWANCE OF DEDUCTION FOR**  
 16 **CERTAIN PRESCRIPTION PHARMACEUTICALS**  
 17 **ADVERTISING AND PROMOTIONAL EX-**  
 18 **PENSES.**

19 “(a) IN GENERAL.—No deduction shall be allowed  
 20 under this chapter for expenses relating to advertising or  
 21 promoting the sale and use of prescription pharma-  
 22 ceuticals other than drugs for rare diseases or conditions  
 23 (within the meaning of section 45C) for any taxable year  
 24 which includes any portion of—



1           “(1) the 3-year period which begins on the date  
2           of a new drug application approval with respect to  
3           such a pharmaceutical, unless the manufacturer of  
4           such pharmaceutical demonstrates to the satisfaction  
5           of the Secretary that such pharmaceutical is subject  
6           to a comparison effectiveness study, including over-  
7           the-counter medication (if appropriate), or

8           “(2) the 1-year period which ends with the  
9           availability of a generic drug substitute, unless such  
10          advertising or promotion includes a statement that  
11          a lower cost alternative may soon be available and  
12          includes the chemical name of such alternative.

13          “(b) ADVERTISING OR PROMOTING.—For purposes of  
14          this section, the term ‘advertising or promoting’ includes  
15          direct-to-consumer advertising and any activity designed  
16          to promote the use of a prescription pharmaceutical di-  
17          rected to providers or others who may make decisions  
18          about the use of prescription pharmaceuticals (including  
19          the provision of product samples, free trials, and starter  
20          kits).”.

21          (b) CONFORMING AMENDMENT.—The table of sec-  
22          tions for such part IX is amended by adding after the  
23          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.”.

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

5 **SEC. 702. ENHANCED NEW DRUG AND DEVICE APPROVAL.**

6       (a) IN GENERAL.—

7           (1) NEW DRUGS.—Section 505 of the Federal  
8 Food, Drug, and Cosmetic Act (21 U.S.C. 355) is  
9 amended by adding at the end the following:

10       “(o)(1) The sponsor of a new drug application under  
11 subsection (b) may include as part of such application a  
12 full report of an investigation which has been made to  
13 show, with respect to the new drug that is the subject of  
14 the application—

15           “(A) the population for whom the drug is ap-  
16 propriate; and

17           “(B) the effectiveness of the drug when com-  
18 pared to the effectiveness of drugs on the market as  
19 of the date that the application is submitted.

20       “(2) If a sponsor of a new drug application under  
21 subsection (b) includes in such application the report de-  
22 scribed under paragraph (1) then, notwithstanding any  
23 other provision of law, the Secretary shall apply section  
24 505A(b) to the drug that is the subject of such application  
25 in the same manner as the Secretary applies such section

1 to a new drug in the pediatric population that is the sub-  
2 ject of a study described in such section.

3 “(3) If a sponsor of a new drug application under  
4 subsection (b) does not include in such application the re-  
5 port described under paragraph (1) then, notwithstanding  
6 any other provision of law, the Secretary shall require  
7 that—

8 “(A) all promotional material with respect to  
9 such drug include the following disclosure: ‘This  
10 drug has not been proven to be more effective than  
11 other drugs on the market for any condition or ill-  
12 ness mentioned in this advertisement.’; and

13 “(B) such disclosure—

14 “(i) appears at the beginning and end of  
15 any audio and visual promotional material;

16 “(ii) constitutes not less than 20 percent of  
17 the time of any audio and visual promotional  
18 material; and

19 “(iii)(I) in any promotional material, in-  
20 cludes a clear and conspicuous printed state-  
21 ment that is larger than other print used in  
22 such promotional material; and

23 “(II) in any audio and visual promotional  
24 material, includes such statement in audio as  
25 well as visual format.”.

1           (2) NEW DEVICES.—Section 515(c) of the Fed-  
2           eral Food, Drug, and Cosmetic Act (21 U.S.C.  
3           360e) is amended by adding at the end the fol-  
4           lowing:

5           “(5)(A) A person that files a report seeking pre-  
6           market approval under this subsection may include as part  
7           of such report a full description of an investigation which  
8           has been made to show, with respect to the device that  
9           is the subject of the report—

10           “(i) the population for whom the device is ap-  
11           propriate; and

12           “(ii) the effectiveness of the device when com-  
13           pared to the effectiveness of devices on the market  
14           as of the date that the report is submitted.

15           “(B) If a person that files a report seeking premarket  
16           approval under this subsection includes in such report the  
17           description referred to under subparagraph (A), then the  
18           Secretary shall certify to the Director of the United States  
19           Patent and Trademark Office that such person included  
20           such description in such report so that the Director may  
21           extend the patent with respect to such device under section  
22           702(b) of the Healthy Americans Act.

23           “(C) If a person that files a report seeking premarket  
24           approval under this subsection does not include in such  
25           report the description referred to under subparagraph (A)

1 then, notwithstanding any other provision of law, the Sec-  
2 retary shall require that—

3 “(i) all promotional material with respect to  
4 such device include the following disclosure: ‘This  
5 device has not been proven to be more effective than  
6 other devices on the market for any condition or ill-  
7 ness mentioned in this advertisement.’; and

8 “(ii) such disclosure—

9 “(I) appears at the beginning and end of  
10 any audio and visual promotional material;

11 “(II) constitutes not less than 20 percent  
12 of the time of any audio and visual promotional  
13 material; and

14 “(III)(aa) in any promotional material, in-  
15 cludes a clear and conspicuous printed state-  
16 ment that is larger than other print used in  
17 such promotional material; and

18 “(bb) in any audio and visual promotional  
19 material, includes such statement in audio as  
20 well as visual format.”.

21 (b) EXTENSION OF DEVICE PATENTS.—If the Direc-  
22 tor of the United States Patent and Trademark Office re-  
23 ceives a certification from the Secretary pursuant to sec-  
24 tion 515(c)(5) of the Federal Food, Drug, and Cosmetic  
25 Act (as added under subsection (a)), the Director shall

1 extend, for a period of 2 years, the patent in effect with  
 2 respect to such device under title 35 of the United States  
 3 Code.

4 (c) EFFECTIVE DATE.—This section shall apply to  
 5 new drug applications filed under section 505(b) of the  
 6 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)  
 7 and to applications for premarket approval of devices  
 8 under section 515 of such Act (21 U.S.C. 350e) 180 days  
 9 after the date of enactment of this Act.

10 **SEC. 703. MEDICAL SCHOOLS AND FINDING WHAT WORKS**  
 11 **IN HEALTH CARE.**

12 Part B of title IX of the Public Health Service Act  
 13 (42 U.S.C. 299b et seq.) is amended by adding at the end  
 14 the following:

15 **“SEC. 918. MEDICAL SCHOOLS AND FINDING WHAT WORKS**  
 16 **IN HEALTH CARE.**

17 “(a) ESTABLISHMENT OF WEBSITE.—Not later than  
 18 1 year after the date of enactment of the Healthy Ameri-  
 19 cans Act, the Agency shall establish an Internet website—

20 “(1) on which researchers at medical schools  
 21 and other institutions may post the results of their  
 22 research concerning evidence-informed best practices  
 23 for improving the quality and efficiency of care; and

24 “(2) that—

1           “(A) includes a description on how to im-  
2           plement such best practices; and

3           “(B) clearly identifies the funding source  
4           for the research.

5           “(b) PILOT PROGRAM.—

6           “(1) ESTABLISHMENT.—Using the information  
7           about evidence-informed best practices from the  
8           website under subsection (a) and other sources, the  
9           Agency, through the National Research Training  
10          Program and in consultation with medical schools,  
11          shall develop a pilot program to establish methods  
12          by which medical school curricula and training may  
13          be updated regularly to reflect best practices to im-  
14          prove quality and efficiency in medical practice.

15          “(2) APPLICATION TO PARTICIPATE.—To par-  
16          ticipate in the pilot program, an entity shall—

17                  “(A) be an accredited medical school; and

18                  “(B) submit an application at such time,  
19                  in such manner, and containing such informa-  
20                  tion as the Secretary may require.

21          “(3) PARTICIPANTS.—The Secretary shall en-  
22          sure that not less than 28 medical schools shall be  
23          included in the pilot program.

24          “(4) DURATION; PUBLICATION OF RESULTS.—  
25          The Agency shall—

1           “(A) operate the pilot program for 3 years;  
2           and

3           “(B) not later than 180 days after the  
4           date of the completion of the pilot program,  
5           publish and make public the results of the pilot  
6           program; and

7           “(C) include, as part of the published re-  
8           sults under subparagraph (B), recommenda-  
9           tions on how to assure that all medical school  
10          curricula is updated on a regular basis to re-  
11          flect best practices to improve quality and effi-  
12          ciency in medical practice.”.

13 **SEC. 704. FINDING AFFORDABLE HEALTH CARE PRO-**  
14 **VIDERS NEARBY.**

15          (a) **IN GENERAL.**—Not later than 2 years after the  
16          date of enactment of this Act, the Secretary, in consulta-  
17          tion with each HHA and health insurance issuers that  
18          offer a HAPI plan, shall establish an Internet website to  
19          assist covered individuals with locating health care pro-  
20          viders in their State of residence who provide affordable,  
21          high-quality health care services.

22          (b) **QUALITY OF CARE STANDARD.**—To develop the  
23          information displayed on the website with respect to the  
24          quality of care of a health care provider, the Secretary  
25          shall—



1           (1) on the date of establishment of the website,  
2           use information on the performance of providers in  
3           quality initiatives under the Medicare program, in-  
4           cluding demonstration projects, reporting initiatives,  
5           and pay for performance efforts; and

6           (2) not later than 3 years after the date of es-  
7           tablishment of the website, in addition to the infor-  
8           mation used under paragraph (1), use quality of  
9           care standards developed in consultation with, and  
10          similar to standards used by, Medicare quality im-  
11          provement organizations of each State.

12          (c) AFFORDABILITY STANDARD.—Not later than 2  
13          years after the date of enactment of this Act, the Sec-  
14          retary shall, in consultation with health insurance issuers  
15          that offer a HAPI plan, develop guidelines by which each  
16          health care provider reports to the Secretary with respect  
17          to the affordability of services by such provider. The Sec-  
18          retary shall ensure that such guidelines—

19                (1) on the date of establishment of such guide-  
20                lines, provide for the reporting of affordability of  
21                primary care services; and

22                (2) by a date that is no later than 3 years after  
23                the date of enactment of this Act, provide for the re-  
24                porting of other services.

1 **Subtitle B—Other Provisions to Im-**  
2 **prove Health Care Services and**  
3 **Quality**

4 **SEC. 711. INDIVIDUAL MEDICAL RECORDS.**

5 The Secretary shall establish procedures to ensure  
6 that an individual's medical record is considered the prop-  
7 erty of such individual.

8 **SEC. 712. BONUS PAYMENT FOR MEDICAL MALPRACTICE**  
9 **REFORM.**

10 (a) **IN GENERAL.**—Effective 3 years after the date  
11 of enactment of this Act, a State shall be eligible for bonus  
12 payments under this Act if the State has enacted and is  
13 implementing a State medical malpractice reform law that  
14 complies with subsection (b).

15 (b) **REQUIREMENTS FOR STATE REFORM LAW.**—A  
16 State medical malpractice reform law complies with this  
17 subsection if such law—

18 (1) requires that an individual who files a med-  
19 ical malpractice action in State court have the facts  
20 of such individual's case reviewed prior to such filing  
21 by a panel that consists of—

22 (A) not less than 1 qualified medical ex-  
23 pert, chosen in consultation with the State  
24 Medicare quality improvement organizations or

1 physician speciality society, whose expertise is  
2 appropriate for case;

3 (B) not less than 1 legal expert; and

4 (C) not less than 1 community representa-  
5 tive to verify that there is reasonable cause to  
6 believe that a malpractice claim exists;

7 (2) permits an individual to engage in voluntary  
8 non-binding mediation with respect to the mal-  
9 practice claim involved prior to filing an action in  
10 State court;

11 (3) imposes sanctions against plaintiffs and at-  
12 torneys who file frivolous medical malpractice claims  
13 in State courts;

14 (4) prohibits attorneys who file 3 frivolous med-  
15 ical malpractice actions in State courts from filing  
16 any another medical malpractice action in such  
17 courts for a period of 10 years; and

18 (5) provides for the application of a presump-  
19 tion of reasonableness with respect to a medical mal-  
20 practice action if the defendant establishes that the  
21 defendant provided the items or services involved in  
22 accordance with accepted clinical practice guidelines  
23 established by the specialty of which the defendant  
24 is board certified or listed in the National Guideline

1 Clearinghouse, unless such presumption is rebutted  
2 by a preponderance of the evidence.

3 (c) USE OF BONUS PAYMENTS.—A State shall use  
4 bonus payments received under this section to carry out  
5 activities related to disease and illness prevention and for  
6 the provision of enhanced health care services for children.

7 (d) PROCEDURES.—The Secretary, in consultation  
8 with the Attorney General, shall by regulation establish  
9 guidelines for the implementation of this section.

10 **TITLE VIII—CONTAINING MED-**  
11 **ICAL COSTS AND GETTING**  
12 **MORE VALUE FOR THE**  
13 **HEALTH CARE DOLLAR**

14 **SEC. 801. COST-CONTAINMENT RESULTS OF THE HEALTHY**  
15 **AMERICANS ACT.**

16 Congress finds that the Healthy Americans Act will  
17 result in the following:

18 (1) Private insurance companies will be forced  
19 to hold down costs and will slow the rate of growth  
20 because they are required to offer standardized  
21 Healthy American Private Insurance plans.

22 (2) Administrative savings will be derived from  
23 decoupling employers from the health care infra-  
24 structure and reducing employers' and insurers' ad-  
25 ministrative costs.

1           (3) Private insurance companies will implement  
2 uniform billing and common claims forms.

3           (4) Congress will reclaim Medicare and Med-  
4 icaid disproportionate share hospital (DSH) pay-  
5 ments because previously uninsured persons will go  
6 to providers on an outpatient basis instead of an  
7 emergency department.

8           (5) State and local governments will save  
9 money on programs they operated for the uninsured  
10 before enactment of this Act.

11          (6) The Federal Government will save money  
12 on Federal tax subsidies that reward inefficient care  
13 and are regressive.

14          (7) The Federal Government and the private  
15 sector will save money if the Food and Drug Admin-  
16 istration determines whether products provide new  
17 value.

18          (8) Reducing medical errors will save the gov-  
19 ernment and the private sector money.

20          (9) Requiring hospitals to send large bills to pa-  
21 tients for their review will reduce errors in medical  
22 billing and force major providers to be more cost  
23 conscious.

1           (10) Requiring insurers to reimburse for quality  
2           and cost effective services will hold down private sec-  
3           tor costs.

4           (11) Reduction of Medicare's restriction on bar-  
5           gaining power for prescription drugs will reduce  
6           costs for sole source drugs and other medications.

7           (12) Establishment of electronic medical  
8           records by insurers will create savings.

9           (13) Publication of cost and quality data will  
10          enable people to look up by zip code affordable high-  
11          quality providers.

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