

111TH CONGRESS
1ST SESSION

S. 391

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

IN THE SENATE OF THE UNITED STATES

FEBRUARY 5, 2009

Mr. WYDEN (for himself, Mr. BENNETT, Mr. INOUE, Mr. SPECTER, Mr. LIEBERMAN, Ms. LANDRIEU, Mr. CRAPO, Mr. NELSON of Florida, Ms. STABENOW, Ms. CANTWELL, Mr. GRAHAM, Mr. ALEXANDER, and Mr. MERKLEY) introduced the following bill; which was read twice and referred to the Committee on Finance

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.**—

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1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Americans want affordable, guaranteed pri-
4 vate health coverage that makes them healthier and
5 can never be taken away.6 (2) American health care provides primarily
7 “sick care” and does not do enough to prevent
8 chronic illnesses like heart disease, stroke, and dia-
9 betes. This results in significantly higher health
10 costs for all Americans.11 (3) Staying as healthy as possible often requires
12 an individual to change behavior and assume more
13 personal responsibility for his or her health.14 (4) Personal responsibility for one’s health
15 should include purchasing one’s own private health
16 care coverage.17 (5) To accompany this new focus on staying
18 healthy and personal responsibility, our government
19 must guarantee that all Americans receive private
20 affordable health coverage that can never be taken
21 away.

1 (6) Financing this guarantee should be a
2 shared responsibility between individuals, the Gov-
3 ernment, and employers.

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

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

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

17 **SEC. 3. DEFINITIONS.**

18 In this Act:

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

21 (A) is—

22 (i) age 19 or older;

23 (ii) a resident of a State;

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

1 (II) an alien with permanent resi-
2 dence;

3 (iv) not a dependent child; and

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

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

9 (2) ALIEN WITH PERMANENT RESIDENCE.—

10 The term “alien with permanent residence” has the
11 meaning given the term “qualified alien” in section
12 431 of the Personal Responsibility and Work Oppor-
13 tunity Reconciliation Act of 1996 (8 U.S.C. 1641).

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

17 (4) DEPENDENT CHILD.—The term “dependent
18 child” has the meaning given the term “qualifying
19 child” in section 152(c) of the Internal Revenue
20 Code of 1986.

21 (5) HAPI PLAN.—The term “HAPI plan”
22 means—

23 (A) a Healthy Americans Private Insur-
24 ance plan described under subtitle B of title I;
25 or

1 (B) an employer-sponsored health coverage
2 plan described under section 103 offered by an
3 employer.

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

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

17 (8) HEALTH MAINTENANCE ORGANIZATION.—
18 The term “health maintenance organization”
19 means—

20 (A) a federally qualified health mainte-
21 nance organization (as defined in section
22 1301(a)),

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

1 (C) a similar organization regulated under
2 State law for solvency in the same manner and
3 to the same extent as such a health mainte-
4 nance organization.

5 (9) PERSONAL RESPONSIBILITY CONTRIBU-
6 TION.—The term “personal responsibility contribu-
7 tion” means a payment made by a covered individual
8 to a health care provider or a health insurance
9 issuer with respect to the provision of health care
10 services under a HAPI plan, not including any
11 health insurance premium payment.

12 (10) QUALIFIED COLLECTIVE BARGAINING
13 AGREEMENT.—

14 (A) IN GENERAL.—The term “qualified
15 collective bargaining agreement” means an
16 agreement between a qualified collective bar-
17 gaining employer and an employee organization
18 that represents the employees of such employer
19 that is in effect until the date that is the earlier
20 of—

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

24 (ii) the date the collective bargaining
25 agreement expires.

1 (B) QUALIFIED COLLECTIVE BARGAINING
2 EMPLOYER.—The term “qualified collective bar-
3 gaining employer” means an employer who pro-
4 vides health insurance to employees under the
5 terms of a collective bargaining agreement
6 which is entered into before the date of the en-
7 actment of this Act.

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

10 (12) STATE.—The term “State” means each of
11 the several States of the United States, the District
12 of Columbia, the Commonwealth of Puerto Rico, the
13 Virgin Islands, American Samoa, Guam, the Com-
14 monwealth of the Northern Mariana Islands, and
15 other territories of the United States.

16 (13) STATE OF RESIDENCE.—The term “State
17 of residence”, with respect to an individual, means
18 the State in which the individual has primary resi-
19 dence.

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

5 **SEC. 101. GUARANTEE OF HEALTHY AMERICANS PRIVATE**
6 **INSURANCE COVERAGE.**

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

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

16 (a) INDIVIDUAL RESPONSIBILITY.—

17 (1) ADULT INDIVIDUALS.—Each adult indi-
18 vidual shall have the responsibility to enroll in a
19 HAPI plan, unless the adult individual—

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

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

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

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

5 (iv) a qualified collective bargaining
6 agreement;

7 (v) the Department of Veterans Af-
8 fairs; or

9 (vi) the Indian Health Service; or

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

15 (2) DEPENDENT CHILDREN.—Each adult indi-
16 vidual shall have the responsibility to enroll each de-
17 pendent child of the adult individual in a HAPI
18 plan, unless the adult individual—

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

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

24 (3) VERIFICATION OF RELIGIOUS EXCEPTION.—
25 Each State shall develop guidelines for determining

1 and verifying the individuals who qualify for the ex-
 2 ception under paragraph (1)(B).

3 (b) PENALTY FOR FAILURE TO PURCHASE COV-
 4 ERAGE.—

5 (1) PENALTY.—

6 (A) IN GENERAL.—In the case of an indi-
 7 vidual described in subparagraph (B), such in-
 8 dividual shall be subject to a late enrollment
 9 penalty in an amount determined under sub-
 10 paragraph (C).

11 (B) INDIVIDUALS SUBJECT TO PENALTY.—
 12 An individual described in this subparagraph is
 13 an adult individual for whom there is a contin-
 14 uous period of 63 days or longer, beginning on
 15 the applicable date (as defined in subparagraph
 16 (E)) and ending on the date of enrollment in a
 17 HAPI plan, during all of which the individual—

18 (i) was not covered under a HAPI
 19 plan or a health plan offered through a
 20 program described in paragraph (1)(A) of
 21 subsection (a); and

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

24 (C) AMOUNT OF PENALTY.—

1 (i) IN GENERAL.—The amount deter-
2 mined under this subparagraph for an in-
3 dividual is an amount equal to the sum
4 of—

5 (I) the number of uncovered
6 months multiplied by the weighted av-
7 erage of the monthly premium for
8 HAPI plans of the same class of cov-
9 erage as the individual’s in the appli-
10 cable coverage area (determined with-
11 out regard to any subsidy under sec-
12 tion 121); and

13 (II) 15 percent of the amount de-
14 termined under subclause (I).

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

22 (I) was covered under a HAPI
23 plan or a health plan offered through
24 a program described in paragraph

1 (1)(A) of subsection (a) for any por-
2 tion of such month; or

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

6 A month shall not be treated as an uncov-
7 ered month if the individual has already
8 paid a late enrollment penalty under this
9 subsection for such month or if the indi-
10 vidual was incarcerated for the entire
11 month.

12 (D) PAYMENT.—Payment of any late en-
13 rollment penalty by an individual under this
14 subsection shall be made to the HHA of the in-
15 dividual’s State of residence under procedures
16 established by the State.

17 (E) APPLICABLE DATE.—In this para-
18 graph, the term “applicable date” means the
19 earlier of—

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

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

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

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

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

20 **SEC. 103. GUARANTEEING YOU CAN KEEP THE COVERAGE**
 21 **YOU HAVE.**

22 (a) PLAN REQUIREMENTS.—

23 (1) IN GENERAL.—A health coverage plan de-
 24 scribed in section 105(h)(6) of the Internal Revenue

1 Code of 1986 (relating to self-insured plans) that is
2 offered by an employer shall be subject to—

3 (A) the requirements of subtitle B (except
4 for subsections (a), (d)(2), and (d)(4) of section
5 111); and

6 (B) a risk-adjustment mechanism used to
7 spread risk across all health plans.

8 (2) OTHER PLANS.—A health coverage plan
9 that is not described in section 105(h)(6) of the In-
10 ternal Revenue Code of 1986 that is offered by an
11 employer shall be subject to the requirements of sub-
12 title B (except for subsection (a) of section 111).

13 (b) DISTRIBUTION OF INFORMATION.—Employers
14 that offer an employer-sponsored health coverage plan
15 shall distribute to employees standardized, unbiased infor-
16 mation on HAPI plans and supplemental health insurance
17 options provided by the State HHA under section 502(b).

18 (c) PLANS OFFERED THROUGH EMPLOYERS.—An
19 employer-sponsored health coverage plan shall be offered
20 by an employer and not through the applicable State
21 HHA.

1 **SEC. 104. COORDINATION OF SUPPLEMENTAL COVERAGE**
2 **UNDER THE MEDICAID PROGRAM TO HAPI**
3 **PLAN COVERAGE FOR NONDISABLED, NON-**
4 **ELDERLY ADULT INDIVIDUALS.**

5 (a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—
6 Subject to section 631(d), the Secretary, States, and
7 health insurance issuers shall ensure that any nondisabled,
8 nonelderly adult individual eligible under title XIX of the
9 Social Security Act (including any nondisabled, nonelderly
10 adult individual eligible under a waiver under such title
11 or under section 1115 of such Act (42 U.S.C. 1315)) cov-
12 ered under a HAPI plan provided through the State HHA
13 receives medical assistance under State Medicaid plans in
14 a manner that—

15 (1) is provided in coordination with, and as a
16 supplement to, the coverage provided the non-
17 disabled, nonelderly adult individual under the
18 HAPI plan in which the individual is enrolled;

19 (2) does not supplant the nondisabled, non-
20 elderly adult individual's coverage under a HAPI
21 plan;

22 (3) ensures that the nondisabled, nonelderly
23 adult individual receives all items or services that
24 are not available (or are otherwise limited) under the
25 HAPI plan in which they are enrolled but that is
26 provided under the State plan (or provided to a

1 greater extent or in a less restrictive manner) under
2 title XIX of the Social Security Act (including any
3 waiver under such title or under section 1115 of
4 such Act (42 U.S.C. 1315)) of the State in which
5 the nondisabled, nonelderly adult individual resides;
6 and

7 (4) ensures that the family of the nondisabled,
8 nonelderly adult individual is not charged premiums,
9 deductibles, or other cost-sharing that is greater
10 than would have been charged under the State plan
11 under title XIX of the Social Security Act of the
12 State in which the nondisabled, nonelderly adult in-
13 dividual resides if such coverage was not provided as
14 a supplement to the coverage provided the child
15 under the HAPI plan in which the nondisabled, non-
16 elderly adult individual is enrolled.

17 (b) GUIDANCE TO STATES AND HEALTH INSURANCE
18 ISSUERS.—The Secretary shall issue regulations and guid-
19 ance to States and health insurance issuers implementing
20 this section not later than 6 months prior to the date on
21 which coverage under a HAPI plan first begins.

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

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

6 (a) OPTIONS.—A State HHA—

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

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

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

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

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

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

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

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

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

16 (A) provide benefits for health care items
17 and services that are actuarially equivalent or
18 greater in value than the benefits offered as of
19 January 1, 2009, under the Blue Cross/Blue
20 Shield Standard Plan provided under the Fed-
21 eral Employees Health Benefit Program under
22 chapter 89 of title 5, United States Code, in-
23 cluding coverage of an initial primary care as-
24 sessment and annual physical examinations;

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

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

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

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

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

1 (G) provide for the application of personal
2 responsibility contribution requirements with re-
3 spect to covered benefits in a manner that may
4 be similar to the cost sharing requirements ap-
5 plied as of January 1, 2009, under the Blue
6 Cross/Blue Shield Standard Plan provided
7 under the Federal Employees Health Benefit
8 Program under chapter 89 of title 5, United
9 States Code, except that no contributions shall
10 be required for—

11 (i) preventive items or services; and

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

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

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

22 (3) COVERAGE FOR FAMILY PLANNING.—

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

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

4 (B) RELIGIOUS AND MORAL EXCEPTION.—

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

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

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

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

23 (A) shall include coverage for—

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

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

3 (ii) inpatient and outpatient hospital
4 services;

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

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

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

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

16 (d) PREMIUMS AND RATING REQUIREMENTS.—

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

20 (A) Coverage of an individual.

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

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

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

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

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

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

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

4 (f) DEFINITION OF PREVENTIVE ITEMS OR SERV-
5 ICES.—In this section, the term “preventive items or serv-
6 ices” means clinical activities that help prevent or detect
7 disease, illness, or disability and may include—

8 (1) immunizations and preventive physical ex-
9 aminations;

10 (2) screening tests for blood pressure, high cho-
11 lesterol, diabetes, cancer, and mental illness; and

12 (3) other services that the Secretary determines
13 to be reasonable and necessary for the prevention or
14 early detection of a disease, illness, or disability.

15 **SEC. 112. SPECIFIC COVERAGE REQUIREMENTS.**

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

18 (1) provide for increased portability through
19 limitations on the application of preexisting condi-
20 tion exclusions, consistent with that provided for
21 under section 2701 of the Public Health Service Act
22 (42 U.S.C. 300gg), as such section existed on the
23 day before the date of enactment of this Act, except
24 that the State shall develop procedures to ensure
25 that preexisting exclusion limitations do not apply to

1 new enrollees who had no applicable creditable cov-
2 erage immediately prior to the first enrollment pe-
3 riod;

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

10 (3) provide for the guaranteed renewability of
11 coverage in a manner similar to that provided for
12 under section 2712 of the Public Health Service Act
13 (42 U.S.C. 300gg-12), as such section existed on
14 the day before the date of enactment of this Act, ex-
15 cept that the prohibition on market reentry provided
16 for under such section shall be deemed to be 2 years;

17 (4) prohibit discrimination against individual
18 enrollees and prospective enrollees based on health
19 status in a manner similar to that provided for
20 under section 2702 of the Public Health Service Act
21 (42 U.S.C. 300gg-1), as such section existed on the
22 day before the date of enactment of this Act;

23 (5) provide coverage protections for enrollees
24 who are mothers and newborns in a manner similar
25 to that provided for under section 2704 of the Pub-

1 lic Health Service Act (42 U.S.C. 300gg-3), as such
2 section existed on the day before the date of enact-
3 ment of this Act;

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

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

16 (8) prohibit discrimination on the basis of ge-
17 netic information, as provided for under the amend-
18 ments made by the Genetic Information Non-
19 discrimination Act of 2008 (Public Law 110-233).

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

1 **SEC. 113. UPDATING HEALTHY AMERICANS PRIVATE IN-**
2 **SURANCE PLAN REQUIREMENTS.**

3 (a) IN GENERAL.—The Secretary shall establish the
4 Healthy America Advisory Committee (referred to in this
5 section as the “Advisory Committee”) to provide annual
6 recommendations to the Secretary and Congress con-
7 cerning modifications to the benefits, items, and services
8 required under section 111(a)(1).

9 (b) COMPOSITION.—

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

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

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

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

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

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

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

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

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

6 (c) TERMS, VACANCIES.—Members of the Advisory
7 Committee shall be appointed for a term of 3 years and
8 may be reappointed for 1 additional term. In appointing
9 members, the Comptroller General shall stagger the terms
10 of the initial members so that the terms of one-third of
11 the members expire each year. Vacancies in the member-
12 ship of the Advisory Committee shall not affect the Com-
13 mittee's ability to carry out its functions. The Comptroller
14 General shall appoint an individual to fill the remaining
15 term of a vacant member within 2 months of being noti-
16 fied of such vacancy.

17 (d) COMPENSATION AND EXPENSES.—Each member
18 of the Advisory Committee who is not otherwise employed
19 by the United States Government shall receive compensa-
20 tion at a rate equal to the daily rate prescribed for GS-
21 18 under the General Schedule under section 5332 of title
22 5, United States Code, for each day, including travel time,
23 such member is engaged in the actual performance of du-
24 ties as a member of the Committee. A member of the Advi-
25 sory Committee who is an officer or employee of the

1 United States Government shall serve without additional
2 compensation. All members of the Advisory Committee
3 shall be reimbursed for travel, subsistence, and other nec-
4 essary expenses incurred by them in the performance of
5 their duties.

6 (e) ACTION BY SECRETARY.—Not later than Decem-
7 ber 31 of the second full calendar year following the date
8 of enactment of this Act, and each December 31 there-
9 after, the Advisory Committee shall provide to Congress
10 and the Secretary a report that—

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

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

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

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

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

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

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

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

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

5 (A) the excess of—

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

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

11 (B) the excess of—

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

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

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

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

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

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

7 (d) CHANGE IN STATUS NOTIFICATION.—

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

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

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

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

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

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

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

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

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

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

8 (B) increased by—

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

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

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

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

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

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

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

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

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

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

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

8 **Subtitle D—Wellness Programs**

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

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

18 (b) DISCOUNTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (4) AVAILABILITY OF DISCOUNTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—
 14 Subject to section 631(d), the Secretary, States, and
 15 health insurance issuers shall ensure that any child eligible
 16 under title XIX of the Social Security Act (including any
 17 child eligible under a waiver under such title or under sec-
 18 tion 1115 of such Act (42 U.S.C. 1315)) covered under
 19 a HAPI plan provided through the State HHA receives
 20 medical assistance under State Medicaid plans in a man-
 21 ner that—

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

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

3 (3) ensures that the child receives all items or
4 services that are not available (or are otherwise lim-
5 ited) under the HAPI plan in which they are en-
6 rolled but that is provided under the State plan (or
7 provided to a greater extent or in a less restrictive
8 manner) under title XIX of the Social Security Act
9 (including any waiver under such title or under sec-
10 tion 1115 of such Act (42 U.S.C. 1315)) of the
11 State in which the child resides; and

12 (4) ensures that the family of the child is not
13 charged premiums, deductibles, or other cost-sharing
14 that is greater than would have been charged under
15 the State plan under title XIX of the Social Security
16 Act of the State in which the child resides if such
17 coverage was not provided as a supplement to the
18 coverage provided the child under the HAPI plan in
19 which the child is enrolled.

20 (b) GUIDANCE TO STATES AND HEALTH INSURANCE
21 ISSUERS.—The Secretary shall issue regulations and guid-
22 ance to States and health insurance issuers implementing
23 this section not later than 6 months prior to the date on
24 which coverage under a HAPI plan first begins.

1 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
 2 tion shall be construed as affecting a State’s requirement
 3 to provide items and services described in section
 4 1905(a)(4)(B) (relating to early and periodic screening,
 5 diagnostic, and treatment services defined in section
 6 1905(r) and provided in accordance with the requirements
 7 of section 1902(a)(43)).

8 (d) CHILD.—In this section, the term “child” has the
 9 meaning given that term under section 201(d), and in-
 10 cludes any individual who would be considered a child
 11 under the Medicaid program of the State in which the in-
 12 dividual resides.

13 **Subtitle B—Service Providers**

14 **SEC. 211. INCLUSION OF PROVIDERS UNDER HAPI PLANS.**

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

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

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

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

3 (3) A federally qualified health center.

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

6 (5) An Indian health service facility.

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

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

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

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

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

19 (4) at a minimum, provides to school-aged chil-
20 dren—

21 (A) primary health care services, including
22 comprehensive health assessments, and diag-
23 nosis and treatment of minor, acute, and chron-
24 ic medical conditions and Healthy Start bene-
25 fits;

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

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

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

14 (E) by not later than January 1, 2012, an
15 electronic medical record relating to the indi-
16 vidual; and

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

22 (b) ACCESS TO SCHOOL-BASED HEALTH CEN-
23 TERS.—

24 (1) IN GENERAL.—A school-based health center
25 may provide services to students in more than 1

1 school if the school district or other supervising
2 State entity determined that capacity and geo-
3 graphic location make such provision of services ap-
4 propriate.

5 (2) ENROLLMENT.—Upon the enrollment of a
6 student in a school with a school-based health cen-
7 ter, the center will provide the student with the op-
8 portunity to enroll, after parental consent (subject to
9 State and local law), to receive health care from the
10 center.

11 (3) REIMBURSEMENT FOR SERVICES.—

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

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

24 (c) DEVELOPMENTAL GRANTS.—

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

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

10 (3) SELECTION CRITERIA.—In awarding grants
11 under this subsection, the Secretary shall give pri-
12 ority to—

13 (A) an applicant that will use amounts
14 under the grant to establish a school-based
15 health center in a medically underserved area,
16 or an area for which there are extended dis-
17 tances between the school involved and appro-
18 priate providers of care for school-aged children
19 in the geographic area involved;

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

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

7 (4) USE OF FUNDS.—A grantee shall use
8 amounts received under a grant under this sub-
9 section to establish and operate a school-based
10 health center (including purchasing and maintaining
11 electronic medical records). Not less than 50 percent
12 of the amounts received under the grant shall be
13 used for the ongoing operations of the center (in-
14 cluding such purchases and maintenance).

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

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

1 **TITLE III—BETTER HEALTH FOR**
2 **OLDER AND DISABLED AMER-**
3 **ICANS**

4 **Subtitle A—Assurance of**
5 **Supplemental Medicaid Coverage**

6 **SEC. 301. COORDINATION OF SUPPLEMENTAL COVERAGE**
7 **UNDER THE MEDICAID PROGRAM FOR EL-**
8 **DERLY AND DISABLED INDIVIDUALS.**

9 (a) ASSURANCE OF SUPPLEMENTAL COVERAGE.—

10 Subject to section 631(d), the Secretary, States, and
11 health insurance issuers shall ensure that any elderly or
12 disabled individual eligible under title XIX of the Social
13 Security Act (including any such individual eligible pursu-
14 ant to a waiver under such title or under section 1115
15 of such Act (42 U.S.C. 1315)) covered under a HAPI plan
16 provided through the State HHA receives medical assist-
17 ance under State Medicaid plans in a manner that—

18 (1) is provided in coordination with, and as a
19 supplement to, the coverage provided the individual
20 under the HAPI plans in which the individual is en-
21 rolled;

22 (2) does not supplant the individual's coverage
23 under a HAPI plan;

24 (3) ensures that the elderly or disabled indi-
25 vidual receives all items or services, including insti-

1 tutional care or home and community-based services
2 that are not available (or are otherwise limited)
3 under the HAPI plan in which they are enrolled but
4 that is provided (or provided to a greater extent or
5 in a less restrictive manner) under the State plan
6 under title XIX of the Social Security Act (including
7 through any waiver under such title or under section
8 1115 of such Act (42 U.S.C. 1315)) of the State in
9 which the individual resides;

10 (4) ensures that the elderly or disabled indi-
11 vidual is not charged premiums, deductibles and
12 other cost-sharing that is greater than would have
13 been charged under the State plan under title XIX
14 of the Social Security Act (including any waiver
15 under such title or under section 1115 of such Act
16 (42 U.S.C. 1315)) of the State in which the indi-
17 vidual resides if such coverage was not provided as
18 a supplement to the coverage provided the individual
19 under the HAPI plan in which the individual is en-
20 rolled.

21 (b) **GUIDANCE TO STATES AND HEALTH INSURANCE**
22 **ISSUERS.**—The Secretary shall issue regulations and guid-
23 ance to States and health insurance issuers implementing
24 this section that takes into account the special health care
25 needs of elderly and disabled individuals who are eligible

1 for medical assistance under State Medicaid programs,
2 particularly with respect to institutionalized care or home
3 and community-based services, not later than 6 months
4 prior to the date on which coverage under a HAPI plan
5 first begins.

6 (c) DEFINITIONS.—In this section—

7 (1) the term “institutionalized care” means the
8 health care provided under the Medicaid plan of the
9 State of residence of an elderly or disabled individual
10 who is a patient in a hospital, nursing facility, inter-
11 mediate care facility for the mentally retarded, or an
12 institution for mental diseases (as such terms are
13 defined for purposes of such plan); and

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

1 **Subtitle B—Empowering Individ-**
 2 **uals and States To Improve**
 3 **Long-Term Care Choices**

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

6 (a) IN GENERAL.—Title XIX of the Social Security
 7 Act (42 U.S.C. 1396 et seq.) is amended by adding at
 8 the end the following new section:

9 “STATE CHOICES FOR LONG-TERM CARE PROGRAM

10 “SEC. 1942. (a) IN GENERAL.—Notwithstanding any
 11 other provision of this title, the Secretary shall permit a
 12 State to establish and operate under the State plan under
 13 this title (including such a plan operating under a state-
 14 wide waiver under section 1115) a State Choices for Long-
 15 Term Care Program in accordance with this section.

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

19 “(1) INDIVIDUALIZED BENEFIT PACKAGE.—

20 Each individual enrolled in the program shall be pro-
 21 vided with long-term care coverage consisting of
 22 medical assistance for long-term care services that
 23 are provided according to the specific needs of the
 24 individual and that best reflect the individual’s needs

1 and preferences, based on a clinical assessment of
2 the individual.

3 “(2) PERSONAL CASE MANAGERS.—Each indi-
4 vidual enrolled in the program shall be provided with
5 a personal case manager who shall assist the indi-
6 vidual in—

7 “(A) determining the individual’s needs
8 and preferences for the long-term care services
9 that are contained within the individual’s ben-
10 efit package, including the selection of the serv-
11 ice providers for such services;

12 “(B) identifying community resources that
13 are available to provide support for the indi-
14 vidual; and

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

18 “(3) INFORMED CHOICE.—The program shall
19 have procedures to ensure that each individual that
20 is likely to satisfy the eligibility criteria established
21 for the program under paragraph (6) who is dis-
22 charged from a hospital or who resides in a nursing
23 facility, intermediate care facility for the mentally
24 retarded, or institution for mental diseases and who
25 requires long-term care services is informed of the

1 options available to the individual under the pro-
2 gram for obtaining such services.

3 “(4) SELF-DIRECTED OPTION.—The program
4 shall provide an individual enrolled in the program
5 with the option to elect to plan and purchase the
6 long-term care services that are contained in the in-
7 dividual’s benefit package under the direction and
8 control of the individual (or the individual’s author-
9 ized representative), subject to an individualized
10 budget developed for, and with the involvement of,
11 the individual (or the individual’s authorized rep-
12 resentative).

13 “(5) EQUAL ACCESS TO INSTITUTIONAL CARE
14 AND HOME AND COMMUNITY-BASED SERVICES.—The
15 program shall provide an individual enrolled in the
16 program who, because of the individual’s mental or
17 physical condition, requires a level of care for long
18 term care services that is above a level of care for
19 such services that can appropriately be provided
20 solely through home and community-based providers
21 (as defined by the State and approved by the Sec-
22 retary), with equal access to long-term care services
23 provided through institutional facilities and long-
24 term care services provided through home and com-
25 munity-based providers.

1 “(6) ELIGIBILITY; PRIORITIZATION OF NEED.—
2 The program shall apply eligibility criteria for indi-
3 viduals desiring to enroll in the program that is es-
4 tablished by the State and approved by the Sec-
5 retary. The eligibility criteria established by the
6 State shall—

7 “(A) require that an individual enrolled in
8 the program—

9 “(i) be eligible for medical assistance
10 under the State plan (or under a statewide
11 waiver of such plan) for nursing facility
12 services, services in an intermediate care
13 facility for the mentally retarded, services
14 in an institution for mental diseases, or
15 services provided under a home and com-
16 munity-based waiver approved for the
17 State; and

18 “(ii) satisfy such other criteria as the
19 State shall establish; and

20 “(B) be based on a strategy for prioritizing
21 and allocating expenditures so that those indi-
22 viduals with the highest level of need for long-
23 term care services are assured of receiving such
24 services through an institutional facility or

1 through a home and community-based provider,
2 based on the individual's needs and preferences.

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

6 “(1) AGREEMENT TO LIMIT FEDERAL EXPENDI-
7 TURES.—

8 “(A) IN GENERAL.—The State agrees to
9 an aggregate limit for a 5-year period for Fed-
10 eral payments under section 1903(a) for ex-
11 penditures for medical assistance for long-term
12 care services under the State plan and adminis-
13 trative expenditures related to the provision of
14 such assistance.

15 “(B) CALCULATION OF AGGREGATE
16 LIMIT.—The 5-year aggregate limit applicable
17 to a State under subparagraph (A) shall be de-
18 termined by the State and the Secretary based
19 on the following:

20 “(i) HISTORICAL AND PROJECTED
21 CASELOADS.—The historical and projected
22 State caseloads (determined for a 5-year
23 period, respectively) of individuals receiving
24 nursing facility services, services in an in-
25 termediate care facility for the mentally re-

1 tarded, services in an institution for men-
2 tal diseases, or services provided under a
3 home and community-based waiver ap-
4 proved for the State under the State plan,
5 based on data from the Secretary, the Bu-
6 reau of the Census, the Commissioner of
7 Social Security, and such other sources as
8 the Secretary may approve.

9 “(ii) HISTORICAL AND PROJECTED
10 EXPENDITURES.—The historical and pro-
11 jected expenditures (determined for a 5-
12 year period, respectively) for the services
13 identified in clause (i). Projected expendi-
14 tures shall be determined without regard to
15 the program established under this section
16 and shall take into account the percentage
17 change (if any) in the medical care compo-
18 nent of the consumer price index for all
19 urban consumers (U.S. city average) for
20 each year of the period.

21 “(C) RULE OF CONSTRUCTION.—Nothing
22 in this paragraph shall be construed as affect-
23 ing the requirement for a State to incur State
24 expenditures for medical assistance for long-
25 term care services in order to be paid the Fed-

1 eral medical assistance percentage determined
2 for the State for such expenditures (not to ex-
3 ceed the aggregate 5-year limit on Federal pay-
4 ments for such expenditures applicable under
5 subparagraph (A)).

6 “(2) PLAN FOR CAPACITY BUILDING AND
7 SKILLS ENHANCEMENT.—The State establishes a
8 plan for building the capacity of the long-term care
9 services system within the State, particularly with
10 respect to the delivery of home and community-
11 based services, and for enhancing the skill levels of
12 the caregivers for individuals eligible for medical as-
13 sistance for such services under the State plan.

14 “(3) DEDICATION OF PROGRAM SAVINGS FOR
15 PREVENTION OR EARLY INTERVENTION SERVICES.—
16 The State agrees that for each fiscal year in which
17 the program is operated, the State will expend an
18 amount equal to the State share of the expenditures
19 that the State would have made under the State
20 plan for providing medical assistance for long-term
21 care services for individuals enrolled in the program
22 but for the operation of such program, for the provi-
23 sion of prevention or early intervention services for
24 nonenrolled individuals residing in the State who re-
25 quire a level of long-term care services that is below

1 the level that individuals enrolled in the program re-
2 quire (regardless of whether such nonenrolled indi-
3 viduals are eligible for medical assistance under the
4 State plan).

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

10 “(e) INDEPENDENT EVALUATION AND REPORT.—

11 “(1) IN GENERAL.—The Secretary shall con-
12 tract with a nongovernmental organization or aca-
13 demic institution to conduct an ongoing independent
14 evaluation of the program that assesses—

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

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

18 “(C) consumer satisfaction; and

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

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

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

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

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

11 (a) QUALIFIED LONG-TERM CARE INSURANCE CON-
 12 TRACT MUST SATISFY QUALIFIED LONG-TERM CARE
 13 PLAN REQUIREMENTS.—Section 7702B(b)(1)(A) of the
 14 Internal Revenue Code of 1986 (defining qualified long-
 15 term care insurance contract) is amended by inserting
 16 “through a qualified long-term care plan” after “qualified
 17 long-term care services”.

18 (b) QUALIFIED LONG-TERM CARE PLAN.—Section
 19 7702B of such Code is amended by adding at the end the
 20 following new subsection:

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

23 “(1) IN GENERAL.—The term ‘qualified long-
 24 term care plan’ means an insurance plan that meets
 25 the standards and requirements set forth in para-

1 graph (2) (including the 2011 NAIC Model Regula-
2 tion or 2011 Federal Regulation (as the case may
3 be)) on or after the date specified in paragraph (5).

4 “(2) DEVELOPMENT OF STANDARDS AND RE-
5 QUIREMENTS FOR QUALIFIED LONG-TERM CARE
6 PLANS.—

7 “(A) IN GENERAL.—If, within 9 months
8 after the date of the enactment of this sub-
9 section, the National Association of Insurance
10 Commissioners (in this subsection referred to as
11 the ‘Association’) adopts a model regulation (in
12 this section referred to as the ‘2011 NAIC
13 Model Regulation’) to incorporate—

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

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

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

22 “(iv) other standards required by the
23 Secretary of Health and Human Services,

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

4 “(B) SECRETARIAL RESPONSIBILITY.—If
5 the Association does not adopt the 2011 NAIC
6 Model Regulation within the 9-month period
7 specified in subparagraph (A), the Secretary
8 shall promulgate, not later than 9 months after
9 the end of such period, a regulation (in this sec-
10 tion referred to as the ‘2011 Federal Regula-
11 tion’) and paragraph (1) shall be applied in
12 each State, effective for policies issued to pol-
13 icyholders on and after the date specified in
14 paragraph (5).

15 “(C) CONSULTATION.—In promulgating
16 standards and requirements under this para-
17 graph, the Association or Secretary shall con-
18 sult with a working group composed of rep-
19 resentatives of issuers of long-term care insur-
20 ance policies, consumer groups, long-term care
21 insurance beneficiaries, and other qualified indi-
22 viduals. Such representatives shall be selected
23 in a manner so as to insure balanced represen-
24 tation among the interested groups.

1 “(3) LIMITATIONS OF GROUPS OR PACKAGES OF
2 BENEFITS.—The benefits under the 2011 NAIC
3 Model Regulation or 2011 Federal Regulation shall
4 provide—

5 “(A) for such groups or packages of bene-
6 fits as may be appropriate taking into account
7 the considerations specified in paragraph (4)
8 and the requirements of the succeeding sub-
9 paragraphs,

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

12 “(C) that the total number of different
13 benefit packages (counting the core group of
14 basic benefits described in subparagraph (B)
15 and each other combination of benefits that
16 may be offered as a separate benefit package)
17 that may be established in all the States and by
18 all issuers shall not exceed 10.

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

21 “(A) provide for benefits that offer con-
22 sumers the ability to purchase the benefits that
23 are available in the market as of November 5,
24 2010, and

25 “(B) balance the objectives of—

- 1 “(i) simplifying the market to facili-
2 tate comparisons among policies,
3 “(ii) avoiding adverse selection,
4 “(iii) providing consumer choice,
5 “(iv) providing market stability, and
6 “(v) promoting competition.

7 “(5) EFFECTIVE DATE.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the date specified in this paragraph
10 shall be the date the State adopts the 2011
11 NAIC Model Regulation or 2011 Federal Regu-
12 lation or 1 year after the date the Association
13 or the Secretary first adopts such standards,
14 whichever is earlier.

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

18 “(i) requiring State legislation (other
19 than legislation appropriating funds) in
20 order for long-term care insurance policies
21 to meet the 2011 NAIC Model Regulation
22 or 2011 Federal Regulation, but

23 “(ii) having a legislature which is not
24 scheduled to meet in 2011 in a legislative

1 session in which such legislation may be
2 considered,
3 the date specified in this paragraph is the first
4 day of the first calendar quarter beginning after
5 the close of the first legislative session of the
6 State legislature that begins on or after Janu-
7 ary 1, 2012. For purposes of the preceding sen-
8 tence, in the case of a State that has a 2-year
9 legislative session, each year of such session
10 shall be deemed to be a separate regular session
11 of the State legislature.”.

12 (c) ADDITIONAL CONSUMER PROTECTIONS.—

13 (1) IN GENERAL.—Section 7702B(g)(1) of such
14 Code (relating to consumer protection provisions) is
15 amended—

16 (A) by striking subparagraph (A) and in-
17 serting the following new paragraph:

18 “(1) the requirements of the 1993 NAIC model
19 regulation and model Act described in paragraph (2)
20 and the 2000 NAIC model regulation and model Act
21 described in paragraph (5),”

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

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

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

3 “(D) the requirements relating to manda-
4 tory offer and information under paragraph
5 (6).”.

6 (2) NAIC MODEL REGULATION AND ACT.—Sec-
7 tion 7702B(g) of such Code is amended—

8 (A) by inserting “1993 NAIC” after “RE-
9 QUIREMENTS OF” in the heading for paragraph
10 (2),

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

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

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

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

20 “(i) MODEL REGULATION.—The fol-
21 lowing requirements of the model regula-
22 tion:

23 “(I) Section 6A (other than para-
24 graph (5) thereof) and the require-

1 ments of section 6B of the model Act
2 relating to such section 6A.

3 “(II) Section 6B (other than
4 paragraph (7) thereof).

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

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

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

11 “(VI) Section 23, including inac-
12 curate completion of medical histories
13 (other than paragraphs (1), (6), and
14 (9) of section 23C).

15 “(VII) Sections 24 and 25.

16 “(VIII) The provisions of section
17 26 relating to contingent nonforfeiture
18 benefits, if the policyholder declines
19 the offer of a nonforfeiture provision
20 described in paragraph (4).

21 “(IX) Sections 29 and 30.

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

24 “(I) Sections 6C and 6D.

1 “(II) The provisions of section 8
2 relating to contingent nonforfeiture
3 benefits.

4 “(III) Sections 6F, 6G, 6H, 6J,
5 6K, and 7.

6 “(B) DEFINITIONS.—For purposes of this
7 paragraph—

8 “(i) MODEL PROVISIONS.—The terms
9 ‘model regulation’ and ‘model Act’ mean
10 the long-term care insurance model regula-
11 tion, and the long-term care insurance
12 model Act, respectively, promulgated by
13 the National Association of Insurance
14 Commissioners (as adopted as of October
15 2000).

16 “(ii) COORDINATION.—Any provision
17 of the model regulation or model Act listed
18 under clause (i) or (ii) of subparagraph
19 (A) shall be treated as including any other
20 provision of such regulation or Act nec-
21 essary to implement the provision.

22 “(iii) DETERMINATION.—For pur-
23 poses of this section and section 4980C,
24 the determination of whether any require-
25 ment of a model regulation or the model

1 Act has been met shall be made by the
2 Secretary.”.

3 (d) MANDATORY OFFER AND INFORMATION.—Sec-
4 tion 7702B(g) of such Code, as amended by subsection
5 (c), is amended by inserting after paragraph (5) the fol-
6 lowing new paragraph:

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

9 “(A) MANDATORY OFFER.—Any person
10 who sells a long-term care insurance policy to
11 an individual shall make available for sale to
12 the individual a long-term care insurance policy
13 with only the core group of basic benefits (de-
14 scribed in subsection (h)(3)(B)).

15 “(B) INFORMATION.—Any person who sells
16 a long-term care insurance policy to an indi-
17 vidual shall provide the individual, before the
18 sale of the policy, an outline of coverage which
19 describes the benefits under the policy. Such
20 outline shall be on a standard form approved by
21 the State regulatory program or the Secretary
22 (as the case may be) consistent with the 2011
23 NAIC Model Regulation or 2011 Federal Regu-
24 lation.”.

1 (e) STATE REGULATION OF OUT-OF-STATE CON-
 2 TRACTS.—Section 7702B of such Code, as amended by
 3 subsection (b), is amended by adding at the end the fol-
 4 lowing new subsection:

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

10 (f) EFFECTIVE DATE.—The amendments made by
 11 this section shall apply to contracts issued after December
 12 31, 2010.

13 **TITLE IV—HEALTHIER**
 14 **MEDICARE**

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

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

22 Section 1839 of the Social Security Act (42 U.S.C.
 23 1395r) is amended—

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

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

3 “(j)(1) With respect to the monthly premium amount
4 for months after December 2010, the Secretary may ad-
5 just (under procedures established by the Secretary) the
6 amount of such premium for an individual based on
7 whether or not the individual participates in certain
8 healthy behaviors, such as weight management, exercise,
9 nutrition counseling, refraining from tobacco use, desig-
10 nating a health home, and other behaviors determined ap-
11 propriate by the Secretary.

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

19 **Subtitle B—Promoting Primary**
20 **Care for Medicare Beneficiaries**

21 **SEC. 411. PRIMARY CARE SERVICES MANAGEMENT PAY-**
22 **MENT.**

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

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

3 “(a) PAYMENT.—

4 “(1) IN GENERAL.—Not later than January 1,
5 2010, the Secretary, subject to paragraph (2), shall
6 establish procedures for providing primary care and
7 participating providers with a management fee (as
8 determined appropriate by the Secretary, in con-
9 sultation with the Medicare Payment Advisory Com-
10 mission established under section 1805) that reflects
11 the amount of time spent with a Medicare bene-
12 ficiary, and the family of such beneficiary, providing
13 chronic care disease management services or other
14 services in assisting in coordinating care.

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

22 “(b) DEFINITIONS.—In this section:

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

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

5 “(3) PRIMARY CARE PROVIDER.—

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

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

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

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

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

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

3 “(a) ESTABLISHMENT.—

4 “(1) IN GENERAL.—Not later than January 1,
5 2010, the Secretary shall develop and implement a
6 chronic care disease management program (in this
7 section referred to as the ‘program’). The program
8 shall be designed to provide chronic care disease
9 management to all Medicare beneficiaries with re-
10 spect to at least the 5 most prevalent diseases within
11 the population of such beneficiaries (as determined
12 by the Secretary).

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

16 “(A) take into consideration—

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

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

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

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

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

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

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

25 “(d) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

3 **Subtitle D—Part D Improvements**

4 **SEC. 431. PROCESS FOR INDIVIDUALS ENTERING THE** 5 **MEDICARE COVERAGE GAP TO SWITCH TO A** 6 **PLAN THAT PROVIDES COVERAGE IN THE** 7 **GAP.**

8 (a) PROCESS.—Notwithstanding any other provision
9 of law, by not later than 30 days after the date of enact-
10 ment of this Act, the Secretary shall establish a process
11 under which an applicable individual may terminate enroll-
12 ment in the prescription drug plan or the MA–PD plan
13 in which they are enrolled and enroll in any prescription
14 drug plan or MA–PD plan—

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

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

24 (b) SPECIAL RULE PERMITTING APPLICABLE INDI-
25 VIDUALS TO ENROLL IN A PRESCRIPTION DRUG PLAN

1 OUTSIDE OF THE REGION IN WHICH THE INDIVIDUAL
2 RESIDES.—In the case of an applicable individual who re-
3 sides in a PDP region under section 1860D–11(a)(2) of
4 the Social Security Act (42 U.S.C. 1395w–111(a)(2)) in
5 which there is no prescription drug plan available that pro-
6 vides some coverage of brand name covered part D drugs
7 (as so defined) after the individual has reached the initial
8 coverage limit under the plan but before the individual has
9 reached such annual out-of-pocket threshold, the Sec-
10 retary shall ensure that the process established under sub-
11 section (a) permits the individual to enroll in a prescrip-
12 tion drug plan that provides such coverage but is in an-
13 other PDP region. The Secretary shall determine the PDP
14 region in which the individual may enroll in such a pre-
15 scription drug plan.

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

1 (d) PROCESS IN EFFECT THROUGH 2014.—The
2 process established under subsection (a) shall remain in
3 effect through December 31, 2014.

4 (e) DEFINITIONS.—In this section:

5 (1) APPLICABLE INDIVIDUAL.—The term “ap-
6 plicable individual” means a part D eligible indi-
7 vidual (as defined in section 1860D–1(a)(3)(A) of
8 the Social Security Act (42 U.S.C. 1395w–
9 101(a)(3)(A)) who, with respect to a year—

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

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

19 (2) PRESCRIPTION DRUG PLAN; MA–PD PLAN.—
20 The terms “prescription drug plan” and “MA–PD
21 plan” have the meanings given those terms in sec-
22 tion 1860D–41(a)(14) of the Social Security Act (42
23 U.S.C. 1395w–151(a)(14)) and section 1860D–
24 1(a)(3)(C) of such Act (42 U.S.C. 1395w–
25 101(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 2009 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 “(4) **ADDITIONAL COST INFORMATION.**—A con-
2 tract under this section shall require a Medicare Ad-
3 vantage Organization to aggregate claims informa-
4 tion into episodes of care and to provide such infor-
5 mation to the Secretary so that costs for specific
6 hospitals and physicians may be measured and com-
7 pared. The Secretary shall make such information
8 public on an annual basis.”.

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

12 **SEC. 462. REDUCING MEDICARE PAPERWORK AND REGU-**
13 **LATORY BURDENS.**

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

21 **TITLE V—STATE HEALTH HELP**
22 **AGENCIES**

23 **SEC. 501. ESTABLISHMENT.**

24 As a condition of receiving payment under section
25 503, a State shall, not later than the date that is 2 years

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 CHIP; 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 1943
4 of the Social Security Act (as added by section 673(a) of
5 this Act), and subsections (a) and (b) of section 1942 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
 20 or local government, or any other type of entity for

1 which the Secretary determines that calculating revenue per employee is not appropriate, the applicable
2 percentage shall be—
3

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

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

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

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

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

20 “(4) REVENUE PER EMPLOYEE NATIONAL PER-
21 CENTILE RANK.—At the beginning of each calendar
22 year, the Secretary, in consultation with the Sec-
23 retary of Labor, shall publish a table, based on sam-
24 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 designated employee health
16 insurance premium amount paid with re-
17 spect to such employee before such dis-
18 tribution.

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

1 mum amount paid by the employer with
2 respect to the employee.

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

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

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

1 “(2) TRANSITION RATE FOR OTHER EMPLOY-
2 ERS.—In the case of any employer who did not pro-
3 vide health insurance to employees on the day before
4 the date of enactment of the Healthy Americans
5 Act—

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

11 “(B) the employer shared responsibility
12 payment for the second year this section applies
13 shall be an amount equal $\frac{2}{3}$ of the amount oth-
14 erwise required under this section (determined
15 without regard to this subsection).

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

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

1 **“Subchapter B—Individual Shared**
2 **Responsibility Payments**

“Sec. 3421. Amount of payment.

“Sec. 3422. Deduction of tax from wages.

3 **“SEC. 3421. AMOUNT OF PAYMENT.**

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

7 “(b) EXCEPTION.—This section shall not apply to
8 any individual—

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

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

16 **“SEC. 3422. DEDUCTION OF INDIVIDUAL SHARED RESPON-**
17 **SIBILITY PAYMENT FROM WAGES.**

18 “(a) IN GENERAL.—The individual shared responsi-
19 bility payment imposed by section 3421 shall be collected
20 by the employer by deducting the amount of the payment
21 from the wages as and when paid. The preceding sentence
22 shall not apply to any employer who employs an average
23 of less than 10 full-time equivalent employees during such
24 year.

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

6 “(c) INDEMNIFICATION OF EMPLOYER; SPECIAL
 7 RULE FOR TIPS.—Rules similar to the rules of subsections
 8 (b) and (e) of section 3102 shall apply for purposes of
 9 this section.

10 **“Subchapter C—General Provisions**

“Sec. 3431. Definitions and special rules.

“Sec. 3432. Labor contracts.

11 **“SEC. 3431. DEFINITIONS AND SPECIAL RULES.**

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

13 “(1) AVERAGE HAPI PLAN PREMIUM
 14 AMOUNT.—The term ‘average HAPI plan premium
 15 amount’ means the national average yearly premium
 16 for HAPI plans with standard coverage (as deter-
 17 mined under section 111(b) of the Healthy Ameri-
 18 cans Act), determined without regard to differing
 19 classes of coverage.

20 “(2) DESIGNATED EMPLOYEE HEALTH INSUR-
 21 ANCE PREMIUM AMOUNT.—The term ‘designated
 22 employee health insurance premium amount’ means
 23 the greater of—

1 “(A) the yearly premium paid by an em-
2 ployer for health insurance coverage for employ-
3 ees for the most recent calendar year ending be-
4 fore the date of enactment of the Healthy
5 Americans Act, or

6 “(B) the yearly premium paid by an em-
7 ployer for health insurance coverage for employ-
8 ees for the year before the first year this section
9 applies.

10 “(3) EMPLOYER.—

11 “(A) IN GENERAL.—The term ‘employer’
12 has the meaning given such term under section
13 3401(d).

14 “(B) AGGREGATION RULES.—For purposes
15 of this chapter, all persons treated as a single
16 employer under subsection (a) or (b) of section
17 52 shall be treated as 1 person.

18 “(4) EMPLOYMENT.—The term ‘employment’
19 has the meaning given such term under section
20 3121(b).

21 “(5) FULL-TIME EQUIVALENT EMPLOYEE.—
22 The term ‘full-time equivalent employee’ means the
23 equivalent number of full-time employees of an em-
24 ployer determined for any year under the following
25 formula:

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

4 “(B) The quotient of—

5 “(i) the sum of the average weekly
6 hours worked during such year for each
7 employee of the employer (including com-
8 mon law employees) who—

9 “(I) was employed by such em-
10 ployer during such year for more than
11 3 months, and

12 “(II) is not a full-time employee,
13 divided by

14 “(ii) 40.

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

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

1 “(8) HAPI PLAN PREMIUM AMOUNT.—The
2 term ‘HAPI plan premium amount’ means, with re-
3 spect to any individual, the monthly premium for the
4 HAPI plan under which such individual is enrolled,
5 determined after taking into account any subsidy
6 provided to such individual under section 131 of the
7 Healthy Americans Act.

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

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

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

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

24 “(b) SPECIAL RULES.—

1 “(1) SPECIAL RULE FOR SELF-EMPLOYED INDI-
2 VIDUALS.—For purposes of this chapter, a self-em-
3 ployed individual (as defined by section
4 401(c)(1)(B)) shall be treated as both a full-time
5 equivalent employee and as an employer.

6 “(2) TREATMENT OF PAYMENTS.—For pur-
7 poses of this title, the payments required by sections
8 3411 and 3421 shall be treated as a tax imposed by
9 such sections, respectively.

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

13 “(A) Section 3122 (relating to Federal
14 service).

15 “(B) Section 3123 (relating to deductions
16 as constructive payments).

17 “(C) Section 3125 (relating to returns in
18 the case of governmental employees in States,
19 Guam, American Samoa, and the District of
20 Columbia).

21 “(D) Section 3126 (relating to return and
22 payment by government employer).

23 “(E) Section 3127 (relating to exemption
24 for employers and their employees where both

1 are members of religious faiths opposed to par-
2 ticipation in social security act programs).

3 **“SEC. 3432. LABOR CONTRACTS.**

4 “(a) IN GENERAL.—This chapter shall not apply with
5 respect to any qualified collective bargaining employee of
6 any qualified collective bargaining employer before the
7 earlier of—

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

11 “(2) the date the collective bargaining agree-
12 ment expires.

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

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

20 “(2) QUALIFIED COLLECTIVE BARGAINING EM-
21 PLOYEE.—The term ‘qualified collective bargaining
22 employee’ means an employee of a qualified collec-
23 tive bargaining employer who is covered by a collec-
24 tive bargaining agreement governing the employee’s
25 health insurance.”.

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

“CHAPTER 24A—HEALTH CARE RESPONSIBILITY PAYMENTS”.

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

9 (1) in subsection (a), by striking “and the tax
10 under chapter 2” and inserting “, the tax under
11 chapter 2, and the individual shared responsibility
12 payment required under subchapter B of chapter
13 24A”, and

14 (2) in subsection (f)—

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

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

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

21 “(3) the individual shared responsibility pay-
22 ment required under subchapter B of chapter 24A,
23 minus

1 “(4) the amount withheld as an individual
2 shared responsibility payment under section 3422,
3 minus”.

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

7 **SEC. 612. DISTRIBUTION OF INDIVIDUAL RESPONSIBILITY**
8 **PAYMENTS TO HHAS.**

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

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

19 **Subtitle C—Insurer**
20 **Responsibilities**

21 **SEC. 621. INSURER RESPONSIBILITIES.**

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

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

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

5 (2) ensure that a wellness program as described
6 in section 131 is available to all covered individuals
7 so long as such a wellness program meets the re-
8 quirements of the health insurance issuers and other
9 relevant requirements;

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

15 (4) ensure enrollees have the opportunity to
16 designate a health home as described in section
17 111(b) and make public how many enrollees per pol-
18 icy have designated a health home;

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

22 (6) create and implement an electronic medical
23 record for each covered individual, unless the indi-
24 vidual submits a notification to the issuer that the
25 individual declines to have such a record;

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

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

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

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

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

19 (A) for parents, if a covered child partici-
20 pates in wellness activities and the health of
21 such child improves; and

22 (B) for adults covered by a plan to partici-
23 pate in prevention, wellness and chronic disease
24 management programs;

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

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

13 (14) provide to the HHA of each State in which
14 the issuer offers a HAPI plan, detailed information
15 on the HAPI plans offered by such issuer, using
16 standardized language as required by the HHA, so
17 that the HHA may compile a document that com-
18 pares the HAPI plans for use by prospective enroll-
19 ees; and

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

25 (c) UNIFORM BILLING PRACTICES.—

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

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

8 (d) CHRONIC CARE PROGRAMS OFFERED BY
9 ISSUERS.—

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

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

19 (3) UNIFORM CLINICAL PERFORMANCE STAND-
20 ARDS.—Each chronic care program offered by a
21 health insurance issuer shall use a uniform set of
22 clinical performance standards prescribed by the
23 HHA of the State in which the issuer offers a HAPI
24 plan (in consultation with the State Medicare quality
25 improvement organizations and patient and physi-

1 cian organizations) which should include encourage-
2 ment that the issuers not require personal responsi-
3 bility contributions for clinically needed services to
4 treat or manage a covered individual's chronic dis-
5 ease, particularly if the individual is taking an active
6 management role in working with their provider to
7 manage any such disease.

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

18 (e) PRIVATE INSURANCE COMPANY LOSS RATIO.—

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

1 (2) DETERMINATION OF LOSS RATIO.—In de-
2 termining the loss ratio, administrative costs shall be
3 defined as expenses consisting of all actual, allow-
4 able, allocable, and reasonable expenses incurred in
5 the adjudication of subscriber benefit claims or in-
6 curred in the health insurance issuer’s overall oper-
7 ation of the business.

8 (3) ADMINISTRATIVE EXPENSES.—Unless oth-
9 erwise determined by an agreement between a State
10 HHA and a health insurance issuer, the administra-
11 tive expenses of an issuer shall—

12 (A) include all taxes (excluding premium
13 taxes) reinsurance premiums, medical and den-
14 tal consultants used in the adjudication process,
15 concurrent or managed care review when not
16 billed by a health care provider and other forms
17 of utilization review, the cost of maintaining eli-
18 gibility files, legal expenses incurred in the liti-
19 gation of benefit payments, and bank charges
20 for letters of credit; and

21 (B) not include the cost of personnel,
22 equipment, and facilities directly used in the de-
23 livery of health care services (benefit costs),
24 payments to HHAs for establishment and ad-
25 ministration of HHAs, and the cost of over-

1 seeing chronic disease management programs
2 and wellness programs.

3 **Subtitle D—State Responsibilities**

4 **SEC. 631. STATE RESPONSIBILITIES.**

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

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

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

11 (A) are sold only through the State HHA
12 (except for employer-sponsored health coverage
13 plans described under section 103 offered by
14 employers); and

15 (B) comply with the requirements of this
16 Act;

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

20 (4) make risk-adjusted payments to all health
21 insurance issuers and employers offering a HAPI
22 plan in such State to account for the specific popu-
23 lation covered by the plan, in accordance with guide-
24 lines established by the Secretary;

1 (5) ensure that HAPI plans offer premium dis-
2 counts and incentives for participation in wellness
3 programs;

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

8 (7) continue to apply State law with respect
9 to—

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

12 (B) fair marketing practices for health in-
13 surance issuers;

14 (C) grievances and appeals for covered in-
15 dividuals; and

16 (D) patient protection;

17 (8) eliminate fictitious group prohibitions; and

18 (9) comply with subsections (b), (c), and (d).

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

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

1 (2) implement methods to check enrollment sta-
2 tus and enroll individuals in HAPI plans, such as
3 through the Department of Motor Vehicles of the
4 State, the enrollment of children in elementary and
5 secondary schools, the voter registration authority of
6 the State, and other checkpoints determined appro-
7 priate by the State;

8 (3) implement mechanisms, which may not in-
9 clude revocation or ineligibility for coverage under a
10 HAPI plan, to enforce the responsibility of each
11 adult individual to purchase HAPI plan coverage for
12 such individual and any dependent children of such
13 individual; and

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

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

24 (1) in the case of the first State fiscal year for
25 which such a report is submitted, 100 percent of the

1 total amount of the State share of expenditures for
2 such services under all public health programs oper-
3 ated in the State that are funded in whole or in part
4 with State expenditures (including the Medicaid pro-
5 gram) for the most recent State fiscal year ending
6 before January 1 of the first calendar year in which
7 HAPI coverage begins under this Act; and

8 (2) in the case of any subsequent State fiscal
9 year for which such a report is submitted, the
10 amount applicable under this subsection for the pre-
11 ceding State fiscal year increased by the percentage
12 change, if any, in the consumer price index for all
13 urban consumers over the previous Federal fiscal
14 year.

15 (d) MAINTENANCE OF ELIGIBILITY AND BENEFITS
16 UNDER STATE MEDICAID PROGRAMS.—A State shall en-
17 sure that eligibility and benefits under the State plan
18 under title XIX of the Social Security Act (including eligi-
19 bility or benefits provided through any waiver under such
20 title or under section 1115 of such Act (42 U.S.C. 1315)
21 and premiums, deductibles, co-payments, or other cost-
22 sharing imposed for benefits under such plan or waiver),
23 are no more restrictive than the eligibility or benefits, re-
24 spectively, under such plan or waiver as in effect on the
25 date of enactment of the Healthy Americans Act.

1 **SEC. 632. EMPOWERING STATES TO INNOVATE THROUGH**
2 **WAIVERS.**

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

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

8 (1) the State approves a plan to provide health
9 care coverage to its residents that is at least as com-
10 prehensive as the coverage required under a HAPI
11 plan; and

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

18 (c) **DETERMINATIONS BY SECRETARY.**—

19 (1) **IN GENERAL.**—Not later than 180 days
20 after the receipt of an application from a State
21 under subsection (b)(2), the Secretary shall make a
22 determination with respect to the granting of a wai-
23 ver under this section to such State.

24 (2) **GRANTING OF WAIVER.**—If the Secretary
25 determines that a waiver should be granted under
26 this section, the Secretary shall notify the State in-

1 involved of such determination and the terms and ef-
2 fectiveness of such waiver.

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

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

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

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

15 **Subtitle E—Federal Fallback**
16 **Guarantee Responsibility**

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

18 (a) FEDERAL GUARANTEE.—

19 (1) IN GENERAL.—If a State does not establish
20 an HHA in compliance with title V by the date that
21 is 2 years after the date of enactment of this Act,
22 the Secretary shall ensure that each individual has
23 available, consistent with paragraph (2), a choice of
24 enrollment in at least 2 HAPI plans in the coverage
25 area in which the individual resides. In any such

1 case in which such plans are not available, the indi-
2 vidual shall be given the opportunity to enroll in a
3 fallback HAPI plan.

4 (2) REQUIREMENT FOR DIFFERENT PLAN
5 SPONSORS.—The requirement in paragraph (1) is
6 not satisfied with respect to a coverage area if only
7 1 entity offers all the HAPI plans in the area.

8 (b) CONTRACTS.—

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

14 (2) COMPETITIVE PROCEDURES.—Competitive
15 procedures (as defined in section 4(5) of the Office
16 of Federal Procurement Policy Act (41 U.S.C.
17 403(5))) shall be used to enter into a contract under
18 this subsection.

19 (c) FALLBACK HAPI PLAN.—For purposes of this
20 section, the term “fallback HAPI plan” means a HAPI
21 plan that—

22 (1) meets the requirements described in section
23 111(b) and does not provide actuarially equivalent
24 coverage described in section 111(c); and

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

3 **Subtitle F—Federal Financing**
4 **Responsibilities**

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

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

10 **SEC. 652. RECAPTURE OF MEDICARE AND 90 PERCENT OF**
11 **MEDICAID FEDERAL DSH FUNDS TO**
12 **STRENGTHEN MEDICARE AND ENSURE CON-**
13 **TINUED SUPPORT FOR PUBLIC HEALTH PRO-**
14 **GRAMS.**

15 (a) RECAPTURE OF MEDICARE DSH FUNDS.—

16 (1) IN GENERAL.—Section 1886(d)(5)(F)(i) of
17 the Social Security Act (42 U.S.C.
18 1395ww(d)(5)(F)(i)) is amended by inserting “and
19 before January 1 of the first calendar year in which
20 coverage under a HAPI plan begins under the
21 Healthy Americans Act,” after “May 1, 1986,”.

22 (2) SAVINGS TO PART A TRUST FUND.—The
23 savings to the Federal Hospital Insurance Trust
24 Fund by reason of the amendment made by para-

1 graph (1) shall be used to strengthen the financial
2 solvency of such Trust Fund.

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

5 (1) HEALTHY AMERICANS PUBLIC HEALTH
6 TRUST FUND.—Subchapter A of chapter 98 of the
7 Internal Revenue Code of 1986 (relating to trust
8 fund code) is amended by adding at the end the fol-
9 lowing new section:

10 **“SEC. 9511. HEALTHY AMERICANS PUBLIC HEALTH TRUST**
11 **FUND.**

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

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

22 “(1) In the case of the second, third, and
23 fourth quarters of the first fiscal year in which cov-
24 erage under a HAPI plan begins under the Healthy
25 Americans Act, an amount equal to 90 percent of

1 the amount that would otherwise have been appro-
2 priated for the purpose of making payments to
3 States under section 1903(a) of the Social Security
4 Act for the Federal share of disproportionate share
5 hospital payments made under section 1923 of such
6 Act for such quarters of that fiscal year but for sub-
7 sections (c)(2) and (d)(2)(D) of section 1943 of the
8 such Act, as determined by the Secretary of Health
9 and Human Services.

10 “(2) In the case of each succeeding fiscal year,
11 an amount equal to 90 percent of the amount that
12 would otherwise have been appropriated for the pur-
13 pose of making payments to States under section
14 1903(a) of the Social Security Act for the Federal
15 share of disproportionate share hospital payments
16 made under section 1923 of such Act for that fiscal
17 year but for subsections (c)(1) and (d)(2)(D) of sec-
18 tion 1943 of such Act, as determined by the Sec-
19 retary of Health and Human Services, taking into
20 account the percentage change, if any, in the con-
21 sumer price index for all urban consumers (U.S. city
22 average) for the preceding fiscal year.

23 “(c) EXPENDITURES FROM TRUST FUND.—With re-
24 spect to each fiscal year for which transfers are made
25 under subsection (b), amounts in the Healthy Americans

1 Public Health Trust Fund shall be available for that fiscal
2 year for the following purposes:

3 “(1) PROVIDING PREMIUM AND PERSONAL RE-
4 SPONSIBILITY CONTRIBUTION SUBSIDIES.—For
5 making appropriations authorized under section 651
6 of the Healthy Americans Act for providing pre-
7 mium and personal responsibility contribution sub-
8 sidies in accordance with section 122 of such Act.

9 “(2) MAKING BONUS PAYMENTS TO STATES
10 FOR IMPLEMENTING MEDICAL MALPRACTICE RE-
11 FORM.—For making appropriations for bonus pay-
12 ments to States in accordance with section 802 of
13 such Act for implementing a State medical mal-
14 practice reform law that complies with subsection
15 (b) of such section.

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

22 (2) CLERICAL AMENDMENT.—The table of sec-
23 tions for such subchapter is amended by adding at
24 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 CHIP**

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 (21) the following
16 new paragraph:

17 “(22) 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 applicable fraction times, in the case of—

6 “(i) coverage of an individual, \$6,025,

7 “(ii) coverage of a married couple or
8 domestic partnership (as determined by a
9 State) without dependent children,
10 \$12,050,

11 “(iii) coverage of an unmarried indi-
12 vidual with 1 or more dependent children,
13 \$8,610, plus \$2,000 for each dependent
14 child, and

15 “(iv) coverage of a married couple or
16 domestic partnership (as determined by a
17 State) with 1 or more dependent children,
18 \$15,210, plus \$2,000 for each dependent
19 child.

20 “(B) APPLICABLE FRACTION.—For pur-
21 poses of subparagraph (A), the applicable frac-
22 tion is the fraction (not to exceed 1)—

23 “(i) the numerator of which is the
24 gross income of the taxpayer for the tax-
25 able year expressed as a percentage of the

1 poverty line (adjusted for the size of the
 2 family involved) minus such poverty line
 3 for the calendar year in which such taxable
 4 year begins, and

5 “(ii) the denominator of which is 400
 6 percent of the poverty line (adjusted for
 7 the size of the family involved) minus such
 8 poverty line.

9 “(C) PHASEOUT OF DEDUCTION
 10 AMOUNT.—

11 “(i) IN GENERAL.—The amount oth-
 12 erwise determined under subparagraph (A)
 13 for any taxable year shall be reduced by
 14 the amount determined under clause (ii).

15 “(ii) AMOUNT OF REDUCTION.—The
 16 amount determined under this clause shall
 17 be the amount which bears the same ratio
 18 to the amount determined under subpara-
 19 graph (A) as—

20 “(I) the excess of the taxpayer’s
 21 modified adjusted gross income for
 22 such taxable year, over \$62,500
 23 (\$125,000 in the case of a joint re-
 24 turn), bears to

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

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

6 “(D) INFLATION ADJUSTMENT.—In the
7 case of any taxable year beginning in a calendar
8 year after 2011, each dollar amount contained
9 in subparagraph (A) and subparagraph
10 (C)(ii)(I) shall be increased by an amount equal
11 to such dollar amount, multiplied by the cost-
12 of-living adjustment determined under section
13 1(f)(3) for the calendar year in which the tax-
14 able year begins, determined by substituting
15 ‘calendar year 2010’ for ‘calendar year 1992’ in
16 subparagraph (B) thereof. Any increase deter-
17 mined under the preceding sentence shall be
18 rounded to the nearest multiple of \$50 (\$1,000
19 in the case of the dollar amount contained in
20 subparagraph (C)(ii)(I)).

21 “(E) DETERMINATION OF MODIFIED AD-
22 JUSTED GROSS INCOME.—

23 “(i) IN GENERAL.—For purposes of
24 this paragraph, the term ‘modified ad-

1 justed gross income’ means adjusted gross
2 income—

3 “(ii) determined without regard to
4 this section and sections 86, 135, 137,
5 199, 221, 222, 911, 931, and 933, and

6 “(iii) increased by—

7 “(I) the amount of interest re-
8 ceived or accrued during the taxable
9 year which is exempt from tax under
10 this title, and

11 “(II) the amount of any social se-
12 curity benefits (as defined in section
13 86(d)) received or accrued during the
14 taxable year.

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

21 (b) CONFORMING AMENDMENT.—Section
22 213(d)(1)(D) of the Internal Revenue Code of 1986 is
23 amended by inserting “amounts paid under section 3421
24 and” after “including”.

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

5 **SEC. 665. MODIFICATION OF OTHER TAX INCENTIVES TO**
 6 **COMPLEMENT HEALTHY AMERICANS PRO-**
 7 **GRAM.**

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

13 “(h) TERMINATION.—This section shall not apply to
 14 payments made in any calendar year beginning at least
 15 2 years after the date of the enactment of the Healthy
 16 Americans Act.”.

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

19 (1) IN GENERAL.—Section 125 of the Internal
 20 Revenue Code of 1986 (relating to cafeteria plans)
 21 is amended by redesignating subsection (i) as sub-
 22 section (j) and by inserting after subsection (h) the
 23 following new subsection:

24 “(i) TERMINATION.—This section shall not apply to
 25 health benefits coverage in any calendar year beginning

1 at least 2 years after the date of the enactment of the
2 Healthy Americans Act.”.

3 (2) LONG-TERM CARE ALLOWED UNDER CAFE-
4 TERIA PLANS.—

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

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

13 (c) TERMINATION OF ARCHER MSA CONTRIBU-
14 TIONS.—Section 220 of the Internal Revenue Code of
15 1986 (relating to Archer MSAs) is amended—

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

20 (2) by adding at the end the following new sub-
21 section:

22 “(k) TERMINATION.—This section shall not apply to
23 contributions made in any calendar year beginning at least
24 2 years after the date of the enactment of the Healthy
25 Americans Act.”.

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

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

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

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

14 (C) by striking subparagraphs (B) and (C)
15 of subsection (c)(2) and by redesignating sub-
16 paragraph (D) of subsection (c)(2) as subpara-
17 graph (B), and

18 (D) by striking “HIGH” in the heading for
19 paragraph (2) of subsection (c) and inserting
20 “QUALIFIED HIGH”.

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

1 **PART II—CLARIFICATION OF ERISA TREATMENT;**
2 **TERMINATION OF COVERAGE UNDER OTHER**
3 **GOVERNMENTAL PROGRAMS AND TRANSI-**
4 **TION RULES FOR MEDICAID AND CHIP**

5 **SEC. 671. CLARIFICATION OF ERISA APPLICABILITY TO EM-**
6 **PLOYER-SPONSORED 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 include the provision of medical, surgical, or
11 hospital care or benefits through a HAPI plan described
12 under section 103 of 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 include any HAPI plan described under section 103 of the
20 Healthy Americans 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 includes health insur-
25 ance coverage offered to individuals through a HAPI plan

1 described under section 103 of the Healthy Americans
2 Act.”.

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

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

7 **“§ 8915. Termination**

8 “No contract shall be entered into under this chapter
9 or chapters 89A and 89B with respect to any coverage
10 period occurring in any calendar year beginning at least
11 2 years after the date of the enactment of the Healthy
12 Americans Act.”.

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

“8915. Termination.”.

16 **SEC. 673. MEDICAID AND CHIP.**

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

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

23 “SEC. 1943. (a) TRANSITION AND SUPPLEMENTAL
24 COVERAGE REQUIREMENTS.—The Secretary shall provide
25 technical assistance to States and health insurance issuers

1 of HAPI plans to ensure that individuals receiving medical
2 assistance under State Medicaid plans under this title or
3 child health assistance under child health plans under title
4 XXI are—

5 “(1) informed of—

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

9 “(B) each individual’s personal responsi-
10 bility—

11 “(i) for health care prevention;

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

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

21 “(2) provided with appropriate assistance in
22 transitioning from receiving medical assistance
23 under State Medicaid plans or child health assist-
24 ance under child health plans for their primary
25 health coverage to obtaining such coverage through

1 enrollment in HAPI plans in a manner that ensures
2 continuation of coverage for such individuals;

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

11 “(4) if the State elects to establish a State
12 Choices for Long-Term Care Program under section
13 1942 and the individual is likely to be eligible for the
14 program, informed of the coverage available under
15 the program and how to enroll.

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

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

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

4 “(c) CONTINUED SUPPORT FOR DSH EXPENDI-
5 TURES.—

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

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

1 1923(f) for that fiscal year so that each such DSH
2 allotment reflects a 90 percent reduction in the allot-
3 ment for the second, third, and fourth quarters of
4 that fiscal year.

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

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

18 “(2) no payment shall be made to a State
19 under section 1903(a) for any item or service fur-
20 nished after that date or for any other sums ex-
21 pended by a State for which a payment would have
22 been made under such section, other than for the
23 Federal medical assistance percentage of the total
24 amount expended by a State for each fiscal year
25 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 1942 (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 CHIP.—

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 1943(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 requirement to provide supplemental medical as-
2 sistance for targeted low-income children who
3 are provided child health assistance as optional
4 targeted low-income children under title
5 XIX).”.

6 (2) TERMINATION.—Title XXI of the Social Se-
7 curity Act is amended by adding at the end the fol-
8 lowing new section:

9 “TERMINATION
10 “SEC. 2111. Notwithstanding any other provision of
11 this title, no payment shall be made to a State under sec-
12 tion 2105(a) with respect to child health assistance for
13 any item or service furnished after December 31 of the
14 last calendar year ending before the first calendar year
15 in which coverage under a HAPI plan begins in accord-
16 ance with the Healthy Americans Act.”.

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 “(v)(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 “(B) not later than 180 days after the
3 date of the completion of the pilot program,
4 publish and make public the results of the pilot
5 program; and

6 “(C) include, as part of the published re-
7 sults under subparagraph (B), recommenda-
8 tions on how to assure that all medical school
9 curricula is updated on a regular basis to re-
10 flect best practices to improve quality and effi-
11 ciency in medical practice.”.

12 **SEC. 704. FINDING AFFORDABLE HEALTH CARE PRO-**
13 **VIDERS NEARBY.**

14 (a) **IN GENERAL.**—Not later than 2 years after the
15 date of enactment of this Act, the Secretary, in consulta-
16 tion with each HHA and health insurance issuers that
17 offer a HAPI plan, shall establish an Internet website to
18 assist covered individuals with locating health care pro-
19 viders in their State of residence who provide affordable,
20 high-quality health care services.

21 (b) **QUALITY OF CARE STANDARD.**—To develop the
22 information displayed on the website with respect to the
23 quality of care of a health care provider, the Secretary
24 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 **SEC. 713. PRIORITIZING HEALTH CARE EMPLOYMENT AND**
11 **TRAINING ACTIVITIES.**

12 (a) DEFINITIONS.—In this section:

13 (1) EMPLOYMENT AND TRAINING ACTIVITY.—
14 The term “employment and training activity”
15 means—

16 (A) a workforce investment activity;

17 (B) a program or activity described in sub-
18 section (b)(1)(B) of section 121 of such Act (29
19 U.S.C. 2841), and a program described in sub-
20 section (b)(2)(B) of such section if the entity
21 carrying out the program is a one-stop partner
22 for the one-stop delivery system involved, other
23 than the provision of housing, health insurance,
24 or another supportive service that is wholly un-
25 related to employment, service, or training as-

1 sistance (as determined by the Secretary of
2 Labor); and

3 (C) any other activity described in title I
4 or V of that Act (29 U.S.C. 2801 et seq., 9271
5 et seq.), other than the provision of housing,
6 health insurance, or another supportive service
7 that is wholly unrelated to employment, service,
8 or training assistance (as so determined).

9 (2) HEALTH CARE PROVIDERS.—The term
10 “health care providers” includes nurses and other
11 nonphysician providers.

12 (3) ONE-STOP PARTNER; WORKFORCE INVEST-
13 MENT ACTIVITY.—The terms “one-stop partner” and
14 “workforce investment activity” have the meanings
15 given the terms in section 101 of that Act (29
16 U.S.C. 2801).

17 (4) STIMULUS OR AUTHORIZATION FUNDS.—
18 The term “stimulus or authorization funds”
19 means—

20 (A) appropriations made available for fis-
21 cal year 2009, in an Act enacted after January
22 1, 2009, for a program that provides an em-
23 ployment and training activity; or

24 (B) appropriations made available for a
25 program that provides an employment and

1 training activity, if Congress has passed legisla-
2 tion after January 1, 2009, that

3 (i) becomes law; and

4 (ii)(I) authorizes appropriations for
5 such program; or

6 (II) extends the authorization of ap-
7 propriations for, or duration of, such pro-
8 gram.

9 (b) PRIORITY.—In using stimulus or authorization
10 funds to provide services for individuals, the Secretary of
11 Labor, or any other Federal officer to whom such funds
12 are made available, shall give priority to individuals who
13 seek employment in or training for positions as health care
14 providers.

15 (c) CONSTRUCTION.—No provision of law shall be
16 considered to supersede or modify this section unless the
17 provision refers specifically to this section.

18 **TITLE VIII—CONTAINING MED-**
19 **ICAL COSTS AND GETTING**
20 **MORE VALUE FOR THE**
21 **HEALTH CARE DOLLAR**

22 **SEC. 801. COST-CONTAINMENT RESULTS OF THE HEALTHY**
23 **AMERICANS ACT.**

24 Congress finds that the Healthy Americans Act will
25 result in the following:

1 (1) Private insurance companies will be forced
2 to hold down costs and will slow the rate of growth
3 because they are required to offer standardized
4 Healthy American Private Insurance plans.

5 (2) Administrative savings will be derived from
6 reducing employers' and insurers' administrative
7 costs relating to health care.

8 (3) Private insurance companies will implement
9 uniform billing and common claims forms.

10 (4) Congress will reclaim Medicare and Med-
11 icaid disproportionate share hospital (DSH) pay-
12 ments because previously uninsured persons will go
13 to providers on an outpatient basis instead of an
14 emergency department.

15 (5) State and local governments will save
16 money on programs they operated for the uninsured
17 before enactment of this Act.

18 (6) The Federal Government will save money
19 on Federal tax subsidies that reward inefficient care
20 and are regressive.

21 (7) The Federal Government and the private
22 sector will save money if the Food and Drug Admin-
23 istration determines whether products provide new
24 value.

1 (8) Reducing medical errors will save the gov-
2 ernment and the private sector money.

3 (9) Requiring hospitals to send large bills to pa-
4 tients for their review will reduce errors in medical
5 billing and force major providers to be more cost
6 conscious.

7 (10) Requiring insurers to reimburse for quality
8 and cost effective services will hold down private sec-
9 tor costs.

10 (11) Reduction of Medicare's restriction on bar-
11 gaining power for prescription drugs will reduce
12 costs for sole source drugs and other medications.

13 (12) Establishment of electronic medical
14 records by insurers will create savings.

15 (13) Publication of cost and quality data will
16 enable people to look up by zip code affordable high-
17 quality providers.

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