

111TH CONGRESS  
1ST SESSION

# H. R. 1940

To amend the Public Health Service Act to establish a Wellness Trust.

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## IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 2009

Ms. MATSUI (for herself, Mr. BRALEY of Iowa, Mrs. CAPPS, and Mr. SARBANES) introduced the following bill; which was referred to the Committee on Energy and Commerce

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## A BILL

To amend the Public Health Service Act to establish a  
Wellness Trust.

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.**

4       This Act may be cited as the “Wellness Trust Act”.

5       **SEC. 2. FINDINGS AND PURPOSE.**

6       (a) FINDINGS.—Congress finds as follows:

7               (1) Preventable and chronic diseases are the  
8       epidemic of the 21st century. The number of people  
9       with chronic conditions is rapidly increasing and it  
10      is estimated that, if there is no intervention now, by

1       2025 nearly half of the United States population will  
2       suffer from at least 1 chronic disease. About 70 per-  
3       cent of deaths and health costs in the United States  
4       are attributable to chronic diseases (such as cardio-  
5       vascular disease and cancer), some of which may be  
6       preventable. Nearly 90 percent of Medicare bene-  
7       ficiaries have some type of chronic illness.

8               (2) This affects Americans' health. The United  
9       States has the highest rate of preventable deaths  
10      among 19 industrialized nations and lags behind 28  
11      other nations in life expectancy. For example, obe-  
12      sity, which is rising rapidly, contributes to a wide  
13      range of problems, from diabetes to stroke to cancer.  
14      The life expectancy for a 20-year old man may be  
15      reduced by 17 percent due to obesity. If trends con-  
16      tinue, children's life spans may be shorter than  
17      those of their parents for the first time in about a  
18      century.

19              (3) The wellness gap also affects health care  
20      costs. About 78 percent of all health spending in the  
21      United States is attributable to chronic illness, much  
22      of which is preventable. Chronic diseases cost the  
23      United States an additional \$1,000,000,000,000  
24      each year in lost productivity, and are a major con-  
25      tributing factor to the overall poor health that is

1 placing the Nation's economic security and competi-  
2 tiveness in jeopardy.

3 (4) Unlike some health care challenges, proven  
4 preventive services and programs exist. If effective  
5 risk reduction were implemented and sustained by  
6 2015, the death rate due to cancer could drop by 29  
7 percent. Improved blood sugar control for people  
8 with diabetes could reduce the risk for eye disease,  
9 kidney disease, and nerve disease by 40 percent.  
10 Similarly, blood pressure control could reduce the  
11 risk for heart disease and stroke by 33 to 50 per-  
12 cent.

13 (5) Yet, only half of recommended clinical pre-  
14 ventive services are provided to adults. About 20  
15 percent of children do not receive all recommended  
16 immunizations, with higher rates in certain areas.  
17 Nearly 70 percent of people with high blood pressure  
18 do not now control it. And racial disparities in use  
19 of prevention exist.

20 (6) The United States faces low use of preven-  
21 tive services because of the low value placed on pre-  
22 vention, a delivery system bent toward fixing rather  
23 than preventing problems, and financial disincentives  
24 for prevention. Insurers have little incentive to invest  
25 in preventive services today that will benefit other

1 insurers tomorrow. This is especially true for those  
2 preventive services that reduce chronic diseases that  
3 develop over a period of several years or decades.  
4 The costs of prevention are incurred immediately  
5 but most of its benefits are realized later, often by  
6 Medicare.

7 (7) There is a low investment in prevention.  
8 The United States spends only an estimated 1 to 3  
9 percent of national health expenditures on preventive  
10 health care services and health promotion. This has  
11 not increased as much as one might expect since  
12 1929, 1.4 percent, despite the development of expen-  
13 sive screenings, early interventions, and the growth  
14 of the preventable disease burden.

15 (8) The workforce to deliver prevention is also  
16 insufficient. The supply of providers who are trained  
17 to emphasize prevention is shrinking. Between 1997  
18 and 2005, the number of medical school graduates  
19 entering family practice residencies dropped by 50  
20 percent. There is an acute shortage of community  
21 health workers. Between 25 and 50 percent of the  
22 existing Federal, State, and local public health work-  
23 force is eligible for retirement in the next 5 years.  
24 As of 2008, more than 75 percent of the existing  
25 public health workforce has no formal public health

1 or prevention training. There is no national, uniform  
2 credentialing system for public health or prevention  
3 workers that would ensure that these workers are  
4 trained in the basics of preventive care.

5 (9) A system that promoted full use of high-pri-  
6 ority prevention could save lives. A recent com-  
7 prehensive assessment found that 1,200,000 quality-  
8 adjusted life years could be saved by achieving 90  
9 percent use of just the following 3 services:

10 (A) Smoking cessation counseling.

11 (B) Use of aspirin to prevent heart at-  
12 tacks.

13 (C) Screening for colorectal cancer.

14 (10) A system that promoted full use of high-  
15 priority prevention could reduce costs. For example,  
16 complete, routine childhood vaccination could save  
17 up to \$40,000,000,000 in direct and societal costs  
18 over time. Promoting screenings and behavioral  
19 modifications in the workplace can lower absentee-  
20 ism and, in most cases, health costs to firms. Pre-  
21 ventive health care services could reduce government  
22 spending on health care. If all elderly received a flu  
23 vaccine, health costs could be reduced by nearly  
24 \$1,000,000,000 per year. Over 25 years, Medicare  
25 could save an estimated \$890,000,000,000 from ef-

1       fective       control       of       hypertension,       and  
 2       \$1,000,000,000,000 from returning to levels of obe-  
 3       sity observed in the 1980s.

4           (11) Investing in community-level interventions  
 5       that promote and enable proper nutrition, increased  
 6       access to physical activity, and smoking cessation  
 7       programs can prevent and mitigate chronic diseases,  
 8       improve quality of life, increase economic produc-  
 9       tivity, and reduce healthcare costs.

10       (b) PURPOSE.—The purpose of this Act is to create  
 11   a 21st century prevention system called the Wellness  
 12   Trust that assures access to clinical and community-level  
 13   prevention services that improve health, quality of life, and  
 14   reduce healthcare costs.

15   **SEC. 3. WELLNESS TRUST.**

16       Title III of the Public Health Service Act (21 U.S.C.  
 17   241 et seq.) is amended by adding at the end the fol-  
 18   lowing:

19                   **“PART S—WELLNESS TRUST**

20   **“SEC. 399KK. DEFINITIONS; ESTABLISHMENT OF WELLNESS**  
 21                   **TRUST.**

22       “(a) DEFINITIONS.—In this part:

23           “(1) CERTIFIED PREVENTION HEALTH WORK-  
 24       ER.—The term ‘certified prevention health worker’  
 25       means a licensed health professional, a public health

1 professional employed by a State or local public  
 2 health agency, or any other health worker deemed  
 3 certified by the Trustees.

4 “(2) PREVENTION HEALTH ENTITY.—The term  
 5 ‘prevention health entity’ means a State or local  
 6 public health agency or other community-based pre-  
 7 vention entity deemed to be an eligible Trust partici-  
 8 pant by the Trustees.

9 “(3) TRUST.—The term ‘Trust’ means the  
 10 Wellness Trust established under subsection (b).

11 “(4) TRUSTEES.—The term ‘Trustees’ means  
 12 the members of the Trust Fund Board appointed  
 13 under section 399LL(b).

14 “(b) ESTABLISHMENT OF THE WELLNESS TRUST.—  
 15 There is established within the Centers for Disease Con-  
 16 trol and Prevention the Wellness Trust.

17 **“SEC. 399LL. STRUCTURE.**

18 “(a) TRUST FUND BOARD.—The Trust shall be  
 19 headed by the Trust Fund Board.

20 “(b) COMPOSITION.—The Trust Fund Board shall be  
 21 composed of 7 members appointed by the President by and  
 22 with the advice and consent of the Senate.

23 “(c) DATE OF APPOINTMENTS.—The initial 7 Trust-  
 24 ees shall be appointed not later than December 31, 2009.

1       “(d) STAGGERED TERMS.—Of the members first ap-  
2 pointed under subsection (c)—

3               “(1) 4 shall be appointed for a period of 4  
4 years; and

5               “(2) 3 shall be appointed for a period of 3  
6 years.

7       “(e) VACANCIES.—A vacancy on the Trust Fund  
8 Board—

9               “(1) shall not affect the powers of the Trust  
10 Fund Board; and

11               “(2) shall be filled in the same manner as the  
12 original appointment was made.

13       “(f) MEETINGS.—The Trust Fund Board shall meet  
14 at the call of the Chairperson.

15       “(g) QUORUM; REQUIRED VOTES.—A majority of  
16 Trustees shall constitute a quorum for purposes of voting,  
17 but a lesser number of members may hold hearings. The  
18 Chairperson shall require a vote of the Trustees on major  
19 decisions regarding prevention priorities, resource alloca-  
20 tion, delivery system structure, and other Trust functions.

21       “(h) CHAIRPERSON AND VICE CHAIRPERSON.—The  
22 Trust Fund Board shall select a Chairperson and Vice  
23 Chairperson from among the Trustees.

24       “(i) REMOVAL.—A Trustee may be removed by the  
25 President only for cause.



1       “(j) RECOMMENDATIONS.—The Trustees may submit  
2 recommendations directly to Congress, without oppor-  
3 tunity for comment or change by the Secretary.

4       “(k) STAFF.—The Trustees may employ and fix the  
5 compensation of personnel as necessary. Not more than  
6 5 percent of the funds appropriated in a fiscal year to  
7 the Trust Fund established under section 399NN may be  
8 used to fund the staff, operations, and other purposes as  
9 the Trustees determine appropriate of the Trust Fund  
10 Board, subject to the oversight of the Secretary.

11   **“SEC. 399MM. REPORTS; PLAN FOR DELIVERY SYSTEMS.**

12       “(a) DEVELOPMENT OF KEY REPORTS.—Not later  
13 than 1 year after the appointment of the Trustees under  
14 section 399LL(c), the Trustees shall submit to Congress  
15 and make publicly available the following reports:

16           “(1) REPORT ON BROADENING THE PREVEN-  
17 TION WORKFORCE.—A report that develops and de-  
18 scribes a system for certification and recertification  
19 of ‘prevention health workers’ to complement the  
20 health system and public health infrastructure as in  
21 existence at the time of such report. Such system  
22 may expand certification efforts in existence at the  
23 time of such report for the public health workforce  
24 and community health workers. Such report shall  
25 also examine the impact of State licensing require-

1       ments and explore and describe options for health  
2       profession training and continuing education, 1 or  
3       more registries of certified prevention health work-  
4       ers, and an employment structure that encourages  
5       flexible deployment but protects prevention health  
6       workers' benefits.

7               “(2) REPORT ON ALIGNING PAYMENTS WITH  
8       PREVENTION GOALS.—A report that examines and  
9       describes payment methodologies and presents op-  
10      tions for paying certified prevention health workers  
11      for clinical preventive care that aligns incentives  
12      with goals, as well as payment methodologies for  
13      community organizations involved in the provision of  
14      prevention services. Such report shall address the  
15      shortfalls of the payment systems in existence at the  
16      time of such report that have not proven effective at  
17      encouraging the provision of prevention services.

18              “(3) REPORT ON IDENTIFYING EXISTING FUND-  
19      ING FOR PREVENTION.—A report that examines and  
20      describes the amount of money spent on prevention  
21      by public health, public and private health insurers,  
22      and applicable self-insured health plans (as defined  
23      in section 3990O) during the most recent year for  
24      which such data is available.

1 “(b) PLAN FOR DELIVERY SYSTEMS.—Not later than  
2 1 year after the appointment of the Trustees under section  
3 399LL(c), the Trustees shall establish a plan for deliv-  
4 ering and financing prevention priorities and imple-  
5 menting pilot programs. Such plan shall include—

6 “(1) identifying effective delivery systems based  
7 on evidence and expert judgment to determine how  
8 best to deliver priority clinical and community-based  
9 prevention activities;

10 “(2) assessing the current capacity of effective  
11 delivery systems and community infrastructure and  
12 actions necessary to ensure adequate infrastructure  
13 and capacity to deliver priority clinical and commu-  
14 nity-based prevention activities as determined by the  
15 Trust; and

16 “(3) identifying cost-saving clinical and commu-  
17 nity-based interventions to implement before Decem-  
18 ber 31, 2011, which shall include evidence-based  
19 interventions in obesity, diabetes, heart disease, and  
20 cancer.

21 **“SEC. 399NN. INFRASTRUCTURE AND PRIORITIES.**

22 “(a) DESIGNATING NATIONAL PREVENTION PRIOR-  
23 ITIES.—The Trustees shall issue and annually update a  
24 ranked list of designated ‘prevention priorities’. The inclu-  
25 sion of an activity on such list shall be based on the poten-

1 tial of such activity to improve health and the cost effec-  
 2 tiveness of such activity. Such list shall—

3 “(1) include clinical preventive services and  
 4 community-based interventions; and

5 “(2) be used by the Trustees to—

6 “(A) determine what prevention services  
 7 and community-based interventions shall be  
 8 paid for through the Trust Fund under section  
 9 39900;

10 “(B) allocate resources within the Trust;

11 “(C) educate the public on critical preven-  
 12 tion priorities; and

13 “(D) emphasize coverage and use within  
 14 existing authorities.

15 “(b) CREATION AND SUPPORT OF INFRASTRUC-  
 16 TURE.—The Trustees shall establish and otherwise sup-  
 17 port and sustain the infrastructure for an effective  
 18 wellness system, including the following components:

19 “(1) CENTRAL SOURCE OF PREVENTION INFOR-  
 20 MATION.—A centralized, national, easily accessible  
 21 information clearinghouse on prevention priorities  
 22 and community-based interventions that shall—

23 “(A) be made available in multiple media;

24 “(B) be updated regularly; and

1           “(C) connect individuals, health care pro-  
2           viders, State and local health departments, and  
3           others to national and local resources that sup-  
4           port the designated prevention priorities under  
5           subsection (a).

6           “(2)    QUALIFIED    ELECTRONIC    HEALTH  
7           RECORDS.—The use and integration of qualified  
8           electronic health records (as defined in section  
9           3000(13))—

10           “(A) to track provision of prevention over  
11           the course of individuals’ lifetimes;

12           “(B) to facilitate reimbursement of cer-  
13           tified prevention health workers and prevention  
14           health entities; and

15           “(C) to assist in evaluations of the efficacy  
16           of the policies of the Wellness Trust.

17           “(3)    SYSTEM    FOR    TRAINING    AND  
18           CREDENTIALING PREVENTION HEALTH WORKERS.—  
19           A system for training and credentialing prevention  
20           health workers and prevention health entities  
21           through agencies such as the Health Resources and  
22           Services Administration and the Centers for Disease  
23           Control and Prevention. In establishing and imple-  
24           menting such system, the Trustees shall—

1           “(A) provide funding to such agencies  
2           through the Trust Fund under section 3990O;

3           “(B) establish a central registry of cer-  
4           tified prevention health workers and prevention  
5           health entities; and

6           “(C) encourage such workers to access ad-  
7           ditional training.

8   **“SEC. 3990O. FUNDING FOR WELLNESS TRUST.**

9           “(a) INITIAL FUNDING.—There is authorized to be  
10          appropriated and there is appropriated to the Trust Fund  
11          Board such sums as may be necessary to carry out sec-  
12          tions 399MM and 399NN and other activities necessary  
13          for the implementation of this part.

14          “(b) ESTABLISHMENT OF WELLNESS TRUST  
15          FUND.—Not later than January 1, 2011, there shall be  
16          established in the Treasury of the United States a trust  
17          fund to be known as the ‘Wellness Trust Fund’ (referred  
18          to in this section as the ‘Trust Fund’), consisting of such  
19          amounts as are appropriated or credited to the Fund as  
20          provided under this section.

21          “(c) APPROPRIATIONS TO THE FUND.—

22                 “(1) FISCAL YEAR 2011.—There is hereby ap-  
23          propriated to the Trust Fund for fiscal year 2011 an  
24          amount equal to the amount spent by all Federal  
25          health programs to pay for prevention services (as

1 defined by the Preventive Services Task Force con-  
2 vened under section 915, except the definition of  
3 such services shall not be limited to those designated  
4 by the Task Force) in the most recent year for  
5 which complete data is available, as estimated by the  
6 Trustees.

7 “(2) FISCAL YEAR 2012.—There is hereby ap-  
8 propriated to the Trust Fund for fiscal year 2012  
9 the amount appropriated to the Trust Fund for the  
10 previous fiscal year, increased by the annual percent-  
11 age increase in the medical care component of the  
12 consumer price index (United States city average)  
13 for the 12-month period ending with April of the  
14 preceding fiscal year.

15 “(3) FISCAL YEAR 2013 AND SUBSEQUENT  
16 YEARS.—There is hereby appropriated to the Trust  
17 Fund for fiscal year 2013 and each subsequent fiscal  
18 year an amount equal to the sum of—

19 “(A) the amount appropriated to the Trust  
20 Fund for the previous fiscal year, increased by  
21 the annual percentage increase in the medical  
22 care component of the consumer price index  
23 (United States city average) for the 12-month  
24 period ending with April of the preceding fiscal  
25 year;

1 “(B) the amount collected by the Secretary  
2 from health insurance issuers and applicable  
3 self-insured health plans under subsection (d)  
4 for the fiscal year; and

5 “(C) the amount associated with preven-  
6 tion priorities for State and local spending,  
7 under-use, and the uninsured for the fiscal  
8 year, as estimated by the Trustees (which shall  
9 not exceed the amount equal to 10 percent of  
10 the amount otherwise appropriated to the Trust  
11 Fund for the fiscal year).

12 “(4) AVAILABILITY.—Amounts appropriated  
13 pursuant to this subsection shall remain available  
14 until expended.

15 “(d) ASSESSMENT OF HEALTH INSURANCE ISSUERS  
16 AND APPLICABLE SELF-INSURED HEALTH PLANS.—

17 “(1) IN GENERAL.—Beginning in fiscal year  
18 2013 and on an annual basis thereafter, the Sec-  
19 retary shall, subject to paragraph (2), assess and  
20 collect a fee from each health insurance issuer and  
21 each applicable self-insured health plan in an  
22 amount equal to the estimated amount spent by  
23 such health insurance issuer and self-insured health  
24 plan, respectively, for prevention services (as defined  
25 by the Trustees).



1           “(2) COLLECTION AMOUNT ADJUSTMENT BE-  
 2           GINNING IN FISCAL YEAR 2013.—The amount deter-  
 3           mined under paragraph (1) shall, on an annual  
 4           basis, be increased by the annual percentage in-  
 5           crease in the medical care component of the con-  
 6           sumer price index (United States city average) for  
 7           the 12-month period ending with April of the pre-  
 8           ceding fiscal year.

9           “(e) DEFINITIONS.—In this section:

10           “(1) APPLICABLE SELF-INSURED HEALTH  
 11           PLAN.—The term ‘applicable self-insured health  
 12           plan’ means any plan for providing accident or  
 13           health coverage if—

14                   “(A) any portion of such coverage is pro-  
 15                   vided other than through an insurance policy;  
 16                   and

17                   “(B) such plan is established or main-  
 18                   tained—

19                           “(i) by 1 or more employers for the  
 20                           benefit of their employees or former em-  
 21                           ployees;

22                           “(ii) by 1 or more employee organiza-  
 23                           tions for the benefit of their members or  
 24                           former members;

1 “(iii) jointly by 1 or more employers  
2 and 1 or more employee organizations for  
3 the benefit of employees or former employ-  
4 ees;

5 “(iv) by a voluntary employees’ bene-  
6 ficiary association described in section  
7 501(c)(9) of the Internal Revenue Code of  
8 1986;

9 “(v) by any organization described in  
10 section 501(c)(6) of such Code; or

11 “(vi) in the case of a plan not de-  
12 scribed in the preceding clauses, by a mul-  
13 tiple employer welfare arrangement (as de-  
14 fined in section 3(40) of the Employee Re-  
15 tirement Income Security Act of 1974), a  
16 rural electric cooperative (as defined in  
17 section 3(40)(B)(iv) of such Act), or a  
18 rural telephone cooperative association (as  
19 defined in section 3(40)(B)(v) of such  
20 Act).

21 “(2) HEALTH INSURANCE ISSUER.—The term  
22 ‘health insurance issuer’ means an insurance com-  
23 pany, insurance service, or insurance organization  
24 (including a health maintenance organization, as de-  
25 fined in paragraph (3)) which is licensed to engage

1 in the business of insurance in a State and which is  
 2 subject to State law which regulates insurance (with-  
 3 in the meaning of section 514(b)(2) of the Employee  
 4 Retirement Income Security Act of 1974).

5 “(3) HEALTH MAINTENANCE ORGANIZATION.—  
 6 The term ‘health maintenance organization’  
 7 means—

8 “(A) a Federally qualified health mainte-  
 9 nance organization (as defined in section  
 10 1301(a));

11 “(B) an organization recognized under  
 12 State law as a health maintenance organization;  
 13 or

14 “(C) a similar organization regulated  
 15 under State law for solvency in the same man-  
 16 ner and to the same extent as such a health  
 17 maintenance organization.

18 **“SEC. 399PP. INSURING PREVENTION PRIORITIES.**

19 “(a) WELLNESS TRUST AS PRIMARY PAYER FOR  
 20 PREVENTION SERVICES.—The Trust shall enter into con-  
 21 tracts with certified prevention health workers and preven-  
 22 tion health entities to reimburse such workers and entities  
 23 for the prevention services and community-based interven-  
 24 tions designated by the Trustees under section 399NN as  
 25 prevention priorities.

1       “(b) PRIORITIES.—The Trustees shall develop annual  
2 and 5-year budget targets for the designated prevention  
3 priorities under section 399NN, including clinical preven-  
4 tive services and community-based interventions. The  
5 Trustees shall publish annually a list indicating which of  
6 these prevention priorities are eligible for funding through  
7 the Fund.

8       “(c) ELIGIBLE INDIVIDUALS AND ENTITIES.—Pursu-  
9 ant to the contracts described under subsection (a), the  
10 Trust shall reimburse certified prevention health workers  
11 and prevention health entities for the prevention services  
12 and community-based interventions described under such  
13 subsection provided to all individuals who are United  
14 States citizens or legal immigrants, without regard to the  
15 insurance status of such individuals.

16       “(d) DEVELOPMENT, REFINEMENT, AND CHANGE OF  
17 PAYMENT SYSTEMS.—The Trustees shall determine pay-  
18 ment methodologies for prevention priorities. Such pay-  
19 ment methodologies shall correspond to the following tiers  
20 of activity:

21               “(1) COMPETITIVE CONTRACTING AUTHOR-  
22 ITY.—The Trustees shall have a competitive con-  
23 tracting authority for the national delivery system  
24 activities.

1           “(2) DIRECT PAYMENT SYSTEMS.—The Trust-  
2       ees shall develop different payment methodologies  
3       for the various designated prevention services and  
4       community-based interventions. These payment sys-  
5       tems shall take into account existing rates, rates for  
6       similar services, and whether geographic adjustment  
7       is needed. Such systems shall link the priority of the  
8       service with payments.

9           “(3) USE OF STATE AND LOCAL GRANT SYS-  
10       TEMS.—The Trustees shall utilize existing grant  
11       programs where feasible to distribute funds from the  
12       Trust Fund for prevention priorities.

13          “(4) REPORTS FROM FEDERAL PROGRAMS.—  
14       Programs that receive funding for prevention prior-  
15       ities through the Trust Fund shall report annually  
16       to Congress on the extent to which this funding dis-  
17       places existing spending on prevention priorities.

18          “(e) PARTNERSHIP WITH MEDICARE AND OTHER IN-  
19       SURERS.—The Trustees shall determine the most efficient  
20       way to transfer funds from the Trust Fund to certified  
21       prevention health workers and prevention health entities.  
22       In making such determination, the Trustees shall carry  
23       out the following:

24               “(1) COORDINATION WITH MEDICARE.—The  
25       Trustees shall examine the use of Medicare systems

for direct payments to certified prevention health workers and prevention health entities. Any additional administrative cost associated with the use of the payment systems, including those of a broader set of providers, shall come from the Trust Fund.

“(2) CONTRACT WITH OTHER INSURERS.—To the extent that the Medicare program, private insurers, or States prove that such program, insurer, or State has the capacity to deliver prevention priorities in a cost effective manner, the Trustees may contract with such entity for delivery of prevention services covered under this Trust Fund.”.

**SEC. 4. INTEGRATION OF PREVENTION HEALTH RECORD.**

Title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.) is amended—

(1) in section 3000(13)(B)—

(A) in clause (iii), by striking “and” at the end;

(B) in clause (iv), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(v) to track the provision of prevention health care over the course of the individual’s lifetime and assist in evaluations

1 of the efficacy of prevention priorities des-  
2 ignated under section 399NN.”;

3 (2) in section 3002(b)(2)(B), add at the end  
4 the following:

5 “(ix) The integration and inclusion of  
6 preventive and community-based health  
7 care services in any qualified electronic  
8 health record, in order to allow individuals  
9 and caregivers to track the provision of  
10 preventive health care services.”; and

11 (3) in section 3011(a), add at the end the fol-  
12 lowing:

13 “(8) Integration of prevention health priorities,  
14 prevention data, and tracking of the provision of  
15 preventive care by means of qualified electronic  
16 health records.”.

○